Bradley #4

AMENDMENT STRIKING 10% FEE ON CHILD SUPPORT COLLECTIONS

INTRODUCED BY SENATOR BRADLEY

Proposal Strike the provision requiring states to impose a 10% fee on all child support payments collected through the Child Support Enforcement program.

Rationale The provision in the Chairman's mark takes money away from single parents payments in order to meet federal budget deficit goals. The money would be taken from the amount which the court has determined that the parent requires to meet their child-raising responsibilities. In addition, this provision charges single parents a high price for having a court order enforced.

Nursing Home Quality of Care

Amendment to Medigrant Bill

Offered by Sen. David Pryor / Rockefeller

Proposal: Maintain current federal standards, survey and certification process, and enforcement mechanism to ensure quality of care in nursing homes.

The amendment would reinstate the nursing home reform provisions enacted as part of the Omnibus Budget Reconciliation Acts of 1987, 1989, and 1990, appearing at 42 USCS @ 1396r, "Requirements for nursing facilities." All current provisions would be retained.

Cost Impact: No expected cost impact. The aggregate cap in the Medigrant bill would not be revised as a result of this amendment.

HCFA Approval of State
Nursing Home Standards
Amendment to Medigrant Bill
Offered by Sen. David Pryor

Proposal: To provide for Federal approval of State nursing home quality standards.

The amendment would require all States to submit their proposed nursing home quality standards as part of their state plan to the Health Care Financing Administration for approval before being approved to participate in the Medigrant program. This is to ensure that States adequately provide for protection of frail nursing home residents.

Cost Impact: No expected cost impact. The aggregate cap in the Medigrant bill would not be revised as a result of this amendment.

Medicaid Drug Rebate Program

Amendment to MediGrant bill

Offered by Sen. David Pryor

Proposal: Retain the Medicaid drug rebate program as an option for state Medicaid programs. The amendment would strike bill language repealing the Medicaid drug rebate program, effective October 1, 1998. States may elect to participate in the existing rebate program or to negotiate and implement rebates independently.

Cost Impact: Continuation of a voluntary Medicaid drug rebate program would generate additional Federal and state savings after October 1, 1998. The aggregate cap in the MediGrant bill would not be revised as a result of this amendment.

Medicaid Drug Rebate Program

Amendment to MediGrant bill

Offered by Sen. David Pryor

Proposal: Maintain current inclusion of nursing facilities in the Medicaid drug rebate program. The amendment would strike bill language excluding nursing facilities from the rebate program. States may elect to exclude nursing facilities, if their unit drug acquisition costs are shown to be equal or lower than historic unit costs under existing rebate agreements.

Cost Impact: Continued inclusion of nursing facilities would generate additional Federal and state savings. The aggregate cap in the MediGrant bill would not be revised as a result of this amendment.

Medicaid Drug Rebate Program

Amendment to MediGrant bill

Offered by Sen. David Pryor

Proposal: The Secretary of HHS shall convene a task force for the purpose of determining whether the Medicaid drug rebate program should be retained or repealed. The task force shall be convened no later than June 1, 1998, and shall report its findings to the Secretary by October 1, 1998.

The report shall assess the extent to which state Medicaid programs rely on the drug rebate program to manage prescription drug expenditures; the impact of repeal of the drug rebate program on recipient access to prescription drugs and pharmacy services; and the likely actions states would take to manage prescription drug expenditures in the absence of drug rebate revenue.

The task force shall consist of volunteer representatives appointed by: the chair and vice chair of the National Governors Association (NGA); the State Medicaid Directors Association; associations representing the prescription and generic drug industries; an association representing pharmacies; and an association representing the interests of Medicaid recipients.

The report shall be transmitted to the Senate Committee on Finance, House Committee on Commerce and the Senate Special Committee on Aging.

Cost Impact: No expected cost impact. The aggregate cap in the MediGrant bill would not be revised as a result of this amendment.

Medicaid Drug Rebate Program

Amendment to MediGrant bill

Offered by Sen. David Pryor

Proposal: Provide for rebate master agreements and statutory definitions necessary to the implementation of the Veterans Health Care Act of 1992 (P.L. 102-585).

The amendment reinstates the requirement that drug manufacturers sign rebate master agreements with the Secretary of Veterans Affairs. The Department of Veterans Affairs and the Veterans Health Administration manage a prescription drug rebate program wholly independent of the Medicaid rebate program. The Veterans Health Care Act refers to specific provisions in the Medicaid statute (section 1927 of the Social Security Act), including key definitions. The amendment would provide such definitions, solely for the purposes of the rebate agreements reached under the Veterans Health Care Act.

Cost Impact: No expected cost impact. The aggregate cap in the MediGrant bill would not be revised as a result of this amendment.

Pryor #7

FINAL VERSION

QUALITY STANDARDS FOR COORDINATED CARE PLANS
Amendment to the Chairman's Mark (Medicare Choice)
Offered by Senator David Pryor

PROPOSAL: The amendment would restore existing regulations and laws pertaining to quality standards that apply to Medicare risk plans (Social Security Act, Section 1876), repealed or altered under the Mark. In addition, new provisions described here would supplement these current regulations and laws.

These new enrollee-protection provisions - as would existing laws and regulations - would apply to all coordinated care organizations that accept Medicare beneficiaries. including HMOs, preferred provider organizations, and "provider service networks" (all referred to in this document as "plans").

The following are the new quality assurance standards that would be added to those already in place in Section 1876.

1. **Access To Services/Appeals Process**

The Secretary shall:

- Provide information to enrollees concerning their rights to appeal plans' decisions not to provide covered services and their rights to address grievances with their health plans to HCFA and the Peer Review Organizations, at time of enrollment and on an annual basis (insert p. 13).
- Ensure that participating plans respond to the request for health services of enrollees in a reasonable amount of time after the request is made. The Secretary would also ensure that plans respond to enrollees' appeals in a reasonable amount of time. The Secretary shall define "reasonable" and may establish different timetables for different types of medical conditions and services (insert page 15).
- Review in an expedited manner plan denials for cases in which denial of care could result in significant harm (insert page 15).

2. **Data Collection, Analysis, and Dissemination**

The Secretary shall:

- Establish and integrate into ongoing external quality assurance activities a

new set of quality indicators, developed specifically for the Medicare population, that would be used to determine whether a plan is providing quality care and appropriate continuity and coordination of care (insert p. 15).

- Require plans to report complete encounter data, including data on physician visits, nursing home days, home health days, hospital inpatient days, and rehabilitation services, using HCFA Form 1500, UB92, or any other form selected by the Secretary (insert p. 15).
- Require plans to provide information to prospective enrollees on the plans' specialist referral process, and on request, the number of referrals to specialists requested by the enrollee and the primary care provider that were denied and reasons for these denials (insert p. 13).
- Publish for use by beneficiaries (i) comparative data it collects on plans such as complaint rates, disenrollment rates, and rates and outcomes of appeals, and (ii) the results of its major investigations or any findings of significant noncompliance by plans (insert p. 13).

3. **Marketing Protections/Enrollment And Disenrollment Issues**

The Secretary shall:

- Require plans to provide standardized, easy-to-read, information at all marketing presentations describing the rules of plan enrollment, including "lock-in" and requirements for referrals to specialty care (insert p. 13).
- Prohibit the payment of commissions to plan marketing agents if a new enrollee disenrolls within three months of enrollment (insert p. 11).
- Prohibit plans' sales agents from visiting the residence of eligible enrollees for purposes of enrolling the individual or providing enrollment information to the individual other than at the individual's request (insert p. 13).

COST IMPACT: No expected cost impact. Under current law, as explained in Social Security 1876(i)(7)(B), the cost of managed care quality oversight activities are born by the health plans.

Rockefeller Medicaid Amendment #1

As a condition of receipt of federal Medicaid funding, each state will cover all children, under age 19 years of age, living under 100% of federal poverty and all pregnant women living under 185% of federal poverty.

Rockefeller Medicaid Amendment #2

As a condition of receipt of federal Medicaid funding, each state will cover all Qualified Medicare Beneficiaries, as defined in the Social Security Act, and all individuals with a diagnosis of Alzheimer's disease living under 100% of federal poverty.

Rockefeller Medicaid Amendment #3

Insert in the appropriate section referencing state payment rates to hospitals and skilled nursing facilities the language from Title XIX of the Social Security Act, Section 1902 (a)(13)(A):

"for payment, which the state finds, and makes satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations, quality and safety standards ...."

insert due process protections for providers

Rockefeller Medicaid Amendment #4

The Congressional Budget Office shall prepare an analysis of the effects of the changes in the Medicaid program on the health insurance status of each of the following populations: 1) children, 2) the elderly, and 3) the disabled. This report shall be made annually, and submitted to the Committees of jurisdiction of the Medicaid program, the Senate Finance and House Commerce Committees, by May 15th.

Rockefeller Medicaid Amendment #5

As a condition of receipt of federal Medicaid funds, each state shall insure that Medicaid beneficiaries have access to primary care services within 30 miles of their residences.

FOSTER CARE AMENDMENT #6
Senator Jay Rockefeller

The amendment would strike the provision that limits a state's cost for administering the foster care program to 10 percent growth per year (on page 12 of the modifications to the mark.)

Replace this proposal with a provision to reduce the federal matching rate for foster care administrative costs from 50% to 44.1%.

This option would exclude the expense of installing new computer systems which are eligible for 75% federal funding through September 30, 1996.

FOSTER CARE AMENDMENT #7
Senator Jay Rockefeller

The amendment would strike the provision that limits a state's cost for administering the foster care program to 10 percent growth per year (on page 12 of the modifications to the mark.)

Replace this proposal with a provision to reduce the federal matching rate for foster care administrative costs from 50% to 45%.

09/21/95 05:02 PM

Foster Care budget options for the Senate Finance Committee
Assumes November 15, 1995 effective date.
D-R-A-F-T
Compared to CBO baseline

By fiscal year, outlays in millions of dollars

		1996	1997	1998	1999	2000	2001	2002	Five-Year Total	Seven-Year Total
Direct Spending										
Reduce growth of foster care administrative costs to 10% a year a/	BA	-60	-190	-200	-220	-260	-270	-290	-800	-1510
	OT	-70	-180	-200	-220	-250	-270	-290	-820	-1470
Reduce federal match rate for foster care administrative costs from 50% to 45%.	BA	-140	-165	-180	-190	-205	-220	-235	-880	-1335
	OT	-115	-165	-175	-190	-200	-215	-230	-845	-1290

This is a preliminary estimate.
a/ This assumes that the 10% cap in growth of administrative costs would apply to each state.

Rockefeller/Grassley Amendment
Provider-Sponsored Network Option

Page 9 of the Chairman's mark:

Modify #2 under Medicare Choice Plan Options to read as follows

"Coordinated care plans -- Health plans that provide health care services through an integrated network of providers, including health maintenance organizations (HMOs), point-of-service (POS) plans, preferred provider organizations (PPOs), and provider sponsored networks (PSNs).

On page 9 of the Chairman's mark:

Add the following after #1 under Organizations eligible to contract with the Secretary of HHS as Medicare Choice plans must:

"There would be a separate federal certification process for provider-sponsored networks. They would not be subject to state regulation but would be subject to federal Medicare Choice standards and federally certified until at least December 31, 2000. By no later than December 31, 1999, the Secretary is required to report to Congress on an evaluation of whether certification of PSNs should be transferred to states with PSN regulatory processes that meet federal criteria."

on page 10 of the Chairman's mark

Insert at the end of #3 under Organizations eligible to contract with the Secretary of HHS as Medicare Choice plans must:

"In developing solvency requirements, the Secretary shall take into account a Medicare Choice plan's delivery system assets and its ability to provide services directly to its enrollees through its affiliated providers.

on page 15 of the Chairman's mark:

Insert at the end of #2, under Capacity and enrollment:

"Provider sponsored networks that have experience in providing coordinated care under arrangements with other health plans would not be subject to rules regarding minimum levels of enrollees, commercial or otherwise."

Rockefeller/Grassley Amendment
Provider-Sponsored Network Option

on page 18 of the Chairman's mark:

Add item #6 under Medicare Payments

"6. The Secretary will conduct a partial capitation demonstration and report to Congress no later than December 31, 1998 on the administrative feasibility of partial capitation methods, and on empirical information necessary for defining threshold levels and risk-share percentages."

on page 21 under Transition Rules for 1996 add #3

The Secretary would be required to publish federal Medicare Choice standards by April 1, 1996.

Rockefeller Amendment
Strike Budget-Driven Caps on Managed Care Payments

Finance Mark: indexes Medicare base payment amount for Medicare Choice plans to the "per capita growth in the gross domestic product (GDP)"

Amendment: strike "per capita growth in the gross domestic product" and insert "and indexed each year to the growth of private health insurance premiums"

Rockefeller

Rockefeller Amendment
Out-of-Pocket Protection for Beneficiaries from BELT

Page 54, line 12, in lieu of following sentence

"The payment reductions would not affect the coinsurance, deductible, or premium amounts payable by Medicare beneficiaries.

insert the following sentence:

The payment reductions would <u>reduce</u> the coinsurance, deductible, and premium amounts payable by Medicare beneficiaries by the same percentage reduction that applies to provider payments.

Rockefeller Amendment
Preserving Current Law Balance Billing Protection
for all Medicare Beneficiaries

Current Law HMOs are protected from paying the full charges of providers when beneficiaries obtain out-of-plan care services. Hospitals and skilled nursing facilities, under section 1866(a)(1)(0), are required to accept Medicare amounts as payment in full for inpatient hospital and extended care services. Medicare participating physicians, under section 1876(j), must accept the fee schedule amounts as payment in full, and nonparticipating physicians must comply with the limiting charge amount. In this current structure, the beneficiary is not vulnerable to extra billing, the HMO is responsible for guaranteeing payment in full for all plan services provided to Medicare enrollees.

Chairman's Mark All Medicare providers, physicians, and suppliers could require payment of full charges. This situation will, undoubtedly, ensure that the real costs to plans and beneficiaries will be higher than today. Traditional Medicare may cease to exist is some geographic areas if, for example, physicians decide to accept payment only from private fee-for-service plans that allow them to collect full charges. To avoid this and to protect Medicare beneficiaries from extra billing charges, it is necessary to extend protections in current law to all Medicare Choice plans.

Amendment

Add to section 4.) Consumer Protections (page 16) g.

g. For services provided by Medicare Choice plans, beneficiary liability would be limited to the cost sharing amounts specified in the plan's marketing materials. For all non-network services (e.g. medical savings account enrollees, private fee for service plan enrollees, network plan enrollees seeking out-of-plan services), apply the payment principles in sections 1866 and 1876 to all items and services covered by Medicare. Thus, participating physicians and suppliers paid under a fee schedule would accept the fee schedule amounts as payments in full. Nonparticipating physicians would be prohibited from billing beyond the limiting charge for their services. All other providers would accept Medicare's payment as payment in full, e.g. DRG and pass-through amounts for hospitals. In fee-for-service plans, beneficiary liability, i.e. deductibles and coinsurance amounts, would be computed using the lesser of the actual charge or the Medicare payment amount.

Breaux #1

EITC Amendment

(Sen. Breaux)

The amendment will require a doubling of taxpayer penalties in areas where fraud, tax underpayment and the like are of similar magnitude to those which have plagued the EITC in the past.

VACCINE AMENDMENT
(Sen. Breaux)

This amendment would clarify that states would have the option of using Medicaid or other state funds to purchase vaccines at a discounted rate for children the state deems eligible for Medicaid. It would thus ensure that states, which under the chairman's mark would be required to offer vaccines to children on Medicaid, could purchase them at a reduced rate as they now do.

It would allow the Secretary of HHS, where appropriate, to contract with multiple vaccine manufacturers.

It would provide the Sense of the Committee that states adhere to the Advisory Committee on Immunization Policies guidelines.

CONRAD AMENDMENT ON MENTAL HEALTH SERVICES

AMENDMENT:

On page 61, after "department of health", insert the following:

1. States also have the flexibility to provide the following options:

- Outpatient and intensive community-based mental health services, including psychiatric rehabilitation, day treatment, intensive in-home services for children, and partial hospitalization.

- (i) Acute inpatient mental health services, including services furnished in a State operated mental hospital and, (ii) residential treatment center services for children

2. States have complete authority to elect the scope of assistance available to Medicaid recipients, but they may not impose treatment limits or financial requirements on mental illness services which are not imposed on services for other conditions. States shall not be prevented from requiring pre-admission screening, prior authorization or services or other mechanisms limiting coverage of mental illness services to those that are medically necessary.

EXPLANATION:

Current Medicaid law permits states great flexibility in defining a range of community-based services for adults and children who have serious mental disorders. Virtually all mental health services provided by state Medicaid programs are optional. This amendment retains the optional nature of mental health coverage, while ensuring that the new program does not unintentionally preclude states that wish to do so from providing a full array of services.

The provisions of this amendment on outpatient community-based services are intended to guarantee state flexibility. There is concern that any legislative language that only refers to "outpatient" services without including options like rehabilitation, day treatment, etc., could be perceived by states as limiting their authority to fund such options.

The inpatient services language is intended to ensure states will not substitute federal dollars for state funds that have historically been spent on the residents of state operated mental hospitals. The Chairman's Mark completely repeals the so-called "IMD" exclusion, under which the Federal government has historically refused to pay the costs of individuals between ages 21 and 65 in Institutions for Mental Disease. Like the Chairman's Mark, the Conrad Amendment permits Medicaid reimbursement for acute care coverage in state-operated facilities and private psychiatric hospitals. However, unlike the Chairman's Mark, the amendment ensures that states will continue to pay the cost of long term services that have been a state responsibility since the 1870s.

The non-discrimination language merely prohibits states from applying arbitrary blanket limits to mental health services that are not applied to other services. The provision does nothing to preclude states from conducting pre-admission screening, prior authorization, etc. Nor does it require that particular groups of people with mental disorders be covered, or that any specific range of mental health services be covered States would be free to set any amount, duration and scope limits.

Conrad #2

CONRAD SENSE OF THE COMMITTEE AMENDMENT

It is the Sense of the Finance Committee that in the event the Congressional Budget Office declares that a fiscal dividend exists in accordance with the Budget Resolution, that such a dividend should be used for further deficit reduction so that Social Security surpluses are not used to balance the budget, and to reduce savings from:

- federal health programs for the elderly, children, disabled and poor;
- programs that benefit working and middle class Americans, and;
- programs that invest in education, infrastructure and research.

Conrad #3

CONRAD/PRESSLER MEDICARE ANESTHESIA SERVICES AMENDMENT

AMENDMENT:

On page 48, at the end of the section entitled "Improving Access to Health Services and Improving Medicare in Rural Areas," insert the text of S.1263, the Medicare Anesthesia Services Reform Act.

EXPLANATION:

This proposal consists of two provisions. The first provision requires the Health Care Financing Administration to defer to state law when determining whether to condition Medicare reimbursement to Certified Registered Nurse Anesthetists (CRNA's) on physician supervision. Current Medicare regulations require physician supervision of CRNA's as a condition for hospitals and ambulatory surgical centers to receive Medicare reimbursement. This federal requirement is in direct conflict with numerous state laws that allow nurse anesthetists to practice without such supervision.

The second provision ensures payment equity between CRNA's and anesthesiologists. Under current Medicare regulations, if an anesthesiologist and a CRNA work together on one case and Medicare later decides that the use of two anesthesia providers was not "medically necessary," neither the hospital nor the CRNA receives payment. This provision does not require Medicare to pay additional funds. Rather, it requires that the fee be split evenly between the two practitioners who jointly worked on the case.

Conrad #3 cont.

104TH CONGRESS
1ST SESSION

S. 1263

IN THE SENATE OF THE UNITED STATES

Mr. CONRAD (for himself, Mr. PRESSLER, Mr. THURMOND, and Mr. INOUYE) introduced the following bill; which was read twice and referred to the Committee on _____

A BILL

To direct the Secretary of Health and Human Services to revise existing regulations concerning the conditions of payment under part B of the medicare program relating to anesthesia services furnished by certified registered nurse anesthetists, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicare Anesthesia Services Reform Act".

SEC. 2. REVISION OF CONDITIONS OF PAYMENT TO FOSTER CONSISTENCY WITH STATE SUPERVISION STANDARDS.

(a) PROMULGATION OF REVISED REGULATIONS.—The Secretary of Health and Human Services shall revise any regulations describing the conditions under which payment may be made for anesthesia services under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to provide that payment may be made under the medicare program for anesthesia services furnished in a hospital or an ambulatory surgical center by a certified registered nurse anesthetist who, under the law of the State in which the service is furnished, is permitted to administer anesthesia services without supervision by the physician performing the operation or the anesthesiologist.

(b) EFFECTIVE DATE.—The revisions to the regulations referred to in subsection (a) shall apply with respect to anesthesia services furnished on or after January 1, 1996.

SEC. 3. ENSURING PAYMENT FOR PHYSICIAN AND CERTIFIED REGISTERED NURSE ANESTHETIST FOR JOINTLY FURNISHED SINGLE CASE ANESTHESIA SERVICES.

(a) PAYMENT TO PHYSICIAN.—Section 1848(a)(4) of the Social Security Act (42 U.S.C. 1395w-4(a)(4)) is

amended by adding at the end the following new subparagraph:

"(C) PAYMENT FOR SINGLE CASE.—Notwithstanding section 1862(a)(1)(A), with respect to physicians' services consisting of the furnishing of anesthesia services for a single case that are furnished jointly with a certified registered nurse anesthetist, if the carrier determines that the use of both the physician and the nurse anesthetist to furnish the anesthesia service was not medically necessary, the fee schedule amount to be applied shall be equal to 50 percent of the fee schedule amount otherwise applicable under this section if the anesthesia service were personally performed by the physician alone.".

(b) PAYMENT TO CRNA.—Section 1833(*l*)(4)(B) of such Act (42 U.S.C. 1395l(*l*)(4)(B)) is amended by adding at the end the following new clause:

"(iv) Notwithstanding section 1862(a)(1)(A), in the case of services of a certified registered nurse anesthetist consisting of the furnishing of anesthesia services for a single case that are furnished jointly with a physician, if the carrier determines that the use of both the physician and the nurse anesthetist to furnish the anesthesia service

was not medically necessary, the fee schedule amount shall be equal to 50 percent of the fee schedule amount otherwise applicable under this section if the anesthesia service were personally performed by the physician alone.".

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply with respect to services furnished on or after January 1, 1996.

Conrad #4

CONRAD MEDICARE INTEGRITY AMENDMENT

AMENDMENT:

On pages 52 through 54 of the chairman's mark, strike the Budget Expenditure Limit Tool.

EXPLANATION:

The Chairman's mark allows seniors to choose coverage options other than traditional Medicare fee-for-service. The Congressional Budget Office scores the savings of this provision at $47.5 billion. However, if those savings are not realized, the BELT provision will cut fee-for-service Medicare spending. Repeated additional cuts in Medicare fee-for-service could erode the integrity of the program and force seniors into health care plans that they do not wish to join.

Conrad #5

CONRAD/BAUCUS SPOUSAL IMPOVERISHMENT AMENDMENT

AMENDMENT:

Current law protections that guarantee that spouses of nursing home residents will be able to retain enough monthly income to remain in the community are reinstated.

EXPLANATION:

Since 1988, states have been required to allow spouses of institutionalized Medicaid beneficiaries to keep a specified amount of the couple's total income and assets. Without these protections, spouses could be forced to sell their home, sue each other for support, or even divorce in order to avoid destitution. The Chairman's mark repeals this protection.

Conrad #6

CONRAD AMENDMENT ON DURABLE MEDICAL EQUIPMENT

On page 41, at the end of the section entitled "Payments for Durable Medical Equipment." insert the following:

> Any individual purchasing or renting customized or upgraded durable medical equipment may do so by paying the difference between such customized or upgraded equipment at the point of sale or rental from a supplier; such supplier shall bill and receive the amount equivalent to such covered durable medical equipment.
>
> The Secretary of Health and Human Services shall promulgate appropriate beneficiary protection safeguards.

Conrad #7

CONRAD AMENDMENT ON ACCESS TO PSYCHOLOGICAL SERVICES

AMENDMENT:

Section 1861 (ff)(1) of the Social Security Act is amended by inserting at the end thereof the following:

Notwithstanding the previous sentence, to the extent permitted under the law of the State in which the services are provided, a clinical psychologist may prescribe and supervise partial hospitalization services, and establish and periodically review an individualized plan of treatment for such services.

Conrad #8

CONRAD AMENDMENT TO PROTECT ALL INDIVIDUALS WITH DISABILITIES

AMENDMENT:

On page 61, amend the paragraph that reads, "For each group, the minimum percentage to be spent would be equal to 85 percent of the average percentage of the state's Medicaid spending during FY1992 through FY1994 devoted to mandatory services for members of that group who were required to be covered under current Medicaid law", shall be amended by replacing the portion of the sentence between "FY1994" and the period with the following:

"all state Medicaid expenditures for members of that group."

RATIONALE:

The Chairman's mark only guarantees that states will spend 85 percent of funds currently spent on "mandatory" Medicaid services. Such a requirement provides virtually no protection for non-elderly people with disabilities who require long term services. For example, federal -state Medicaid expenditures for long term developmental disabilities services currently total about $13.5 billion (of which about $8 billion represents the federal share). Because intermediate care facilities for the mentally retarded and home and community-based waiver services are both "optional" state plan coverages exercised by every state, none of the expenditures for their services are included in the Chairman's 85% figure.

Any definition or description of home and community-based services and related supportive services should include habilitation services, non-medical transportation services, assistive devices and minor modifications in a person's home or personal vehicle, as options for states.

Graham #1

AMENDMENT BY SENATOR GRAHAM

"Medicaid Access and Quality Protection Act of 1995" -- Per Capita Cap Alternative

pp. 56-77: Strike the "Medicaid Reform Proposal" and replace with the "Medicaid Access and Quality Protection Act of 1995". This alternative to Medicaid block grants seeks to reduce funding by $60 billion over seven years as opposed to $182 billion in the Republican block grant.

* Per Capita Cap: Maintains the individual entitlement to Medicaid coverage but controls spending by restraining the inflationary growth per person covered. Demographic and economic changes would be automatically adjusted for, but spending per person would be restrained. The federal government would make payments to each state based on the statutory federal matching rate or the per capita cap, whichever is lower.

  Stated in Inflation-Adjusted Terms: Protects states from potential increases in inflation.

  Separate Caps by Category: Caps would be applied separately to the (1) elderly, (2) the disabled, (3) children and (4) adults.

  Non-Discrimination: Prohibits de jure or de facto enrollment discrimination on the basis on age, health and other risk factors. Further prohibits de jure or de facto discrimination in the access to or delivery of services within a category of enrollees.

* State Flexibility: Provides for greater state flexibility and innovation in the Medicaid program by repealing the 1115 waiver process (language from Sen. Chafee's Medicaid Managed Care Act of 1995 or S. 839).

  Phase-Out of Boren Amendment and Cost Reimbursement for Federally Qualified Health Centers and Rural Health Centers.

  Eliminate the 1915(c) waivers for home and community based care and make it a state option.

  Permit nominal copayments for Medicaid services other than prenatal care, well-child exams and immunizations for those above 100% of poverty.

* State Accountability/Performance Measures and State Rankings: States would be held accountable for performance measures they develop in conjunction with the Health Care Financing Administration with respect to quality and access to care.

* Maintenance of Effort: Maintains state effort.

* Disproportionate Share: Retargets disproportionate share funding, as outlined in the "Medicaid Reform Proposal". However, creates a set-aside for community health centers and rural health centers.

* Health Access and Quality Fund: Sets aside $10 billion over the next seven years for the expansion of access and the improvement of quality for states to access. This fund would be over and above the allocations under the per capita cap.

* Freezes Administrative Costs: In exchange for greater flexibility, saves additional funding by freezing administrative costs over the seven year period.

* Caps Payments to Institutions for Mentally Retarded Persons: Average Medicaid reimbursement in 1991 for large ICF/MRs ranged among states, according to the HHS Inspector General, from $27,000 to $158,000 per resident. This proposal establishes a national ceiling of reimbursement at the present average cost of payments by states to institutions for the care of mentally retarded persons.

Savings is obtained by implementing a per capita cap, retargeting disproportionate share funding, freezing administrative costs and capping payments to institutions for mentally retarded persons.

Cost Estimate: $60 billion could be saved over seven years.

Graham #2

AMENDMENT BY SENATOR GRAHAM AND MOSELEY-BRAUN

Uninsured Rate -- Sunset Trigger

On page 77, at the end of the "Medicaid Reform Proposal" section, add a sunset provision to the Medicaid provisions of this Act. The sunset provision would apply and revert back to Medicaid law prior to enactment of this Act if the uninsured rate for the general population, according to Current Population Survey estimates, exceed 45 million for any year or 10 million for children.

Graham #3

AMENDMENT BY SENATOR GRAHAM AND MOSELEY-BRAUN

Infant Mortality Rate -- Sunset Trigger

On page 77, at the end of the "Medicaid Reform Proposal" section, add a sunset provision to the Medicaid provisions of this Act. The sunset provision would apply and revert back to Medicaid law prior to enactment of this Act if the infant mortality rate increases nationwide. However, if the infant mortality rate increases for an individual state but not for the entire nation, the state must cover up to 133% for all prenatal and pregnancy-related services to pregnant women and infants to age one.

Graham #4

AMENDMENT BY SENATOR GRAHAM

Pre-Existing Conditions

At the appropriate place, "prohibit Medicaid plans from instituting preexisting condition exclusions for coverage of any item or service for an eligible individual."

Graham #5

AMENDMENT BY SENATOR GRAHAM

Medicaid Formula Proposal

On page 71, strike the Medicaid formula proposal and insert an alternative funding formula. It would include --

* Each state's Medicaid program would be allowed to grow at a rate of 3 percent per year.

* The amount above the 3 percent growth allowed under the federal budget would be allocated through an equity index which would work as follows:

    * Growth Factor: One-fourth would be allocated to the 25 states with the highest rate of growth with each state receiving a pro-rata share based on the FY 1995 base.

    * Efficiency Factor: One-fourth would be allocated to the 25 states with the least cost per person with each state receiving a pro-rate share based on the FY 1995 base.

    * Elder and Disabled Factor: One-fourth would be allocated to the states above the mean plus one standard deviation of the SSI population with each state receiving a pro-rata share based on FY 1995 base.

    * Poverty Factor: One-fourth would be allocated to the states above the mean plus one standard deviation of the poverty population with each state receiving a pro-rata share based on FY 1995 base.

Rationale

The principle is rather simple: any restructured Medicaid program should distribute federal funds on the basis on need. It is a compromise between two other major proposals -- a flat growth cap and a total redistribution of federal funds based on need.

Cost Estimate

None. A redistribution of funding among the states.

Graham #6

AMENDMENT BY SENATOR GRAHAM

Improved Medicaid Funding Distribution Proposal

On p. 70, add the following program efficiency measures:

* Freezes Administrative Costs: In exchange for greater flexibility, save additional funding by limiting a state's administrative expenditures to 4% and by freezing administrative costs for all states over the seven year period.

* Caps Payments to Institutions for Mentally Retarded Persons: Average Medicaid reimbursement in 1991 for large ICF/MRs ranged among states, according to the HHS Inspector General, from $27,000 to $158,000 per resident. This proposal establishes a national ceiling of reimbursement at the present average cost of payments by states to institutions for the care of mentally retarded persons.

With the scorable savings by the Congressional Budget Office, raise the funding formula cap on p. 71 from "no more than 133 percent above the national growth rate" to a higher allowable figure that more quickly moves states to equity.

Rationale

Rather than moving all states to a common payment per person in poverty, the present proposal expands the inequity.

Cost Estimate

None. A redistribution of savings from present program inefficiencies.

MOSELEY-BRAUN AMENDMENT #6

DISABLED CHILDREN AMENDMENT

On page 73, after the sentence, "Goals and objectives related to rates of childhood immunizations . . . will be developed," insert the following:

Goals and objectives related to standards of care and access to services for children with special health care needs, as defined by the state, will also be included.

On page 92, the Secretary of HHS would be required to:

(1) Fund the refinement and validation of a national, quantifiable classification system for the purposes of defining children with special health care needs. Such children would be those with conditions that are, or can be anticipated to be, of at least a year's duration and service needs significantly greater than well children. The classification system should be based on commonly recognized diagnostic codes, be compatible with state and health plan data systems, and be capable of serving as a basis for identifying these children and their medical expenditures and monitoring the quality of care they receive. The system should be further expanded to incorporate the consideration of the child's (1) severity status, (2) prognosis, and (3) desired outcome, including tertiary prevention, maintenance of function, or improvement of function.

(2) Fund state or regional demonstration projects which would:

- develop methods of providing and assuring the quality of managed care for children with special health care needs. This would include the development of adequate capitation rates specific to this population and quality indicators such as system performance standards, care guidelines for specific populations, outcomes measures and patient/parent satisfaction;

- provide for initial methods for identifying children with special health care needs based on the diagnoses accounting for the majority of the chronic conditions affecting children in the state or region which are likely to require significant medical interventions whether in number o interventions or costs;

- include appropriate representatives of providers of services to children with special health care needs and representatives of appropriate state agencies and programs in the development of initial methods of identifying children with special health care needs and in the design and implementation of the demonstration projects; and

- test the reliability and validity of the national classification system for children with special health care needs described in paragraph (1).

Graham #

AMENDMENT BY SENATOR GRAHAM

Maintenance of Effort -- Real State Dollars

At the appropriate place, insert language that clarifies that states may only use provider donations and taxes to match federal funds if such donations and taxes would quality for federal matching funds under present law.

Rationale

Current limits on provider donations and taxes were enacted in response to state abuses. A few states have used "creative financing" methods to increase their receipt of federal funds without spending additional state resources. In effect, these states avoided their state match responsibilities. These abuses creates significant interstate inequities, as a few states evaded their obligations.

The proposed amendment would clarify that states cannot use these "creative financing" techniques to avoid their state match responsibilities under the bill. For example, without the amendment, a state could meet its matching obligations with supposed "provider tax revenues" that are returned automatically to the taxpaying providers through Medicaid payments. This amendment is needed for the bill's state match requirement to have any meaning.

Graham #8

AMENDMENT BY SENATOR GRAHAM AND BRADLEY

Maintenance of Effort -- No Cost Shifting to Local Governments

At the appropriate place, insert language that clarifies that states may not shift the burden on their matching rate requirements to local units of government without their expressed consent.

Rationale

This amendment would seek to clarify that states cannot shift their federal matching rate requirements on to local units of government.

Graham #9

AMENDMENT BY SENATOR GRAHAM

Maintenance of Effort -- Disallow Supplanting of Funds

At the appropriate place, insert language that clarifies that states cannot supplant present state health funding for activities such as the provision of health care services, including public health activities, with Medicaid block grant funding.

Rationale

This would ensure that states do not supplant their present in-state health spending with federal Medicaid block grant dollars.

Gordham

AMENDMENT BY SENATOR GRAHAM

Coverage Standards if Performance Goals are Not Met

In order to assure that the Medigrant program does not cause severe deterioration in the health status of children or pregnant women in any state because that state's choices cause a significant increase in the number of uninsured children or pregnant women not getting timely prenatal care:

- if the Secretary of HHS makes two successive annual findings that the uninsured rate, as defined by the Secretary consistent with Bureau of the Census Current Population Survey Data, among children in a state is higher than that state's average rate of uninsured children under age 18 over the three most recent years for which Current Population Survey Data is available, then the state shall provide coverage for all children with family incomes below the federal poverty level until such time as the uninsured rate falls below the average in the base years.

- if the Secretary of HHS makes two successive annual findings that a state's rate of women receiving prenatal care in the first trimester of pregnancy, as defined by the Secretary consistent with official National Center for Health Statistics data, is lower than the state's rates available for the most recent year prior to enactment of this legislation, then the state shall provide coverage for all pregnant women and infants with family incomes below 133⅓% of the federal poverty level until such time as the early prenatal care rate rises above the average in the base years.

Each year the Secretary shall develop a report to Congress based upon data for children's insurance coverage, low birth weight, early prenatal care, infant mortality and immunization rates with respect to each state participating in the program. The Secretary shall provide the report to all states and shall provide each state the opportunity to respond to such determinations made in the Secretary's report. If the response by a State does not result in the Secretary reversing a determination that the state's rates fail to meet the targets for children's insurance coverage or early pre-natal care, then the Secretary shall notify the state of the coverage required under this section.

Graham‡

AMENDMENT BY SENATOR GRAHAM

Continuation of Treatment

This amendment would require a State plan to provide, once an eligible individual received services for a condition, illness or injury under the plan, that ongoing treatment necessary for that same condition, illness or injury would continue so long as the individual's or family's income or resources did not change in a way to create ineligibility under the plan. Such an amendment would prevent states from making arbitrary decisions to terminate necessary medical care in situations such as "Baby Doe" cases. This would especially protect seriously ill or injured persons, or persons who have received partial treatment or are in the middle of an ongoing treatment plan and acting in reliance on it.

Rockefeller #.

Rockefeller Amendment
Primary Care Access Amendment

Add new item under section 3.) Access, Health Plan Standards, (pages 15,16)

d.) A Medicare Choice plans must make primary care services available within 30 minutes or 30 miles from a beneficiary's place of residence in rural areas.

Graham #12

AMENDMENT BY SENATORS GRAHAM, PRYOR AND BAUCUS

Medicare Anti-Fraud and Abuse Program (MAAP) -- Program Integrity

On p. 49, add a provision that would assure a dependable mandatory source of funds for all Office of Inspector General (OIG) and Department of Health and Human Services (HHS) Medicare anti-fraud and abuse activities by supporting them through the Medicare HI Trust Fund. Program integrity activities will be better able to protect the Trust Funds as their growth will be able to keep pace with the increase in Medicare claims.

Funding would include $200 million in FY 1996, $225 million in FY 1997, $250 million in FY 1998, and for each succeeding fiscal year, an amount equal to the greater of --

* $250 million increased by a percentage equal to the percentage increase in expenditures under Title XVIII for the preceding fiscal year over fiscal year 1997; or

* an amount equal to the aggregate amount expended for anti-fraud activities in fiscal year 1998, increased, as determined by the Secretary, to reflect inflation and any costs attributable to oversight responsibilities added with respect to periods after fiscal year 1998.

Scorable savings will be used expressly to restore funding to hospitals in Part A and to reduce the deductible increase to Medicare beneficiary in Part B.

Rationale

The Office of Inspector General estimates this would save the Medicare Trust Funds at least $8 billion over 7 years by ensuring a stable source of funding for OIG and HHS activities, removing them from discretionary budget limits. For example, this would support a dramatic expansion of OIG's anti-fraud activities to protect Medicare and its investigative capacity from 24 states to all 50 states and Puerto Rico.

Graham #1

Amendment by Senator Graham

Purpose

To assure equitable coverage and treatment of emergency services under managed care plans which contract to provide health care services for Medicare beneficiaries. The amendment would require such health care plans to cover and pay for their fare share of emergency services for Medicare beneficiaries that hospital emergency departments and emergency physicians are required to provide. In addition, the amendment would do the following:

(1) it would protect Medicare beneficiaries by establishing a "prudent layperson" definition of emergency;

(2) it would prohibit managed care plans from requiring prior authorization for emergency medical services;

(3) it would require managed care plans to provide emergency services without regard to contractual arrangment;

(4) it would require managed care plans to instruct Medicare beneficiaries that it is appropriate to use 911 in the event of an emergency.

Rationale

Federal law requires emergency physicians, emergency nurses, and other health care providers to evaluate, treat and stabilize any individual seeking treatment in a hospital emergency department. This law specifically prohibits emergency physicians from delaying treatment needed to evaluate or stabilize an individual in order to determine the health insurance status of the individual.

Today, managed care plans participating in the Medicare program routinely deny payment for emergency services provided to Medicare beneficiaries, basing such denials on (a) failure to obtain prior approval of such services from the plan, or (b) an "after-the-fact" determination that the medical condition identified through the federally required evaluation was not an emergency medical condition.

In 1992, a study conducted for the Health Care Financing Administration of disputed claims by Medicare beneficiaries participating in the HMOs found that 60 percent of disputed claims involved disputes over emergency care. The study's authors described these cases as "dispute prone" and recommended that HCFA's definition of emergency be amended to take into account the actions of a reasonable or prudent layperson when confronted with a potential medical emergency.

These denials by managed care plans impose significant financial burdens on Medicare beneficiaries who based upon symptoms that reasonably suggest a medical emergency, prudently seek care in the a hospital emergency department. These burdens discourage Medicare beneficiaries from seeking emergency care in cases where it is appropriate and, ultimately, threaten the financial livelihood of hospital emergency departments in providing emergency services to the entire population, including the Medicare population.

ORGANIZATIONS THAT SUPPORT THE GRAHAM AMENDMENT

American College of Emergency Physicians
National Association of EMS Physicians
Coalition for American Trauma Care
American Ambulance Association
Emergency Medical Services Section of the International Association of Fire Chiefs
International Association of Firefighters
Emergency Nurses Association
National Association of Emergency Medical Technicians
Association of Air Medical Services
National Association of State EMS Directors
American College of Cardiology
American College of Surgeons
Congress of Neurological Surgeons
American Association of Neurological Surgeons
American Association for the Surgery of Trauma
Consumer's Union
Citizen Action
Public Citizen
National Committee to Preserve Social Security and Medicare
American Heart Association
American Academy of Pediatrics

Graham #14

AMENDMENT BY SENATORS GRAHAM AND BRADLEY

Medicare Dependent Hospitals

On p. 47, add the requirement that the Prospective Payment Advisory Commission (ProPAC), in addition to its recommendations on payment rate updates for all hospitals, make a separate recommendation on updates for urban Medicare dependent hospitals.

In addition, the bill would require ProPAC's Annual Report to Congress to include recommendations to ensure that beneficiaries served by the nation's 1400 Medicare dependent hospitals would retain the same access and quality of care as Medicare beneficiaries nationwide.

Rationale

According to the most recent report by the ProPAC, "The ability to use cost shifting to fill the revenue gap where Medicare cost increases exceed payment increases varies across hospitals. Facilities that treat larger shares of Medicare, Medicaid and the uninsured patients have a lesser ability to cost shift to the private sector. In view of growing price competition in the marketplace, these facilities will face a greater risk of declining margins, which eventually could threaten their financial viability and their ability to care for Medicare beneficiaries."

Graham #15

AMENDMENT BY SENATORS GRAHAM

Nondischargeability of Certain Medicare Debts

On p. 49, add a provision that would prevent providers and suppliers from using the Bankruptcy Code as a vehicle to defeat the Secretary's effort to recoup overpayments from the Medicare Trust Funds.

This provision would further prevent an excluded individual or entity from attempting to halt exclusions imposed by the Office of Inspector General (OIG) by filing a bankruptcy petition immediately prior to the effective date of the exclusion, asserting that the automatic stay precludes the OIG from imposing an exclusion.

Rationale

Providers and suppliers, who owe financing obligations to Medicare, are seeking relief from bankruptcy courts to have their outstanding overpayments, which are unsecured, discharged or greatly reduced. The Medicare program has been unsuccessful in efforts to halt such actions. A 1992 report issued by the Office of Inspector General entitled Federal Recovery of Overpayments from Bankrupt Providers found that as of March 1991, the Medicare Trust Funds lost $109 million due to the ability of providers and suppliers to discharge their outstanding overpayments. Therefore, this provision would amend the Social Security Act to state that providers and suppliers cannot use the bankruptcy forum to avoid these outstanding obligations. Note that education loans already have this status.

Graham #16

AMENDMENT BY SENATORS GRAHAM

Improved Prevention in Issuance of Medicare Provider Numbers

On p. 49, add a provision that allows the Secretary of Health and Human Services to impose fees to providers for the expressed purpose of upfront investigation and recertification of providers prior to the issuance of Medicare provider numbers.

Moseley Braun #1

° Grassley

EITC AMENDMENT

SENATOR CAROL MOSELEY-BRAUN

STRIKE CHILD SUPPORT AS PART OF THE DEFINITION OF ADJUSTED GROSS INCOME USED FOR PHASING OUT THE CREDIT AND OFFSET THE SPENDING CUT BY DECREASING THE INVESTMENT INCOME CAP FROM $2,350 TO AN AMOUNT SUFFICIENT TO REPLACE THE CHILD SUPPORT OUTLAY AMOUNT.

Moseley Braun #2

EITC AMENDMENT

SENATOR CAROL MOSELEY-BRAUN

STRIKE THE REPEAL OF THE EITC FOR INDIVIDUALS WITHOUT QUALIFYING CHILDREN AND OFFSET THE SPENDING OUTLAYS BY LOWERING THE INVESTMENT INCOME CAP FROM $2,350 TO AN AMOUNT NECESSARY TO CUT SPENDING OUTLAYS BY $4.2 BILLION.

CENTER ON BUDGET AND POLICY PRIORITIES

September 13, 1995

THE CONSEQUENCES OF ELIMINATING THE EITC FOR CHILDLESS WORKERS

Legislation is moving forward in Congress that would repeal the small EITC for poor workers without children. While those leading efforts to reduce the EITC often describe their proposals as necessary steps to reduce errors and slow the growth of the program, this proposal would do little to accomplish either objective. Indeed, the EITC for workers without children provides needed tax relief for a group of poor workers who generally receive little aid from other government assistance programs, who experienced an exceptionally sharp increase in their tax burdens from 1980 to 1993, and who frequently pay a substantial percentage of their very small incomes in federal taxes.

If the childless workers credit is ended, poor workers without children would face a large increase in their federal tax burdens; the payroll taxes they pay on their first $4,230 of earnings would no longer be offset. Moreover, their federal tax burdens would rise to still higher levels than these tax burdens had reached before the childless workers credit was established in 1993. These workers would be affected by the gasoline tax increase enacted in 1993 while losing the EITC they received that year designed, in part, to offset the effects of the gas tax hike on them.

The Treasury Department estimates that 4.4 million workers would face an average tax increase of $173 if the credit for workers without children is repealed, with households who would have qualified for the maximum credit experiencing a tax increase exceeding $300. Every dollar reduction in the childless workers tax credit translates to an effective increase of a dollar in taxes since the value of the credit is never greater than the amount of employee payroll taxes owed.

As a consequence, single workers with incomes at the poverty line would see their already-high federal tax liability climb still higher. Under current law, a single worker at the poverty line — projected to be $8,200 in 1996 — would owe nearly $1,400 in income and payroll tax in 1996. If the EITC for these workers is eliminated, this worker's tax liability will rise by $100 to $1,500.[1]

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[1] In accordance with standard economic analysis, these figures include the employer's and the employee's share of the payroll tax. The Congressional Budget Office data used for Figure 1 also include both the employer's and the employee's share of the payroll tax.

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Robert Greenstein, Executive Director

still in poverty. They should not be taxed further by the elimination of their small EITC.

Table 1

Changes in Federal Tax Burdens, 1980-1993

Household Category	Change in the Percentage of Income Consumed by Federal Taxes
Non-elderly households without children	
poorest fifth	+38%
middle fifth	5
top fifth	-3
Families with children	
poorest fifth	-19%
middle fifth	1
top fifth	1
Aged	
poorest fifth	-22%
middle fifth	-14
top fifth	-11
All households	
poorest fifth	4%
middle fifth	-2
top fifth	-3

Source: Congressional Budget Office data published in House Committee on Ways and Means, *1992 Green Book*, pp. 1526-7.

MOSELEY-BRAUN AMENDMENT #3

COST-SHARING AMENDMENT

On page 62, insert language that would prohibit states from denying Medicaid services to individuals who are unable to meet cost-sharing obligations required by the state.

MOSELEY-BRAUN AMENDMENT #4

TRANSITIONAL MEDICAID

On page 61, insert language that would require states to provide Medicaid coverage to persons who are transitioning off of either AFDC or Temporary Employment Assistance (TEA). States would be required to extend Medicaid coverage to these persons for twelve months from the time the person stopped receiving AFDC or TEA benefits.

MOSELEY-BRAUN AMENDMENT #5

CIVIL RIGHTS AMENDMENT

Strike from the bill any provision that bars any cause of action against states in relation to the modified Medicaid program.