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Senate Finance Committee
Chairman's Mark
September 22, 1995

MEDICARE REFORM PROPOSAL

Section I -- Medicare Choice

Medicare Health Plan Options

Beneficiaries can enroll in the existing fee-for-service Medicare program or the following Medicare Choice plans:

1. Traditional fee-for-service plans

2. Coordinated care plans (HMOs, POS, PPOs)

3. High-deductible/medical savings account plans, which require a minimum annual per person deductible of $3,000

4. Union or association sponsored plans

5. Any other plan that meets the Medicare Choice plan standards

All Choice plans except union and association plans must be licensed by each state in which they wish to enroll beneficiaries. All plans must assume full financial risk except for specified reinsurance. They must meet solvency standards, but the Secretary of Health and Human Services (HHS) may deem plans if they meet state solvency standards at least as stringent as Medicare's.

Issues

- There is no indication in that under the mark beneficiaries would have extra-billing protection in private fee-for-service plans, MSA/high deductible plans and other private plans. If a significant portion of physicians in an area begin serving beneficiaries only through these alternative plans in order to avoid extra-billing limits under traditional Medicare, choosing to remain in traditional Medicare will not be a "real" option for beneficiaries.

- The mark creates a Medicare program with high potential for dramatic risk segmentation between three coverage options: traditional Medicare, coordinated care plans and MSAs. In clear contrast to this approach, employers in recent years have moved to eliminate the risk segmentation they experienced between their fee-for-service plans and HMOs. No major employer allows the risk segmentation that would result from MSAs.

  - Under such a system, risk adjustment would be critical to

ensure that plans are not penalized if their enrollee population is sicker than average or rewarded if their enrollment is healthier than average. However, the development of reliable risk adjustment methods is in its early stages.

- Many union and association sponsored plans would have access to the medical history of their members. Thus, plans would be able to determine if based on the Medicare payment amount and their members medical history they would be able to make a profit. Only those groups that believe they could make a profit would choose to contract with the Medicare program.

- It appears that HMOs will be able to contract on a cost basis and beneficiaries will be able to enroll in cost plans. HCFA has found it difficult to establish limits on reasonable costs for cost HMOs, and Medicare's total costs for enrollees in many cost plans exceeds 100 percent of the AAPCC. The cost option could become very popular in a world where payment increases do not reflect actual cost growth.

Eligibility

All persons entitled to Medicare Part A and enrolled in Part B are eligible to enroll in a Choice plan, except those with end stage renal disease (ESRD). Medicare Part B-only enrollees will not be eligible for Choice plan enrollment. By December 1999, the Secretary will provide recommendations regarding enrollment of beneficiaries with ESRD. Union and association plans are available only to full-fledged members of the organization.

Enrollment

Beneficiaries will be able to enroll in Choice plans at initial eligibility and during annual coordinated open enrollment periods. The Secretary will be responsible for enrolling individuals and shall provide for enrollment, to the extent possible, by telephone, through the mail, or in person at Social Security offices. Beneficiaries will continue in the Medicare option of the previous year if they fail to notify the Secretary of an alternative choice.

Issues

- The requirement for the Secretary to run an annual enrollment process for 37 million people would be a significant new responsibility, and adequate time to implement would be necessary. One of the reasons that HCFA is initiating HMO competitive pricing demonstrations, which involve an open enrollment process, is to learn how best to run such an enrollment process, but these demonstrations are only starting.

- Enrollment capacity of competing plans is an issue. How would a situation where a plan has the capacity to enroll 5,000 beneficiaries, but 15,000 beneficiaries want to enroll be addressed? This problem may become more of an issue if plans are offering rebates, i.e., if the plans offering the highest rebates do not have the capacity to enroll all interested beneficiaries.

Disenrollment

In general, beneficiaries can disenroll from Medicare Choice or traditional Medicare only during annual coordinated open enrollment periods except for "qualifying events" such as a move to a new area and for cause. Also, they may disenroll within ninety days of their initial enrollment in a Choice plan.

Information

The Secretary (or a private organization contracting with the Secretary) would develop and distribute informational materials to beneficiaries describing the Medicare Choice plans available in the area. The information would be distributed to each beneficiary no later than 30 days before the annual open enrollment period. The Secretary would also be required to provide newly eligible beneficiaries with this information two months prior to their eligibility date.

The informational materials should be in "simple terms" and at minimum include the following -- the Medicare Part B premium; traditional Medicare's covered services, deductibles and coinsurance amounts, and any coverage changes from the previous year; the Medicare payment amount for the area; instructions on how to enroll in Medicare Choice plans; information on plans available in the area including premiums charged, the difference between the plan premium and the Medicare payment amount, restrictions on coverage, out-of area coverage and coverage of emergency services, appeal rights, supplemental coverage and the associated additional premiums, and quality indicators, including consumer satisfaction information, outcome measures, and adjusted disenrollment rates.

The Secretary can provide additional information that could be useful in beneficiaries' selection of a Medicare Choice plans.

Issues

- In order for beneficiaries to compare competing alternative plans under the Medicare Choice system, they will need comparative information on quality as well as price, network composition, benefits, cost-sharing, and other factors. Comparative information on the quality of care provided by competing plans is difficult to measure -- but of vital

importance to potential enrollees, particularly if they can only change plans on a yearly basis, as proposed in the mark. The need for reliable quality of care assessments is of particular concern to Medicare beneficiaries, because they are more likely to be alone and frail and, thus, unable to navigate the bureaucracy of a managed care plan or to have others do so on their behalf. However, development of reliable methods to measure quality of care is still in its early stages.

- The Secretary's information development and dissemination activities would require substantial personnel and financial resources. The mark does not indicate if trust fund or appropriated monies would be available to carry out these required duties.

Marketing

In addition to information provided by the Secretary, plans could develop and distribute their own marketing materials provided that they meet certain requirements. The marketing materials should accurately compare benefits under traditional Medicare and the plan; should not be distributed so as to violate anti-discrimination requirements; should not contain false or misleading information; and should adhere to other fair marketing and advertising standards. All marketing materials would have to be submitted to the Secretary for approval 45 days before distribution.

Benefits

As under current law, all Choice plan must offer at least the Medicare benefit package. Except for high deductible plan, all plans may restructure cost-sharing so long as the average total cost-sharing does not exceed the average for beneficiaries in traditional Medicare. High deductible plans ($3,000 deductible) may not require annual costs (deductible, coinsurance, and copayments) for Medicare covered items and services in excess of $6,000 per year.

Choice plans may include additional benefits under their basic premium price. They may also offer optional, supplemental benefits for an additional premium, provided they offer the same benefit options to all Choice plan enrollees for the same premium.

Issue

- The proposal eliminates the review of the reasonableness of plan premiums as is currently done through the adjusted community rate process. Plans may opt for higher profits in lieu of providing additional benefits.

Health Plan Standards

Medicare choice plans must meet certain requirements for quality assurance, capacity and enrollment, access, provider compensation and advance directives and consumer protections. Consumer protections include guaranteed issue and renewal of coverage, appeals and grievance procedures, provision of supplementary coverage by plans terminating Medicare contracts, solvency standards, and requirements for plans to submit to the Secretary its rates for all categories of enrollees.

Medicare Choice plans could meet requirements for quality assurance by receiving accreditation from a private entity recognized by the Secretary as establishing standards at least as stringent as Medicare standards.

Issue: It is unclear whether plans would be prevented from discriminating on the basis of race, income, or neighborhood.

Medicare Payments

A base rate will be established for each payment area over an unspecified transition period, using the current AAPCC method with certain changes.

- The payment areas will be Metropolitan Statistical Areas (MSA) and one statewide rate for all counties not in an MSA.
- Local rates will be a blended with the national average rate, in order to narrow the current wide geographic variation.
- Payment for graduate medical education and disproportionate share payments will be excluded from the calculations. (Hospitals will submit claims to Medicare for these payments when they serve Medicare Choice enrollees.)

Rates will be adjusted for an individual enrollee's demographic and health status factors.

At the end of the transition, the base rate will then be indexed using an "appropriate" growth factor.

If the Medicare payment is less than the Choice plan premium, the plan and the beneficiary shall "mutually arrange" for the payment, that is, the beneficiary may have to pay out of pocket. As Medicare payments drop, more and more beneficiaries may be in this situation. If the Medicare payment is more than the Choice plan premium, the difference may be placed in a medical savings account, applied to supplemental benefits, or partially (75 percent) rebated to the beneficiary.

The Secretary will conduct a competitive pricing demonstration

and report to Congress by December 2001 on this method of setting Medicare Choice payment amounts.

Issue

- Beyond the unspecified transition period, the federal contribution is increased according to fixed growth rates, presumably based on the per capita spending amounts assumed under the Budget Resolution. As a result, the federal contribution would not keep pace with projected health care inflation or projected growth in private health insurance. Thus, over time, the fixed contribution would be insufficient for beneficiaries to purchase their plan of choice without incurring significant out-of-pocket expenses.

- The document is unclear about whether the all or some of the savings from excluding disproportionate share and indirect medical education payments from the calculation will be returned to the hospitals, or whether it will be used for deficit reduction.

- While managed care in Medicare is growing, enrollment rates are still below those in the commercial market. It is questionable how reducing payments to plans, which will result in reduced extra benefits, will lead to greater beneficiary participation in Medicare Choice plans. In addition, it is questionable whether adequate numbers of private plans would participate in Medicare Choice system if the federal contribution is inadequate.

- The mark refers to a transition period for setting base payment amounts. There are three components to the transition -- changing geographic areas, doing blended rates, and excluding GME and DSH payments. However, the proposal does not specify the duration of this period or whether all three changes will take place at the same time. Effecting these changes over a short transition could be destabilizing. Excluding GME and DSH payments would result in substantial cuts in rates in areas with large teaching hospitals.

- It is misleading to have cash rebates if a plan is also permitted to have deductibles and coinsurance at Medicare levels or at the same actuarial level. The only Medicare beneficiaries who benefit from cash rebates in such a case are those who use no medical services or are low utilizers of services--resulting in a compounding of the currently existing problem of favorable selection by Medicare HMOs.

- If the beneficiary can keep overpayments to the plan as a cash rebate or an MSA deposit, does this mean beneficiaries can have both an MSA and coverage a managed care plan? Does the beneficiary have an option to have and MSA that is not

connected to a high deductible plan?

Administration and Enforcement

Contracts shall be for one year and may be automatically renewable. They may be terminated, after notice and hearing, for failure to meet the contract terms. The Secretary may also impose sanctions for denial of medically necessary services, overcharging, enrollment violations, misrepresentation, failure to pay promptly for services, or employment of providers barred from Medicare participation. (See Item 5 of Anti-fraud and Abuse Policies.)

The Secretary shall make monthly payment to Choice plans in advance.

Medicare Medical Savings Accounts

Medical savings accounts (MSAs) would be for "the exclusive benefit of the account beneficiary." MSAs must meet certain requirements. Contributions to the MSA are limited to the difference between the Medicare payment amount and the premium for the accompanying high deductible policy and any "rollover" contributions. The trustee of the MSA could be a bank, insurance company, or other persons determined by the Secretary. MSA funds cannot be commingled with other property except in common trust or investment funds and cannot be invested in life insurance contracts. Interest on the balance in the MSA is nonforfeitable. The MSA account is terminated if the individual engages in a prohibited transaction.

Interest accrued on the MSA balance is taxable. Amounts withdrawn from the MSA for medical expenses are not taxable while amounts withdrawn for non-medical expenses are taxed as income.

Trustees of MSAs must make reports to Secretary and the beneficiary according to regulations established by the Secretary or be subject to a $50 penalty for each failure to report.

Issue

- The MMSA option could lead to a self-selection bias against fee-for-service Medicare and Medicare HMOs, with healthy individuals choosing the MSA and others left in the traditional Medicare program.
  - The MMSA option for Medicare could potentially be costly to the program if low cost beneficiaries opted for this option. Medicare's payment for these beneficiaries would exceed what the program would have paid had these individuals remained in traditional Medicare.

- In addition, under this scenario, the per capita cost of providing care in traditional Medicare would escalate dramatically since the costs of care for sicker beneficiaries would be spread across a smaller and sicker base. This escalation in per capita spending resulting from adverse selection bias could trigger provider cuts under the "fail safe" provisions further destabilizing traditional Medicare.

- Self-selection of the healthiest beneficiaries into the MMSA could also have an adverse impact on private coordinated care, fee-for-service, and provider service network plans.

- Beneficiaries would be allowed in and out of the Medisave option annually, thus dramatically increasing the potential for adverse selection against Medicare fee-for-service Medicare. (Adverse selection would be a problem even with a one time selection.)

- Are beneficiaries permitted to make contributions of their own money to their MSAs?

- Is double coverage permitted?

- Are MSAs restricted to a high deductible policy? This may be problematic if double coverage is permitted or if the MSA can be used for long-term care expenses.

Transition Rules for 1996

Existing risk contractors are automatically grandfathered as Choice plans and have up to three years to meet any new or different standards.

Medicare Part-B only risk plan enrollees are also grandfathered. The Secretary will develop regulations for these enrollees.

Section II

Inpatient Hospital Payment Update

The prospective payment system (PPS) update factor is the amount that the PPS base payment rate is increased each year. Current law sets the PPS update factor at 2 percentage points lower than the hospital market basket index (MB-2.0) for FY 1996, MB-0.5 for FY 1997 and MB for FY 1998 and beyond. This proposal sets the update at MB-2.5 for FY 1996 and MB-2.0 for FY 1997-FY 2002.

PPS-Exempt Hospital Payment Update

- The update factor for PPS-exempt hospitals is reduced to the market basket minus 2.5 percentage points for FY 1996 and

market basket minus 2.0 percentage points for 1997-2002. For hospitals exceeding the TEFRA limits by 10 percent or more, the update will equal the market basket. Hospitals near the limit receive partial reductions to the market basket using the same formula as in OBRA 1993. Hospitals with costs 150 percent or more below TEFRA limits receive no inflation updates for FY 1996-2002.

Issues: It is impossible at this time to calculate the cost impact of this provision. However, because it reduces the update factor and the current market basket minus 1 percent expires in 1997, this provision would probably save a significant amount of money.

- New rehabilitation and long-term hospitals and units (established on or after October 1, 1995) have TEFRA limits of 130 percent of the mean of all similar hospitals and units. For these facilities and units established before October 1, 1995, a floor to the TEFRA limits is set at 50 percent of the mean of all such hospitals and units.

  Issues: Setting a uniform limit for all similar facilities simplifies the program; it begins to eliminate the hospital-specific payments. However, because this provision only relates to new hospitals and units, its impact may not be dramatic. For existing low cost hospitals and units, their payments will be rebased. This will cost the Medicare program some unknown, but probably small amount of money.

- The Secretary, in consultation with ProPAC, shall report to Congress by June 1996 on a prospective payment system for rehabilitation hospitals and units and other PPS-exempt hospitals.

  Issues: It is very unlikely that HCFA will be able to develop a prospective payment system by June 1996. We will, however, be able to report on obstacles to implementing a prospective system.

Inpatient Hospital Capital Payments

- In FY 1992, Medicare began a ten-year transition toward prospective payment for hospital capital-related costs. During the transition, hospitals receive a gradually decreasing portion of their historic capital costs and a gradually increasing portion of payment based on a national rate. During the first four years of the transition, the rates were adjusted so that total payments equalled 90 percent of estimated Medicare capital costs.

- The proposal would reduce the Federal capital rate by 7.47 percent, and the hospital specific rate by 8.27 percent.

- The proposal would also set payments under the capital prospective system at 85 percent of costs for fiscal years 1996-2002.

Issues:

- The philosophy of prospective payment includes eliminating a rigid link to cost. Under a prospective system, the expectation is that hospitals will respond to the incentives of rate-based payment by operating more efficiently and restraining their costs.

- Setting aggregate payments at 90 percent of cost during the first few years of the transition to prospective payment prevented an abrupt change in the level of payments.

- However, the proposal would extend a link to cost at the level of aggregate payments (at 85 percent rather than the previous 90 percent) for seven more years.

- Because the proposal extends the rigid link to cost, the proposed reductions to the rates will have no actual effect on the level of aggregate payments until the link to cost expires in FY 2002.

- It is not clear why a rigid link to cost should be maintained for such an extended period when provisions that are more congenial to prospective payment, such as reductions to the prospective rates, could be employed to achieve budget savings immediately in FY 1996 and beyond.

- The proposed reductions to the capital Federal rate and hospital-specific rate are apparently designed to correct the rates for overestimations of costs originally used to set the rates. The proposal is based on data available at the time of the proposed PPS rule for FY 1996. The most recent data suggests that reductions of 6.98 percent and 7.93 percent, respectively, would be warranted.

PPS Exempt Hospitals' Capital Payments

Medicare currently pays the reasonable costs of capital to PPS-exempt hospitals. The proposal would reduce cost-based payment by 15 percent for fiscal years 1996-2002.

Issues: The proposal extends to PPS-exempt hospitals the same reduction in cost-based payments that PPS hospitals faced just prior to the introduction of prospective payment for capital.

Hospital Outpatient Departments Capital Payments

Payments for outpatient capital were reduced 10 percent through

1998 as a result of OBRA 93. The proposal would reduce hospital outpatient capital-related costs an additional 5 percent in FYs 1996-1998. (The total reduction in these years would be 15 percent.) This 15 percent reduction would also be extended through 2002.

Disproportionate Share Hospital (DSH) Payments

The provision phases down Medicare DSH payments so that baseline spending in the year 2000 will equal 25 percent less than projected in the March 1995 baseline. To accomplish the phase-down, DSH payments will be reduced 5 percent a year from 1996-2000. In the years 2001 and 2002, the amounts will continue at about 25 percent less than the amount projected in the March 1995 baseline.

As a result of the phase-down, DSH payments are asserted to average 5.0 percent of base PPS payments (operating PPS payments excluding DSH and IME) between 1996-2002, assuming the proposed reductions in the PPS hospital updates.

Issues:

- It is not clear whether all hospitals will face cuts of the same proportion. Some hospitals may face cuts larger than 25 percent. However, no details of the distribution are provided. Specifically, the proposal does not indicate whether the cuts will be targeted to protect the most vulnerable DSH hospitals.

- The proposal states that DSH payments will average 5.0 percent of base PPS payments (operating PPS payments excluding IME and DSH) between 1996-2002. It is not clear whether DSH payments are expected to average 5.0 percent of base payments during that period in the aggregate or on a year-to-year basis.

Direct Medical Education Payments

Medicare pays teaching hospitals for the direct costs of teaching (i.e., resident salaries, faculty salaries, administrative overhead) through direct medical education (DME) payments. This proposal makes no changes to the current methodology.

Indirect Medical Education Payments

Medicare currently reimburses teaching hospitals for the indirect costs of teaching (i.e., lower efficiency and productivity, higher case mix) through indirect medical education payments (IME). The payment adjustment is currently based on a formula that increases the DRG payment by approximately 7.7 percent for each 10 percent increase in the ratio of interns and residents to beds. This proposal reduces the formula increase to 6.7 percent

in FY 1996, 5.6 percent in FY 1997 and 4.5 for FY 1998-FY 2002.

Issue: This was ProPAC's recommendation for an IME phase-down in their latest report.

Hospital Outpatient Department Formula

Under current law, there is an anomaly in Medicare's payment for certain hospital outpatient department services which are paid on the basis of a blend of hospital costs and fee schedules. As a result of the anomaly, beneficiaries' coinsurance payments do not reduce Medicare payments on a dollar-for-dollar basis. This provision would correct this anomaly in the current payment formula.

Issues: The formula would be fixed without addressing the issue of beneficiary coinsurance. A preferable policy would be to propose a prospective payment system for OPDs and use part of the savings to offset the program costs from making modest improvements in coinsurance.

Hospital Outpatient Department Payments

A 5.8 percent reduction for hospital OPD services paid on a cost basis (and the cost portion of blended payments) has been in place since 1991 and is authorized through FY 1998. This proposal would extend this policy through 2002.

Nursing Home Payments

- The OBRA 1993 savings on routine cost limits would be extended for an additional year. Savings appear to be extended through a lowering of the cost limits to 100 percent of the mean.
- Beginning in FY 1997, routine cost limits will include all ancillaries, supplies and equipment except a specified list.
- Beginning in FY 1997, all services not subject to routine cost limits (therapies, prescription drugs, complex medical equipment, IV therapy and solutions, and diagnostic services) would be subject to a limit equal to a blend of facility specific and national average cost of ancillaries per stay.
- Non-routine services must be billed to Medicare through the nursing facility. For Part B services, SNFs must be paid on the basis of the available fee schedule, or on a lesser of costs or charges basis. The cost portion of Part B billings will be reduced by 5.8 percent for FY 1996-2002.
- Capital costs will be reduced by 15 percent.
- A pool is established for exceptions payments equal to the

1995 aggregate exceptions payments. Future exceptions must be made on a budget neutral basis. Exceptions for non-routine payment limits cannot exceed 5 percent of total non-routine payments each year.

- OBRA 93 savings provisions and Part B savings are extended to low volume nursing facilities. These facilities would also be subject to broader definition of routine costs.

- The Secretary, in consultation with ProPAC and nursing home experts, will report on (by June 1997) a separate payment limit for patients with intensive nursing and therapy needs. The payment limit will be implemented in a budget neutral manner in FY 1998. ProPAC must report on the new payment system within one year of its operation.

Issues:

- Lower cost limits and imposition of limits on ancillaries may place more complex patients at risk of inadequate services. In addition, in 1997 the definition of what is covered under the routine cost limit is expanded, but there is no indication that the limits would be adjusted to account for this. Restrictions on the exception process could limit the ability to respond to changes in the severity of cases in the future.

- Simultaneous lowering of hospital and SNF payments may place more complex patients, who might otherwise be shifted from hospitals to SNFs, at risk of not receiving needed services.

- The payment limit specified for ancillary costs is different from the Ways and Means proposal in that the limit is established on a per discharge basis in Finance, while on a per visit basis in Ways and Means. The variation surrounding costs per discharge are so great that, in the absence of an adequate case-mix adjustor (which currently does not exist) HCFA would have real concerns about the advisability of this type of a payment limit.

- A separate payment limit for patients with "intensive nursing and therapy needs" may create a subacute payment rate. While such a rate may be pertinent in view of the other amendments, it may not be possible on a budget neutral basis.

- HCFA supports the concept of consolidated billing (requiring the nursing facility to bill for all non-routine services).

Home Health Services Payments

- Home health agencies (HHAs) would be paid a per visit prospective rate subject to an annual dollar cap.

- The base year national average per visit rates would be established to assure budget neutrality with respect to the OBRA-93 freeze. They would be updated annually at the market basket minus 2.0 percentage points.

- The cap is calculated to approximate all covered services delivered to a beneficiary during a period of 120 days, multiplied by the number of beneficiaries served by the HHA per year. But the cap would be applied to all home health services rendered to a beneficiary from day 1 to day 165 of an episode.

- After 165 days, an HHA may request that additional payments be made on a per visit basis.

- No new episode of care would be recognized for reimbursement purposes until after a beneficiary has been discharged from the HHA for at least 60 days.

- The cap would be adjusted by a crude case mix based on HCFA's PPS demo. To combat case mix creep for the first 3 years after implementation, the Secretary would be required to adjust the dollar cap to assure that case-mix remains budget neutral.

- HCFA would rebase the episode cap every 2 years to adjust for case mix changes. The episode cap would be adjusted annually by the market basket minus 2.0 percentage points.

- HHAs that keep total payments for the year below the annual cap would be allowed to retain 50 percent of the savings; shared savings cannot exceed 5 percent of an agency's aggregate Medicare payments in a year.

- Recertification for home health eligibility would be made every 30 days, as opposed to the current law 60-day interval.

- Creates many new responsibilities for HCFA to police gaming of the system. HCFA could adjust payments where gaming was found.

- The "favorable presumption" toward the limitation on liability for HHAs (due to expire 12/31/95) would not be extended.

Issues:

- The proposal envisions immediate implementation. It assumes that PPS and case mix adjustment methodologies have already been tested and refined. In fact, substantial lead time would be required to collect case and other data and to ensure their validity and reliability. Implementation requires reliable data, systems to collect them, and a tested working model.

- The cap is designed to control volume, but it is nothing more than a budget ceiling and does not reflect a meaningful episodic prospective rate.

- In spite of the shared-savings provision, the cap appears to give incentives to HHAs to provide services up to the cap. That is, to the extent that HHAs can make more money from providing low cost (low skilled) visits than they would receive from sharing 50 percent of the savings, they will provide services up to the cap.

- The aggregate cap provides incentives to HHAs to avoid heavy-care patients and admit large numbers of low cost cases.

- The requirement that HHAs provide care up to 165 days (but get paid for only 120 days worth of service) for patients who need extended care is a gimmick posing as a budget saver. HHAs will simply avoid providing care after 120 days and find some clinical or other justification for this.

- Proposal allows outliers that represent cases exceeding 165 days. These would be paid a per visit rate with no control on utilization. This opens the possibility for gaming in which HHAs would extend cases for certain patients in order to get the unlimited outlier payment.

- The proposal's case mix adjustment methodology is inappropriately based on a simplified model that was designed only for use in HCFA's Phase II prospective payment demonstration and not intended for use in establishing episodic payment rates. The demo's case-mix categories should not be used to establish a national episodic prospective pay system because they explain only 10 percent of the variation in costs (as compared to about 30 percent when hospital PPS was implemented).

- Protections against case mix creep would only be in place for the first 3 years of implementation.

- The proposal places a huge administrative burden on the medical review process without appropriating additional dollars to this exercise.

- HCFA would be allowed to investigate -- and make payment adjustments to account for -- "irregularities intended to circumvent" the system (premature discharges, transferring patient between HHAs, creating mini-episodes, etc.) There is absolutely no mechanism by which HCFA could learn of these irregularities while they are happening. HCFA has limited medical record review capability and can randomly audit a small percentage of HHA bills.

- Exception payments are allowed but not defined.

Hospice Service Payments

Would set the update for hospice services at market basket minus 2.0 percentage points each year for fiscal years 1996-2005.

Payments for Physician Services

This proposal would change the method used to update the Medicare physician fee schedule by a series of proposals recommended by the Physician Payment Review Commission. It ostensibly repeals the current Medicare Volume Performance Standard and replaces it with a very similar system, with:

(1) A single conversion factor, instead of the current three different factors,
(2) Specification of the single conversion factor for 1996 at $36.00 in statute (1.7 percent less than would occur under current law),
(3) Establishment of cumulative growth targets and basing them on real GDP per capita rather than historical physician volume/intensity, and increasing the maximum reduction in updates due to performance from 5 to 7 percentage points, and establishment of limits on annual bonuses at 3 percentage points.

Payments for Clinical Laboratory Services

Payments for clinical lab services are based on local fee schedules, which are updated annually based on changes in the CPI. There is a cap on payment amounts, which for 1996 and subsequent years is set at 76 percent of the national median. The provision would (1) eliminate CPI updates from 1996 through 2003; (2) reduce the payment cap to 65 percent of the national median fee beginning 1997; and (3) direct the Secretary to compare rates paid by Medicare with other volume purchasers and recommend changes in the fee schedule methodology.

Payments for Durable Medical Equipment

The fee schedules for DME (except for oxygen) would be maintained at 1995 levels through January 1, 2003 rather than increased annually by the CPI-U as required by current law. The fee schedule amounts for oxygen would be reduced by 40 percent.

Issues: HCFA is currently in the process of determining whether Medicare's payments for home oxygen are grossly excessive through the inherent reasonableness process. Preliminary analysis could justify payment reductions in the range of 7 to 43 percent.

Payments for Ambulance Services

Medicare covers ambulance services when other forms of transportation would endanger the patient's health. Payments are based on "reasonable charges," which are updated annually. The provision would eliminate payment updates from 1996 through 2002.

Payments for Other Part B Services

- The fee schedules for prosthetics and orthotics would be maintained at 1995 levels through 2002 rather than increased annually by the CPI-U as required by law.
- The annual updates would be eliminated for ambulatory surgical center payments from 1996 through 2002.

Part B Annual Deductible

The Committee proposal will raise the annual Part B deductible in 1996 to $150. In subsequent years through 2002, it will be increased by $10.00 each year.

Part B Premium

The proposal would permanently establish the Part B premium at 31.5 percent of program cost.

Eliminate the Subsidy of the Medicare Part B Premium

Effective January 1, 1997, individuals with adjusted gross incomes plus tax-exempt interest in excess of $75,000, or couples with incomes in excess of $100,000 would be responsible for an additional Part B premium. The individuals would assume an increased percentage of the premium, with the premium subsidy being completely phased out at $100,000 for individuals and $150,000 for couples. That is -- between the 31.5 percent base premium and the income-related premium, these individuals would pay 100 percent of program costs.

Medicare enrolles will declare during open enrollment whether their incomes will exceed the thresholds for the coming year. The premium will be deducted from their Social Security checks. HHS will determine the correct premium deduction and notify SSA. SSA and the IRS will reconcile the amount of the premium deduction through verification of the individuals declared income with the actual income reported to IRS.

Issues: The plan would implement a income-related premium through HHS and SSA rather than through the IRS. Under the Catastrophic Coverage Act and the Health Security Act, the income-related premium would have been administered through the IRS. Implementation through HHS/SSA would require the creation a new

bureaucracy and duplicative reporting system.

Medicare Secondary Payer

- Makes permanent the provision that makes Medicare the secondary payer for disabled employees with employer-based health insurance.

  Issue: This provision is included in the President's FY 1996 budget and would result in savings to the program.

- Mandates that for 30 months after entitlement, Medicare would be the secondary, rather than the primary payer for beneficiaries with ESRD who have health coverage through an employer group health plan.

  Issues:

  - This proposal would result in savings, but would increase by 12 months the time during which employers would be exposed to the high health care costs of covering ESRD beneficiaries. Concern has been raised in the past about the possibility that such an extension might lead insurers and employers to drop ESRD coverage. The President's budget proposed to make permanent only that, for 18 months after entitlement, Medicare would be the secondary, rather than the primary payer for beneficiaries with ESRD who have health coverage through an employer group health plan.

  - Our current interpretation of OBRA 93 is that group health plans that cover disabled or aged Medicare beneficiaries who develop ESRD would not have to switch to be the primary payer for an 18 month period after the beneficiary developed ESRD. This provision would make permanent the court injunction of April 1995 prohibiting HCFA from deeming group health plans the primary payer (and attempting to collect from them) for current retired or disabled beneficiaries who developed ESRD between August 1993 and April 1995.

- Makes permanent HCFA's current authority to match data among HCFA, IRS, and SSA in order to identify the primary payers for Medicare beneficiaries with health coverage in addition to Medicare.

  Issue: This provision is included in the President's FY 1996 budget and would result in savings to the program.

Improving Access to Health Services and Improving Medicare in Rural Areas

- The Medicare Dependent Hospital program is re-instituted effective for cost reporting periods on or after September 1,

1995. This program was terminated September 30, 1994. Criteria for inclusion in this program remain unchanged (100 or fewer beds and at least 60 percent Medicare patient days or discharges.) These hospitals receive Sole Community Hospital payment.

Issues: There are a relatively few hospitals which meet these criteria, and therefore the reinstitution of this program will probably result in a minor cost impact.

- A new program (similar to the Rural Primary Care Hospital (RPCH) program) is established in all states with an unspecified grant program. These limited service hospitals must have a length of stay below 72 hours and no more than 6 acute care beds. Hospitals participating in the swing bed program may use 12 beds. These hospitals are paid on a reasonable cost basis.

  Issues: This provision institutes a program similar to the RPCH program prior to the recent changes announced in the September 1, 1995 regulation, based on a strict interpretation of the 1994 Social Security Amendments. The major change in the current rule is the elimination of the swing bed option for new RPCHs.

- The Medical Assistance Facility Program in Montana is continued for all qualified facilities in that State.

  Issues: This does not change current Medicare policy.

- A new Rural Emergency Access Hospital (REACH) program is established for rural hospitals to serve patients that stay only 24 hours. Medicare payments are based on reasonable costs.

  Issues: This program is similar to the RPCH program on a more restrictive scale, i.e., shorter length of stay and no overnight beds. Any hospital could apply for the RPCH program and limit its services to meet these criteria, if it wanted to.

- An additional telemedicine grant program will be available through the PHS Office of Rural Health.

- Currently, Medicare makes direct payments to nurse practitioners in rural areas and in nursing facilities. Payment is 75 percent of the physician fee schedule for services furnished in inpatient settings and 85 percent for all other services. Medicare also makes direct payments to physician assistants (payments go to the employer) in hospitals, nursing facilities, and in rural health professional shortage areas. Payment is 75 percent of the

physician fee schedule for services in inpatient settings, 65 percent for assistant-at-surgery services, and 85 percent for nursing facility and outpatient settings. It appears that this proposal would allow physician assistants and nurse practitioners to be paid directly in all areas. Payment would be 85 percent of the physician fee schedule in outpatient settings (unspecified for inpatient).

Anti-fraud and Abuse Policies

Coordinated Anti-Fraud Program. The Secretary, acting through the OIG and the Attorney General, would jointly establish a program to coordinate Federal, State, and local law enforcement efforts to combat fraud and abuse in the delivery of, and payment for, health care.

Issue: HCFA, OIG, and DOJ are currently coordinating such activities under Operation Restore Trust.

Health Care Fraud and Abuse Account. Establishes an account to receive all monies (up to a ceiling of $200 million in FY 1996 with 10 percent annual increases thereafter) from all civil money penalties, fines, forfeitures, and damages assessed in criminal, civil, or administrative health care cases, along with any gifts. The account is to cover the costs of administration and operation of the coordinated anti-health care fraud and abuse program for HHS-OIG and DOJ.

Health Care Fraud and Abuse Guidelines. The Secretary shall publish an annual notice in the Federal Register soliciting proposals for modifications to existing safe harbors, new safe harbors, interpretive rulings, and special fraud alerts. Final rules modifying existing safe harbors and establishing new safe harbors will be published. The public can at any time request interpretive rulings related to Medicare and Medicaid anti-fraud and abuse laws. Ninety days after receipt of a request, the HHS-OIG in consultation with DoJ, must publish in the Federal Register interpretive rulings that will not have the force of law. The public can request the OIG to investigate and issue a special fraud alert informing the public of practices which could relate to fraud and abuse against Medicare and Medicaid.

Revisions to the Current Sanctions for Medicare and Medicaid Fraud and Abuse. This provision mandates that the Secretary exclude providers from Medicare and Medicaid if they have been convicted of a felony relating to health care fraud. The Secretary may exclude persons convicted of a criminal misdemeanor related to health care fraud. The proposal sets minimum (but unspecified) periods of exclusion. The Secretary may exclude individuals with a direct or indirect ownership or control interest of 5 percent or more in an entity or is an officer or managing employee if the entity is already excluded from Medicare

or Medicaid or has been convicted of a criminal offense relating to health care fraud.

Intermediate Sanctions.

- Provides for termination of contract, civil money penalties, or suspension of enrollment or payments as intermediate sanctions against HMOs.
- HMOs will be permitted to develop and implement corrective action plans before penalties are imposed.
- Each HMO must have an agreement with a peer review organization (PRO) or similar organization to perform quality review.

Data Collection Program. Establishes a national health care fraud and abuse data collection program for reporting final adverse actions against health care providers, suppliers, or practitioners.

Civil Monetary Penalties.

- Civil money penalties and assessments will be used to pay back Medicare and Medicaid. Remaining dollars will go to the health care fraud account.
- Civil money penalties are increased to $10,000 for many current law fraud and abuse activities. Allows civil money penalties to be assessed for (1) incorrect coding; (2) medically unnecessary services; and (3) persons offering remuneration (including waiving coinsurance and deductible amounts) to induce the individual to order from a particular provider or supplier receiving Medicare or State health care funds.

Issues:

- There should be an abnormal pattern of ordering medically unnecessary services before a civil money penalty is levied.
- The Secretary can impose intermediate civil money penalties of not more than $10,000 per violation for criminal anti-kickback violations.

Criminal Law Provisions. A health care fraud section is added to the criminal code.

State Health Care Fraud Control Units. Extends the authority of the units by allowing the units to investigate other federal fraud abuses and allowing investigation and prosecution in the case of patient abuse in non-Medicaid board and care facilities.

Budget Expenditure Limit Tool

- The Medicare BELT proposal sets mandatory Medicare outlay targets at: $191 billion in FY 1996, $201 billion in FY 1997, $213 billion in FY 1998, $226 in FY 1999, $239 in FY 2000, $255 in FY 2001, and $274 in FY 2002. The Medicare outlay target in 1996 alone is $11 billion less than CBO projection.

- Beginning for FY 1996, based upon CBO and OMB estimates of Medicare outlays for the fiscal year in comparison to baseline Medicare outlays (as defined by the FY 1995 Budget Act) for the fiscal year, a presidential order to bring spending within the annual target for the fiscal year will be issued by October 15. This order will specify the reduction in payment amounts to meet the annual spending target.

- Each payment amount for covered services would be reduced by a specified percentage which, when applied proportionately to all payments, will equal the amount of reductions needed to bring spending within BELT targets.

- Congress retains the ability, through an expedited process similar to reconciliation, to alter the way across-the-board cuts are applied to the various Medicare payments for services. Three-fifths of the Senate and House are needed to approve such changes.

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

Issues:

- The rate of growth allowed under the BELT is 6.2 percent, considerably lower than rates of growth projected in either the CBO or President's baseline.

- The across-the-board cuts are likely to be quite large, and could potentially result in negative payment increases from one year to the next.

- Is the BELT limited to fee-for-service Medicare?

Age of Eligibility for Medicare

In 1983, Congress raised the eligibility age for Social Security old-age benefits from 65 to 67, over a transition period from 2003 to 2027. The proposal would raise the age of eligibility for Medicare to the same age as that for Social Security old age benefits.

The eligibility age for Supplemental Security Income (SSI) is

raised in tandem with that for Medicare.

Issues:

- It is not clear that an insurance market exists for persons age 65 or over. The proposal could thus have a harmful impact on individuals who would otherwise be eligible for Medicare.

- Raising the eligibility age for SSI would mean that those who would otherwise have qualified for Medicaid through SSI could not do so until later.

Extension of Hospital Insurance (HI) Tax to All State and Local Government Employees

State and local government employees hired before April 1, 1986 have never paid the HI tax nor earned credit toward eligibility for Medicare Part A coverage. The total HI tax rate for Medicare covered employees is 2.9 percent, with half imposed on the employee and half imposed on the employer. This proposal would mandate that all State and local government employees and their employers pay the HI tax and earn credit toward Medicare eligibility. The service of State and local government employees prior to January 1, 1996 would be considered covered employment for Medicare eligibility purposes.