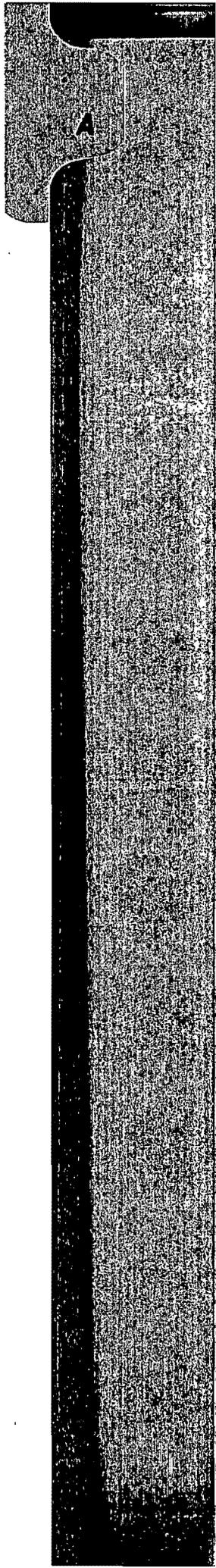


HCFA BRIEFING ON BALANCED BUDGET ACT (BBA) IMPLEMENTATION

SECTION A	OVERVIEW
SECTION B	MEDICARE+CHOICE
SECTION C	BENEFICIARY INFORMATION CAMPAIGNS & NEW PREVENTION BENEFITS
SECTION D	PPS & OTHER PAYMENT CHANGES
SECTION E	PROGRAM INTEGRITY STANDARDS
SECTION F	BBA ISSUES RAISED BY CONGRESSIONAL STAFF
SECTION G	BBA IMPLEMENTATION TABLE

Med. December announcement
of benefits.

January fund searched
capitalization



HCFA BRIEFING ON BALANCED BUDGET ACT (BBA) IMPLEMENTATION

SECTION A OVERVIEW

- o Fact Sheet
- o Agenda

HCFA BRIEFING ON BALANCED BUDGET ACT
NOVEMBER 14, 1997
FACT SHEET

DATE/TIME: Friday, November 14, 1997
3:00-3:10 p.m. - Nancy-Ann DeParle
3:10-3:25 p.m. - Kathy Buto
3:25-3:40 p.m. - Michael McMullan
3:40-3:55 p.m. - Kathy Buto
3:55-4:05 p.m. - Linda Ruiz
4:05-4:10 p.m. - Nancy-Ann Min DeParle
4:10-4:30 p.m. - Discussion

LOCATION: Room 216 OEOB

PARTICIPANTS: White House
Chris Jennings, Deputy Assistant to the President for Health Policy
Sara Bianchi, Office of Policy Development
Jean Lambrew, Senior Advisor for Health Policy

OMB
Josh Gotbaum, Executive Associate Director
Mark Miller, Branch Chief, Health Financing Branch

HCFA
Nancy-Ann Min DeParle, Administrator
Kathy Buto, Deputy Director, Center for Health Plans & Providers
Michael McMullan, Acting Director, Center for Beneficiary Services
Linda Ruiz, Dir., Program Integrity Grp., Office of Financial Management
Pam Gentry, Director, Office of Communications & Operations Support
Don Johnson, Acting Deputy Director, Office of Legislation
Tim Love, Special Assistant to the Administrator
Corinne Marvin, Special Assistant to the Administrator
Dan Waldo, BBA Implementation Team Leader

TOPIC: Implementation of the Medicare provisions of the Balanced Budget Act

HEADS UP: This briefing will be at the summary level. More details, as requested, can be provided later. Medicaid and children's health initiative work will be discussed another time.

AGENDA

HCFA implementation of the Medicare provisions of BBA

- Nancy-Ann Min DeParle - Introduction and Overview
- Kathy Buto - Medicare+Choice
- Michael McMullan - Beneficiary Information Campaigns and
New Prevention Benefits
- Kathy Buto - Summary of PPS and Other Payment Changes
- Linda Ruiz - Program Integrity Safeguards in the BBA

B

HCFA BRIEFING ON BALANCED BUDGET ACT (BBA) IMPLEMENTATION

SECTION B

MEDICARE+CHOICE

- o Medicare+Choice Program
- o BBA Implementation: Provider Sponsored Organizations
- o BBA Implementation: Medical Savings Accounts

MEDICARE+CHOICE PROGRAM

CONTRACTS WITH MEDICARE+CHOICE PLANS (Medicare Part C)

Public Law 105-33, The Balanced Budget Act of 1997, establishes a new authority permitting contracts between HCFA and a variety of different managed care and fee-for-service entities. The types of entities that may be granted contracts under this new authority include:

- + **Coordinated care plans**, including Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Provider-Sponsored Organizations (PSOs). A PSO is defined as a public or private entity established by health care providers, which provide a substantial proportion of health care items and services directly through affiliated providers who share, directly or indirectly, substantial financial risk.
- + **Religious fraternal benefit society plans** which may restrict enrollment to members of the church, convention or group with which the society is affiliated. Payments to such plans may be adjusted, as appropriate to take into account the actuarial characteristics and experience of plan enrollees.
- + **Private fee-for-service plans** which reimburse providers on a fee-for-service basis, and are authorized to charge enrolled beneficiaries up to 115% of the plan's payment schedule (which may be different from the Medicare fee schedule).

In addition to the above Medicare+Choice contractors, beginning in January, 1999, up to 390,000 beneficiaries will have the choice (on a demonstration basis ending January 1, 2003) of enrolling in a **Medical Savings Account (MSA)** option. Under this option, beneficiaries would obtain high deductible health policies that pay for at least all Medicare-covered items and services after an enrollee meets the annual deductible of up to \$6,000. The difference between the premiums for such high deductible policies and the applicable Medicare+Choice premium amount would be placed into an account for the beneficiary to use in meeting his or her deductible expenses.

Current §1876 Contracts: Current HMO/CMP risk plans that remain in compliance with current contracting standards and comply with new requirements established under this statutory authority will automatically transition into the Part C Medicare+Choice program. Beginning January 1, 1998, section 1876 risk-based contractors will be paid under a new Medicare+Choice payment methodology rather than the current AAPCC method in section 1876(a), and will be subject to certain other Medicare+Choice provisions. Contracting standards for Medicare+Choice plans (except for PSO solvency standards) will be published by June 1, 1998 as interim final regulations. Upon publication, the Secretary will no longer accept new §1876 risk applications. As of January 1, 1999, existing §1876 risk-based contracts will be terminated, and plans in good standing will transition to the Medicare+Choice program.

Repeal of Cost Option: As of August 5, 1997, the Secretary is prohibited from entering into any new §1876 cost-based contracts, unless the plan is a Health Care Prepayment Plan with an agreement under section §1833 of the Social Security Act. The §1876 cost-based payment authority is repealed and all cost contracts are terminated as of December 31, 2002.

Limited HCPP Option: Beginning January 1, 1999, the Secretary may only contract with those HCPPs that are sponsored by Union or Employer groups, or HCPPs that do not "provide, or arrange for the provision of, any inpatient hospital services ...". This amendment will result in the termination of §1833 agreements with any organization that does not meet the new definition. HCFA will establish transition rules for §1876 risk-based contractors that currently receive reimbursement on a cost basis for enrollees remaining under a previous HCPP agreement.

§1876 Contracting Option for PSOs: During the transition, PSOs that are licensed by a State may be eligible organizations for purposes of obtaining a Medicare risk contract under section §1876. State licensed PSOs which apply for a risk contract would be required to meet all applicable standards for Competitive Medical Plans, except that the minimum enrollment requirements may be reduced or waived beginning January 1, 1998.

Medicare Subvention: The balanced budget amendment authorizes six (6) sites for a Medicare managed care subvention demonstration between HCFA and DoD. Under this demonstration DoD will be paid a reduced percentage of the Medicare+Choice reimbursement rate in return for providing Medicare covered services to eligible military retirees who are also eligible for Medicare. Enrollment is expected to begin in January of 1998, and for the first DoD managed care sites should begin providing health care services in February of 1998.

MEDICARE+CHOICE PROGRAM REQUIREMENTS

Unless otherwise noted, the following discussion is intended to summarize briefly only those statutory provisions which establish new Medicare+Choice program requirements, or amend existing contractual standards. New contractual standards will apply to §1876 risk plans which transition to the Medicare+Choice program for contract years beginning on January 1, 1999.

Beneficiary eligibility: Only beneficiaries entitled to Part A and enrolled in Part B are eligible to enroll in any Medicare+Choice plan that serves their geographic area. HCFA will promulgate rules to permit the continued enrollment of Part B-only enrollees in those §1876 risk-based plans that transition into the Medicare+Choice program.

According to rules to be determined by the Secretary, Medicare+Choice plans may allow beneficiaries who move out of the geographic area served by the Medicare+Choice plan to remain enrolled in the plan, provided those enrollees have reasonable access to the full range of covered services as part of the basic benefit package.

Contracting standards: By June 1, 1998, the Secretary will publish interim final regulations to establish standards for Medicare+Choice organizations. These standards will be based on existing requirements contained in Part 417 of the Public Health Title of the Code of Federal Regulations. All Medicare+Choice applications will be reviewed for compliance with the new standards, and §1876 risk plans that wish to transition to the Medicare+Choice option will be required to meet the contracting standards for contract years beginning January 1, 1999.

Federal standards will preempt any State authority with regard to benefit requirements, requirements relating to inclusion of or treatment by providers, and coverage determinations (including related appeals and grievance processes).

(NOTE: Fiscal solvency standards for PSOs will be established on a different track.)

Special Information Campaign: During November 1998 the Secretary will conduct an educational campaign to inform Medicare beneficiaries about the availability of Medicare+Choice plans, and plans with Medicare risk contracts. Current §1876 risk contractors must accept new enrollees during this period.

Enrollment: Beginning in November of 1999, the Secretary will provide for an annual national educational and publicity campaign to inform eligible beneficiaries about their Medicare+Choice plan options. Beneficiary plan choice is effective January 1 of the following year. Newly eligible enrollees who do not choose a Medicare+Choice plan are deemed to have chosen the original Medicare fee-for-service option, except that the Secretary may establish procedures under which "age-ins" enrolled in a contracting plan may be deemed to have elected the entity's Medicare+Choice plan.

Any beneficiary who is enrolled in a §1876 plan as of December 31, 1998 will be considered to be enrolled with that organization under the Medicare+Choice program if the plan is granted a Medicare+Choice contract beginning January 1, 1999.

Disenrollment: Starting in 2002, beneficiaries who are enrolled in a Medicare+Choice coordinated care plan will be able to disenroll from their elected plan option once during the first 6 months of 2002. Beneficiaries who enroll in a Medicare+Choice plan at the time they become eligible for Medicare will be permitted to disenroll at any time during the first year of enrollment.

Beginning January 1, 2003, beneficiaries may only disenroll from a Medicare+Choice coordinated care plan and choose another plan, leave Medicare fee-for-service to enroll in a Medicare+Choice plan, or return to Medicare fee-for-service, one time during the first 3 months of the calendar year. Beneficiaries will be effectively locked in to their Medicare+Choice plan election for the remaining nine months following this window. Exceptions to the lock-in period are available for enrollees under the following circumstances: the Medicare+Choice plan contract is terminated, the beneficiary leaves the plan service area, the Medicare+Choice plan fails to provide covered benefits or is found to be improperly marketing the Medicare product, or under other conditions specified by the Secretary.

Medicare+Choice plans may disenroll Medicare beneficiaries if it is determined that the enrollee was disruptive to plan operations, or failed to pay required premiums on a timely basis.

Coordinated Open Enrollment Period: In November 1999, the Secretary will hold the first annual coordinated open enrollment period to allow eligible beneficiaries to enroll in Medicare+Choice plans. Medicare+Choice plans will be required to submit comparative information to the Secretary.

Marketing Material Approval: If a Medicare+Choice plan's marketing materials were approved for one service area, they will be deemed to be approved in all of the plan's service areas, except with regard to area-specific information. Medicare+Choice plans are prohibited from giving monetary incentives as an inducement to enroll, and from completing any portion of the enrollment application.

Benefits: Public Law 106-33 establishes some new preventive benefits, and increases coverage for others. The updates to payment rates for current §1876 risk contractors and Medicare+Choice plans will reflect the costs of these new benefits.

BENEFIT	EFFECTIVE DATE
Annual Screening Mammography (for women over 40)	January 1, 1998
Screening PAP Smear and Pelvic Exam (every 3 years)	January 1, 1998
Colorectal Cancer Screening Exam	January 1, 1998
Bone Density Measurement (to rule out osteoporosis)	July 1, 1998
Prostate Cancer Screening Exam (for men over 50)	January 1, 2000

Disclosure: The Medicare+Choice plan must provide in a clear, accurate and standardized form certain information to each enrollee such as the plan's service area, benefits, number, mix and distribution of providers, out-of-area coverage, emergency coverage, supplemental benefits, prior authorization rules, appeals and grievance procedures and quality assurance program. Upon request, enrollees must be provided comparative information, information on the plan's utilization control mechanisms, information on the number of grievances and appeals and their disposition in the aggregate and a summary of physician compensation arrangements.

Access to non-network providers: Medicare+Choice plans must cover services provided by non-network providers in the case of urgent care that is medically necessary when the enrollee is out of the plan service area, renal dialysis services for enrollees who are temporarily out of the plan's service area, and maintenance or post-stabilization care after an emergency condition has been stabilized.

Medicare+Choice plans are required to pay for emergency services without regard to prior authorization or the emergency provider's status as a network provider. An emergency medical condition is defined using a "prudent layperson" standard which may include the beneficiary's assertion of "severe pain".

QA Program: Medicare+Choice plans must undergo external quality reviews by independent review organizations. The Secretary is authorized to waive the external review requirement if the Medicare+Choice plan can demonstrate a record of excellence in meeting quality assurance standards, and compliance with other applicable requirements. Plans could be deemed to meet internal quality assurance requirements by becoming accredited by a private organization approved by the Secretary.

Providers: Medicare+Choice plans must establish procedures relating to physician participation in the plan, including notice of rules of participation, written notice of adverse participation decisions, and an appeals process. Medicare+Choice plans must consult with participating physicians regarding medical policy, quality and medical management procedures.

Medicare+Choice plans are prohibited from requiring contracting providers to indemnify the plan against actions resulting from the plan's denial of medically necessary care.

Plans may not restrict health care professionals' advice to enrollees regarding the beneficiary's health status or treatment options. The Act includes a "conscience protection" clause exempting a plan from being required to provide or cover a counseling or referral service if the plan (1) objects on moral or religious grounds, and (2) informs prospective enrollees of such policy before or during enrollment, and current enrollees within 90 days after adopting a change in such policy.

Minimum enrollment: Medicare+Choice plans will be required to meet the following minimum enrollment requirements: 5000 for HMOs, PPOs, and FFS plans in urban areas, and 1500 for PSOs; 1500 for HMOs, PPOs, and FFS plans in rural areas, 500 for PSOs. These requirements could be waived in the first 3 contract years.

The enrollment composition requirements, (known as the "50/50 rule") no longer counts Medicaid enrollees in the federal portion of the enrollment mix. The Secretary is given immediate explicit authority to waive the 50/50 requirement for contract years beginning January 1, 1997. The 50/50 requirement is repealed as of January 1, 1999.

Annual Audit: The Secretary must annually audit the financial records annually of at least one third of Medicare+Choice plans. The audit will include review of data related to Medicare utilization, costs, and computation of the ACR, and will be monitored by the GAO.

Plan User Fees: Medicare+Choice plans and section 1876 contractors must contribute their pro rata share, as determined by the Secretary, of estimated costs related to enrollment and dissemination of information and certain counseling and assistance programs. The Secretary is authorized to collect user fees but such fees are limited to \$200 million in fiscal year 1998; \$150 million in fiscal year 1999 and \$100 million in fiscal year 2000 and beyond.

Payment: The 1998 payment rates for §1876 risk-based contracts and new Medicare+Choice plans will be announced on September 8, 1997. On **March 1**, beginning in 1998, the Medicare+Choice payment rates will be announced for the following contract year. In general, beginning in 1998 Medicare capitation rates to plans will be the greater of:

- + a blend of the input-price adjusted national rate and an area-specific rate, adjusted by a budget neutrality factor. The area-specific rate will be based on 1997 rates, and adjusted to reflect 1) a national average Medicare per capita growth rate, and 2) gradual removal of IME/GME costs;
- + a minimum payment amount of \$367 for 1998, not to exceed 150% of the prior year rate, adjusted annually by a defined update factor; or
- + a minimum percentage increase (2% per year).

The 1997 capitation rates (from the 1997 AAPCC ratebook) will be the base for (1) the area specific rates in the blend and (2) the minimum percentage increase rates. In an area where the 1997 AAPCC varies by more than 20 percent from the 1996 AAPCC, the Secretary can substitute for the 1997 rate a rate more indicative of the cost of enrollees in the area.

The update factor for the area specific rates in the blend and the minimum payment amount will be the national average per capita Medicare+Choice growth rate, reduced by 0.8 percentage points for 1998, and 0.5 percentage points for 1999 through 2002, and 0.0 percentage points thereafter.

The payment area is the county or equivalent area specified by the Secretary. Beginning in 1999, states would be able to request a statewide payment rate, or rates based on Metropolitan Statistical Areas and a statewide rural area. Such changes would be subject to a budget neutrality requirement.

Reporting of Encounter Data: Beginning January 1, 1998, the Secretary will require that current Medicare managed care contractors submit hospital encounter data covering the period beginning July 1, 1997. Beginning on or after July 1, 1998, the Secretary has the authority to establish other encounter data reporting requirements for Medicare+Choice plans, including current §1876 risk contractors that transition to the new program on January 1, 1999.

Premiums: Beginning in 1998, by May 1 all Medicare+Choice coordinated care plans including HMOs, PSOs, and PPOs must submit adjusted community rate (ACR) proposals for basic and supplemental benefits, the plan's premium for the basic and supplemental benefits, a description of cost sharing and the actuarial value of cost sharing for basic and supplemental benefits and a description of any additional benefits and the value of these benefits.

State taxes: States may no longer tax the premium revenue of Medicare+Choice plans.

Provision of Information: As part of the monitoring and compliance process, Medicare+Choice plans must disclose financial information to demonstrate fiscal soundness, including data related to business transactions concerning property transfers and trades, loans, and extensions of credit.

IMPLEMENTATION
(Selected Key Dates)

<u>Provision</u>	<u>Date</u>
Enactment of the Balanced Budget Act of 1997, Public Law 105-33	August 5, 1997
Convening notice for negotiated rulemaking to establish federal solvency standards for PSOs published in FR.	September 19, 1997
Medicare+Choice plans begin reporting encounter data	January 1, 1998
Fiscal solvency standards for PSOs published in the FR	April 1, 1998
Interim final reg with contracting standards for Medicare+Choice plans published in FR	June 1, 1998
Special information campaign to inform eligible beneficiaries about Medicare+Choice options - 1876 risk plans must accept any new enrollees during the coordinated information campaign	November, 1998
1876 risk-based plans must transition to Medicare+Choice program	January 1, 1999
Elimination of HCPP option for entities eligible to contract as Medicare+Choice managed care plan	January 1, 1999
Termination of 1876 cost contracts	January 1, 2002

BBA Implementation: Provider Sponsored Organizations (PSOs)

PSOs, an emerging form of managed health care similar to HMOs, are one of the new Medicare+Choice options under Medicare Part C. PSOs are the only entity for which a waiver of the State licensure requirement, in certain circumstances, will be available for the first 3 years of the Medicare+Choice program. PSOs will be required to comply with Medicare Part C standards, except as waived by statute. In order for these new entities to be active Medicare contractors 1/1/99, several activities must occur.

- PSO solvency standards must be developed.
- An interim final rule must be issued to define PSOs.
- A waiver process must be developed.
- Policy for waiving the minimum enrollment requirement must be developed.

PSO Solvency Standards

The statute required that Medicare PSO solvency standards be developed through accelerated negotiated rulemaking. The negotiations, which are underway, must be completed so that a regulation may be published by April 1, 1998. The negotiating committee is comprised of 15 members from associations representing the hospitals, physicians, managed care, insurers, Medicare beneficiaries, rural interests, as well as a state insurance commissioner and the Administration. The committee is small to help achieve consensus in the time given. If the committee fails to agree on standards, the Secretary is authorized to issue the rule.

Definition of a PSO

The statute broadly defines a PSO as a provider-based managed care entity in which the provider or group of affiliated providers provide a substantial proportion of the services, share substantial financial risk for the items and services they provide and for the operation of the PSO as an enterprise, and have a majority interest in the organization. Several of the terms used in the statute require further definition, including affiliated provider, substantial proportion, substantial financial risk (used in 2 different ways), majority financial interest. Currently, HCFA is considering requiring that affiliated providers own or control at least 51% of the PSO, be at risk for more than individual services (i.e., share in the risk of operating the PSO enterprise), and provide 70 to 75% of all Medicare services. (A lower standard will be established for rural areas.) Groups excluded by the definitions, such as physician practice management companies, will be critical. Although not required by Congress until June, 1998, HCFA is planning to issue definitions in early 1998 in order to inform negotiations regarding PSO solvency standards.

Waiver Processes

The process for waiving State licensure requirements is under development. Currently, most states (approximately 40) do not have a licensure process for PSOs. Thus, most PSO applicants will be coming to the Medicare program as unlicensed entities. Medicare standards and monitoring will be the only oversight for these PSOs. The waiver process for allowing PSOs to enroll fewer than 1500 commercial lives (500 in rural areas) is under development also. We expect to issue policy guidance in January 1998.

**BBA Implementation:
Medical Savings Accounts**

Medical Savings Accounts (MSAs) are one of the Medicare+Choice options authorized by the Balanced Budget Act of 1997. The purpose behind the option is to enable Medicare beneficiaries to play a greater role in purchasing health care services.

Under this option, Medicare funds will be used to purchase a high deductible health insurance policy. Funds allocated to the individual in excess of the insurance premium will be placed in an MSA.

If the MSA funds are used to meet medical expenses or are allowed to accrue from year to year, they remain tax deferred.

MSA funds, i.e., Medicare trust funds, used for non-medical expenses will be considered taxable income.

Beneficiaries are prohibited from contributing personal funds to their MSAs.

As indicated in the legislation, up to a total of 390,000 Medicare beneficiaries may participate in this program. The deductible for the health insurance policy cannot exceed \$6,000.

Implementation Schedule

Regulations governing the MSA option will be published as part of the Medicare+Choice regulation on June 1, 1998.

The application process for organizations interested in entering into an MSA contract with HCFA is being coordinated with the general Medicare+Choice application procedures and is expected to be implemented in the spring of 1998.

Medicare beneficiaries will be able to enroll in November 1998 for MSAs which will be effective starting January 1, 1999. The legislation requires a 1-year lock-in for beneficiaries.

Progress to Date

HCFA staff are working to implement the MSA option within the legislation's time frame.

A HCFA MSA Workgroup and a larger Medicare+Choice Workgroup have already begun to identify and address issues involving MSAs as well as the Choice program in general.

Demonstrations staff have conducted conference calls with industry representatives to discuss their concerns and recommendations.

The RAND Corporation is preparing an options paper under a task order agreement.

The Robert Wood Johnson Foundation is sponsoring meetings of HCFA personnel and recognized external experts in the MSA field to consider various approaches.

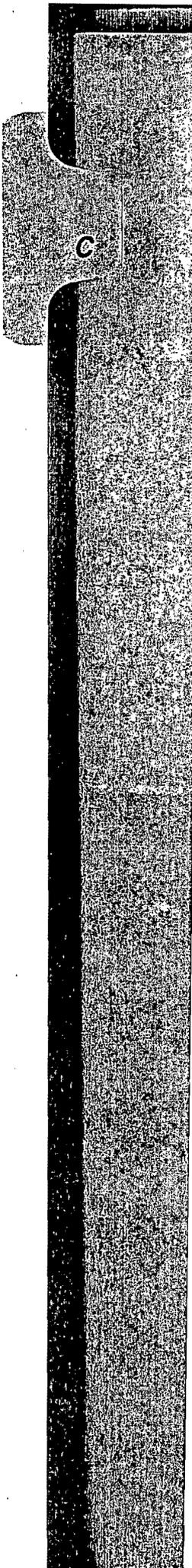
Some Major Issues

HCFA will need to develop guidelines for identifying participating entities, both insurers and MSA custodians, for participation in the Medicare program.

While MSAs have strong political support among some sectors, interest in MSAs within the insurance and banking industry is unclear.

Since MSA enrollees are assumed to be healthier than the general Medicare population, the role and application of risk adjustment for insurance premiums and MSA contributions will have to be determined.

Encounter data will be required for both the monitoring and evaluation of the MSA option as well as the calculation of risk adjustments for future payments. Industry representatives are interested in keeping reporting requirements to a minimum.



HCFA BRIEFING ON BALANCED BUDGET ACT (BBA) IMPLEMENTATION

SECTION C

BENEFICIARY INFORMATION CAMPAIGNS & NEW PREVENTION BENEFITS

Beneficiary Information Campaigns

- o Beneficiary-Centered Education Program
- o BBA Prevention Provisions
- o Physician/Provider Education Plans
- o Partnership Dissemination Plan
- o Media Plan

New Prevention Benefits

- o Coverage of Screening Mammography
- o Coverage of Screening Pap and Pelvic Exams
- o Coverage of Prostate Cancer Screening
- o Coverage of Colorectal Screening Services
- o Barium Enema X-Ray Issue
- o Diabetes Self-Management Benefits
- o Standardization of Coverage of Bone Mass Measurements

Beneficiary-Centered Education Program

HCFA is embarking on a beneficiary-centered public education program to ensure that consumers receive accurate, easily understandable information about their health plans, facilities, and professionals to assist them in becoming more active participants in their health care decisions.

Purpose of Beneficiary-Centered Public Education Program

This program will employ multidimensional strategies for educating beneficiaries in making informed decisions concerning:

- program benefits and choice of health plan
- health care choices
- program protections and rights and beneficiary responsibilities
- healthy behaviors and health promotion

Calendar year 1998 will be used to *broadcast* this information in the context of Medicare + Choice. Our goal for 1998 is to prepare Medicare beneficiaries, and those that act on their behalf and who counsel them, for the significant changes resulting from the BBA.

Immediate Plans

- November 21 **Medicare Compare:** Medicare managed care plan comparability chart made available on HCFA.gov website, allowing users to compare plan benefits on a county, state or zip code and access applicable health plans.
- December 3 Alliance Building Meeting -- 45+ organizations with an interest in the beneficiary population will meet to share ideas and give input to beneficiary-centered education program.

Early Calendar Year 1999

- Medicare.gov** Launch a Medicare beneficiary-centered consumer website to provide a broad array of information on program benefits, health system performance, health care choices, healthy behaviors and health promotion. This site will be continuously improved to meet the mandate for easily understandable information to support Medicare + Choice.

**Satisfaction
Survey**

HCFA will field test the Consumer Assessment of Health Plan Survey to measure the satisfaction of Medicare beneficiaries with their health plans. The results of the survey will be incorporated in **Medicare Compare** and will be available for the 1998 National Information Program in November.

**Quality
Performance**

Plan-specific quality performance measures from the HEDIS information **Measures** set will be incorporated into **Medicare Compare**. Educational information will be made available on Medicare.gov to prepare consumers on use of this information in making decisions about plan comparisons and about their health care.

Focus Groups

The Medicare + Choice program education message will be focus group tested in five metropolitan areas to pre-test mock-up designs for the education program. Five focus groups (one in each city) will be composed of Medicare beneficiaries without chronic health conditions requiring specialized care; three (3) additional focus groups will be composed of beneficiaries with serious chronic medical conditions requiring special care; two (2) additional focus groups will be composed of family members who assist the beneficiaries in care-related decision making.

BBA Prevention Provisions

There are two major sets of activities that are underway to implement the prevention provisions: (1) ensuring that the infrastructure is in place to support provision of new benefits (including developing regulations, policies, and instructions to implement coverage/payment for new benefits as well as physician/provider education about the new benefits); and (2) beneficiary education campaigns about the new benefits.

I. Infrastructure To Support Provision of New Benefits

These are CHPP and OCSQ led activities and all actions are either completed or underway for provisions effective January 1, 1998.

Coverage Rules: The prevention benefits effective January 1, 1998 were published on October 31 as part of the Physician Fee Schedule regulation. The coverage and payment instructions will be sent to the Medicare Carriers for implementation by the end of November.

Notification: We are notifying our providers and partners about the new benefits. Physicians are being notified via the "Dear Doctor" letter (participating physician supplier agreement). This was sent to carriers for distribution in late October and includes basic information about the new benefits.

Managed care organizations were notified via Operational Policy Letter Number 55 (September 5, 1997) that they are required to include these prevention services in their benefit packages.

OCSQ is developing a two phase provider/physician education campaign. Phase I will focus on ensuring provider/physician awareness about the new benefits, and clinical guidelines and appropriate use of the prevention services effective January 1 (see Tab A). Phase II will focus on the clinical guidelines and appropriate use of the prevention services effective July 1, 1998.

II. Beneficiary Education Plan

The beneficiary education plan consists of two components: Awareness campaign (implementation December 1997) and Health Promotion campaign (implementation mid-1998). The Awareness campaign is to inform beneficiaries about the new prevention benefits. The Health Promotion campaign is to educate beneficiaries about the appropriate use of prevention services and to stimulate beneficiaries to change their behavior, if necessary.

Phase I Beneficiary Awareness Campaign

Phase I of the beneficiary education campaign is a broad dissemination targeting the entire Medicare population. Its focus is to inform the beneficiary about the new prevention benefits which are effective January 1. We will also mention the continuation of other covered prevention services (flu/pneumococcal) and state that additional information will be forthcoming on the diabetes and bone mass measurement services.

Print Message
Through

Agents/Partners:
Unfunded Cost:
\$31,000

A succinct message about the new coverage benefits will be widely disseminated through an extensive network of HCFA contractors, partners, advocacy groups, and other government agencies beginning in early December. (See Tab B - Partnership Dissemination Plan.) This portion of the dissemination strategy will encourage a "ripple effect" to reach out to the maximum number of beneficiaries possible through our agents/partners. (Estimated cost - \$51,000 including \$20,000 for message development, testing, and limited copies (cost and task covered using existing task order contract); \$16,000 to print 500,000 copies; and \$15,000 to mail copies to partners/agents.)

Medicare
Handbook:

The new prevention benefits will be included in the 1998 Medicare Handbook which will be mailed directly to each beneficiary. Potential proposals include: a brief description of all the prevention benefits; a user-friendly prevention reference chart that lists prevention services, coverage frequency, and a section beneficiaries can use to track receipt of these services/use as a reminder for next service date; and a pocket size prevention card that the beneficiary can take to

his/her physician explaining the prevention coverage.
(This will be particularly useful in 1998 when some
physicians may not be aware of the benefit changes.)

Media Strategy: The press office has developed a strategy to capitalize on newspaper and radio/TV shows on what is happening in the New Year and to disseminate materials on the new Medicare benefits for trade, minority, and mainstream press. The press office will also coordinate with the regional office media contacts to ensure broad coverage in the local markets. (See Tab C - Media Plan)

Additional Vehicles: We will utilize the HCFA home page to publicize the new benefits and will include a message on the EOMBs/Medicare Summary Notices about the new benefits.

Optional Use of NIA Video Series: The National Institutes on Aging has produced a 5-part video series entitled "Living Well--A Guide to Healthy Aging".
Unfunded Costs: The NIA contractor has suggested that HCFA use the video on prevention and wellness as an additional vehicle to promote awareness of the new Medicare benefits (by dubbing in a message from the HCFA Administrator). All 5 videos were focused tested by persons ages 50 plus and reviewed by a panel of experts. (Estimated costs: \$1500 for reproduction and distribution.)
\$1,500

Other Approaches Considered - Not Feasible Due to Costs

Optional Radio PSAs: We can produce radio PSAs for widespread distribution to radio stations across the country. Estimated cost: \$35,000 including development, marketing, and distribution.
Unfunded Costs:
\$35,000

Optional Postcard Mailing: We could produce and mail a postcard to each Medicare beneficiary. Approximate cost would be \$11 Million (\$1.1 million for printing; \$9.9 million for postage).
Unfunded Costs:
\$11 Million

Phase II Health Promotion Campaign

Phase II of the beneficiary education campaign will be designed to encourage appropriate use of prevention services by beneficiaries (i.e., to change behavior).

HCFA/CBS and the Division of Cancer Prevention and Control/CDC have begun plans to jointly develop the beneficiary health promotion campaign. This health promotion campaign would be targeted specifically for Medicare beneficiaries and would focus on the January 1 prevention benefits (colorectal cancer screening, pap smear and cervical cancer screening, and mammography). The Division of Cancer Prevention and Control has a contract mechanism in place with Ogilvy, Adams & Rinehart to develop the campaign and can begin work immediately. (This is the same contractor who is developing the OIG/AARP fraud and abuse campaign.) CBS staff is in the process of developing the Interagency Agreement (pending funding approval).

Estimated costs: \$400,000. CDC will provide \$200,000 and HCFA will need to provide the remaining \$200,000.

CBS has requested \$250,000 for the prevention campaign under the FMIB process; \$50,000 for Phase I Awareness Campaign and \$200,000 for the Phase II Health Promotion Campaign.

Physician/Provider Education
Roll out Plan for Informing Providers about New Preventive Health Benefits

Purpose of Phase I: Inform providers about the preventive health benefits Medicare will cover as of January, 1998. These benefits include: mammography, pap smears/pelvic exams, colorectal cancer screening, flu/pneumococcal, nausea reduction drugs for chemotherapy. We will include diabetes and bone mass benefits even though their coverage begins in July. Phase II of provider roll out will include clinical guidelines and appropriate use of the prevention services effective July 1, 1998.

HCFA will distribute this information through the Medicare Carriers and Fiscal Intermediaries, as well as provider and disease organizations. Ideas for hard copy dissemination include provider newsletter and journal articles. We will also use the HCFA website to distribute this information and ask provider and disease organizations to either include a link to this information on HCFA's website, or include information on these new preventive benefits on their websites.

Phase I information dissemination, at a minimum, will include the following on benefits effective January 1:

- what is covered
- when does coverage begin
- who is eligible for coverage and reimbursement
- who to call if there are questions regarding these benefits
- what is the impact of each condition and recommendations of major medical authorities from "Put Prevention into Practice"

Task	Responsible Party	Time line
Produce Message	OCSQ, CHPP	November 14
Clear Message	OCSQ	November 21
Develop a Detailed Distribution List	OCOS, CHPP	November 14
Send Message to Providers and Provider Organizations	OCOS, CHPP, OCSQ	December 1
Send Operational Policy Letter to Plans	CHPP	December 1
Provide Internet Message to all Provider Organization Web Sites	OCOS	December 12
Put Internet Message on HCFA web site	OCOS, OSCQ	December 12
Write an article for JAMA or NEJM	OCSQ (Jencks with OCSQ staff)	January
Send out "Dear Dr" letter (participating physician supplier agreement)	CHPP	November

Partnership Dissemination Plan

We will develop a succinct message about new coverage benefits that will be beneficiary friendly and widely disseminated through an extensive partnership network. CBS has developed a broadly focused partnership network strategy. Included in the network are:

- o beneficiary advocacy groups (numbering over 150 and including coalitions of senior groups, individual senior consumer groups, disabled population groups, disease specific groups, minority groups and others),
- o government agencies (the Administration on Aging, the Department of Housing and Urban Development, the Social Security Administration, the Centers for Disease Control and the National Institutes of Health, for example), and
- o other health related organizations with a shared interest in Medicare beneficiaries (caregiver associations, employers and unions, the Public Library Association, the National Library Association, the Health Insurance Association of America, and the National Association of Insurance Commissioners, to name a few).

CBS's Partnership Development Group staff have initiated a telephone campaign to contact the larger and key beneficiary advocacy groups, Federal agency partners, and other health related organizations to assess their willingness to disseminate our fact sheets on the new prevention benefits to their constituents and/or field structure in early December. We will be following up with an additional 80 beneficiary advocacy groups to ascertain if they will help with the distribution of our fact sheet to their membership as well as inquire if they could incorporate our message into their newsletters, magazine articles, or other communication media they use.

In addition, we will be speaking with other Federal agencies and other organizations who have access to Medicare beneficiaries to determine if they will partner with us in this educational effort, e.g. Social Security Administration (notifying their district offices, and seeing if it is possible to get a brief description of the new benefits in their annual "Dear Beneficiary" letter), Department of Housing and Urban Development, Department of Education (for their Individual Learning Centers where a large number of disabled Medicare beneficiaries reside), Department of Labor (since the disabled population uses Department of Labor's Rehabilitation Services), and the Indian Health Service. We are confident that these beneficiary groups, Federal agencies, and other organizations will cooperate in this project.

We will also be notifying our partners through an extensive mailing that includes the following organizations (that expands the distribution capacity tremendously):

PROs
ICA programs
Fiscal intermediaries
Carriers
ESRD Networks
Professional groups
Area Agencies on Aging
Regional Beneficiary Branch Chiefs

As of November 4, we have commitments from the organizations listed below. Where possible, we have included estimates of the membership size of the organization. Please see Tab D - complete listing of beneficiary advocacy groups that will be used for further contacts and commitments.

Beneficiary Advocacy Groups - Definite Commitments to Communicate New Benefits

American Association of Retired Persons (5 Regional Offices, 50 state offices)
American Federation for the Blind (30 member organizations, 12,000 members)
American Speech-Language-Hearing Association
Children of Aging Parents (1500 members)
Consumer Coalition on Quality Health Care (40 member organizations, 80 affiliated organizations)
Families USA
Medicare Rights Center
National Association of Developmental Disabilities Councils
National Caucus and Center on the Black Aged, Inc.
National Council on the Aging (3,000 organizations)
National Council of Senior Citizens (2,000 clubs)
Peoples Medical Society (125,000 members)
Summit Health Care Coalition
The Congress of National Black Churches, Inc.
United Seniors Health Cooperative

Federal Agencies - Definite Commitment to Communicate New Benefits

The Administration on Aging (50 State Units on Aging, 670 Area Agencies on Aging).
AoA has agreed to both communicate to their network and revise their grant requirements for prevention grants (made to State Units on Aging) to include mention of the new Medicare benefits in their scope of work.
Office of Minority Health Resource Center (10 Regional Offices)

Media Plan

The Press Office will work with the other components within HCFA to inform the public on the new preventive benefits included in the Balanced Budget Act. We will be responsible for helping produce and distribute public materials for trade, minority and mainstream press.

These will include:

- Press releases
- Fact sheets
- A column written by Secretary Shalala or Administrator Nancy-Ann Min DeParle
- Letter for possible publication in Ann Landers' column

In order to capitalize on papers and radio/TV shows that may be doing stories that look ahead to what is happening in the New Year, it will be important to have our materials and spokespeople ready to go early in December. The following is a **DRAFT** timetable for the Press Office's products.

Week of 11/3/97

- 11/3 Check with the Office of the Assistant Secretary for Public Affairs (OASPA) about the possibility of doing a radio actuality with Secretary Shalala about the new benefits.
- 11/3 Contact Tammy Pittman, the Administrator's speechwriter, about writing a column with a Nancy-Ann Min DeParle or Secretary Shalala byline. Provide her with information about the new benefits. Discuss possibility of target columns for specific audiences.
- 11/4 Alert regional office media contacts about the plan to inform beneficiaries of the new preventive benefits. Advise them to start thinking about opportunities for the Regional Administrators to talk about the new benefits including visits to senior centers, media events, one-on-one interviews with reporters, and distribution of press releases, fact sheets and columns.

NOTE: Because Sid Kaplan and Maurice Hartman will be retiring at the end of the year, the Press Office will work with the Boston and Philadelphia Regional Offices to designate a spokesperson on this issue.

- 11/5 Meet with Laurie Boeder, Deputy Assistant Secretary for Public Affairs, about the Department's involvement in the roll out for the new benefits.
- 11/5 Check with other HCFA components about the time schedule for the printing of any other public documents in order to coordinate release of all public materials.
- 11/6 Contact James Alexander of the Office of the Assistant Secretary for Public Affairs about minority outreach. Also, check with Moya Thompson, Public Affairs Director for the Administration on Aging, about her press list.
- 11/7 Send sample questions to HCFA components so answers can be provided for Q and A sheet.

Week of 11/10/97

- 11/10 Contact Ann Landers about the possibility of running a letter from Secretary Shalala or Administrator Nancy-Ann Min DeParle about the new benefits.
- 11/10 Start to develop a master press list and determine which materials should be included in mailings and fax runs.
- 11/11 Veterans Day
- 11/12 First draft of press release, fact sheet and Questions and Answers to the press office.
- 11/12 Information to Jackie Nedell in the Office of the Assistant Secretary for Public Affairs so she can put together radio actualities on the new benefits.
- 11/12 Check in with regional office media contacts on scheduling for the Regional Administrators to discuss new benefits.

Week of 11/17/97

- 11/17 Press release, fact sheet, column and Qs and As to HCFA for clearance.
- 11/18 Weekly call to the media contacts in the regional offices. Check on progress.
- 11/20 Press release, fact sheet, column and Qs and As to OASPA for clearance.

Week of 11/24/97

11/25 Weekly call to the media contacts in the regional offices. Alert them that we will send materials to them next week.

11/27 Thanksgiving

Week of 12/1/97

12/1 All materials ready to be sent to the regional offices.

12/8 Press release, fact sheet, and column ready for early distribution to the media.

12/8 Press Office mail/fax materials

12/8 Regional offices mail/fax to mainstream press/senior & minority papers in the region.

12/9 Provide all public materials to senior staff and urge them to talk about the new benefits when they are giving a speech or meeting with beneficiary or professional groups.

Week of 12/22/97

12/22 Provide regional offices with an updated version of the press release stating that the new benefits are now available.

Week of 12/29/97

12/29 Send the updated press release out (with a January 1, 1998 release date) to reflect that the new benefits are now covered.

Month of January 1998

Continue pitching the new benefits story to selected media.

Continue working with the regional offices to make sure that the Regional Administrators are talking about the new benefits at every opportunity.

Continue working with senior staff to make sure that anyone giving a speech includes information about the new benefits.

Section 4101: Coverage of Screening Mammography

- Provides coverage for annual screening mammograms for women age 40 and over, and waives the Part B deductible for these services.
- Before enactment of the BBA, biennial coverage of screening mammograms was available for (1) women at least age 40 but under age 50 who were not at high risk for breast cancer, and (2) women age 65 and over. Annual coverage was only available for (1) women at least age 40 but under age 50 who were at high risk for breast cancer, and (2) women at least age 50 but were under age 65.
- Coverage of one screening mammogram for women at least age 35 but under age 40 remains unchanged since the original screening mammography benefit was enacted effective January 1, 1991.
- A screening mammogram is defined for Medicare purposes as a radiological procedure that is provided to an asymptomatic woman for unsuspected breast disease, and it includes a physician's interpretation of the results of the procedure.
- Medicare only pays for screening mammograms that are furnished by facilities and physicians that meet FDA certification requirements.
- In regulations published in the Federal Register on October 31, 1997, as part of the final rule on the Medicare Physician Fee Schedule for 1998, HCFA announced the expanded coverage of screening mammograms for all women age 40 and older.
- Effective Date for New Coverage: January 1, 1998.

Section 4102: Coverage of Screening Pap and Pelvic Exams

- Adds coverage of screening pelvic exams (including a clinical breast exam) to the existing coverage of screening Pap smears, (effective July 1, 1990), and waives the Part B deductible for all of these services.
- Provides for coverage of all of these services every three years, or annually for women (1) at high risk for cervical or vaginal cancer, or (2) of childbearing age and who have had a Pap smear or pelvic exam during any of the preceding three years that indicated the presence of cervical or vaginal cancer or other abnormality.
- In regulations published in the Federal Register on October 31, 1997, as part of the final rule on the Medicare Physician Fee Schedule for 1998, HCFA announced the conditions of coverage, the frequency of coverage limitations, and the payment amounts that will be allowed physicians and other qualified practitioners who furnish such screening services.
- Specifically, the regulations defined the following terms--
 - + Women at high risk for cervical cancer;
 - + Women at high risk for vaginal cancer; and
 - + Women of childbearing age.

Effective Date for New Coverage: January 1, 1998.

Section 4103: Coverage of Prostate Cancer Screening

- Provides coverage of certain annual prostate cancer screening tests for men over 50 years of age.
- These tests will include (1) a digital rectal examination, (2) a prostate-specific antigen (PSA) blood test, and (3) for years beginning after 2002, such other procedures as the Secretary finds appropriate, taking into account changes in technology and standards of medical practice, availability, effectiveness, costs, and such other factors as the Secretary considers appropriate.
- Effective Date: January 1, 2000.

Section 4104: Coverage of Colorectal Screening Services

- Provides coverage of certain colorectal screening tests such as (1) fecal-occult blood tests for persons age 50 and over, (2) flexible sigmoidoscopy exams for persons age 50 and over, (3) colonoscopies for persons at high risk for colorectal cancer, and (4) other procedures (including screening barium enema x-rays) as the Secretary determines appropriate.
- Provides that within 90 days of enactment (i.e., November 3, 1997) the Secretary shall publish a notice in the Federal Register with respect to the determination as to whether the barium enema x-ray will be covered under this screening benefit, and, if so, the frequency and other details of that coverage.
- In a notice that was published in the Federal Register on October 31, 1997, as part of the final rule on the Medicare Physician Fee Schedule for 1998, HCFA announced that it had decided to cover the screening barium enema x-ray as an alternative to (that is, as a substitute for) either a screening flexible sigmoidoscopy or a screening colonoscopy, if the test is ordered in writing by the beneficiary's attending physician.
- The law also sets frequency limits for each covered test, except where the Secretary was provided the authority to set these limits (for example, the screening barium enema x-ray). These statutory and regulatory frequency limits are the following:
 - + Annual exams for fecal-occult blood tests;
 - + Every 2 years for colonoscopies;
 - + Every 4 years for flexible sigmoidoscopies; and
 - + Every 2 or 4 years for barium enemas, depending upon which test the exam is an alternative to.
- Effective Date: January 1, 1998.

Barium Enema X-Ray Issue

Issue: Should Medicare include coverage of screening barium enemas under the colorectal cancer screening benefit that was authorized by section 4104(a) of the BBA, effective January 1, 1998?

- We have received letters from a number of Senators and Congressional representatives--many in support of, but several opposing--the recent Medicare coverage determination to include payment for the barium enema x-ray under the new colorectal cancer screening benefit.

Background:

- **Statutory mandate**

- + In developing the legislative amendment on the colorectal cancer screening benefit, the Congress was unable to decide whether to include coverage of screening barium enema x-rays under that benefit.
- + Thus, in enacting this new benefit, the Congress included a special provision, which required that the Secretary of Health and Human Services make a coverage determination on this issue, and that this determination be published in the Federal Register within 90 days of enactment.

- **Publication of notice of coverage determination**

- + On October 31, 1997, Secretary Shalala's coverage determination on the screening barium enema issue was published as part of the preamble to final rule on the Medicare Physician Fee Schedule.
- + The Secretary's determination was that the screening barium enema may be covered as an alternative to either a screening flexible sigmoidoscopy or a screening colonoscopy, if--

- the beneficiary's attending physician orders the test in writing after a determination that the test is the appropriate screening test.
- That is, the attending physician must determine that, in the case of a particular individual, the estimated screening potential for the barium exam is equal to or greater than the screening potential that has been estimated for a flexible sigmoidoscopy, or for a colonoscopy for that same individual.
- For example, in the case of an individual who is taking anticoagulant medications, the individual's attending physician may decide to order a barium enema instead of a flexible sigmoidoscopy because it is less likely to produce bleeding and typically allows for a total inspection of the colon, while the flexible sigmoidoscopy does not.
- In the case of an individual at high risk for colorectal cancer who may not be able to receive a complete colonoscopy due to a markedly long and/or twisting loop(s) of colon, the individual's attending physician may decide to order a barium enema x-ray in lieu of a screening colonoscopy because it is more likely to permit a complete view of the entire colon.

- **Rationale for barium enema coverage determination**

- + As required by section 1861 (pp)(1)(D) of the Act, we, acting on behalf of the Secretary, consulted with a wide number of organizations both inside and outside of the Federal Government regarding the efficacy of barium enema exams for detecting colorectal cancer.
- + Based on our review of the information and other data collected during this consultation, we concluded that there was not a consensus in the medical community regarding the specific role of a barium enema exam under the Medicare colorectal cancer screening benefit. However, it was concluded that there was a sufficient basis for us to include the use of barium enema x-rays as part of the new national Medicare coverage for colorectal cancer screening.

- + We believe that not allowing for coverage of the barium enema x-ray option under the colorectal cancer screening benefit might create an access problem for Medicare beneficiaries in some parts of the country because of the limited availability of physicians who can perform flexible sigmoidoscopy and colonoscopy screening services. In order to permit full utilization of the colorectal cancer screening benefit in all parts of the country, we believe that it is essential to make the barium enema x-ray screening option available to all Medicare beneficiaries.

- + Specifically, the role of the barium enema exam has recently been studied by several multi-disciplinary expert panels and, as a result of those studies, it appears that usefulness of the screening exam is becoming widely accepted in the United States.
 - First, the American Gastroenterological Association, which completed their report earlier this year, recommended the double contrast barium enema x-ray as a screening option for all average risk patients (those with no predisposing factors) and selected groups of high risk patients (those with a history of prior polyps, or those with a first degree relative with colorectal cancer).

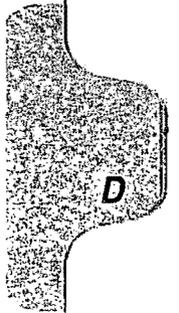
 - Second, earlier this year the American Cancer Society also revised their guidelines to include the double contrast barium enema as an option for patients at average and moderate risk (nearly identical to the above described American Gastroenterological Association guidelines).

Section 4105: Diabetes Self-Management Benefits

- Provides for diabetes outpatient self-management training to include services furnished in non-hospital-based programs (already covered in hospital-based programs and, to some extent, as incident to the services of a physician or other qualified practitioner (for example, a nurse practitioner)).
- Services may be provided by physicians or other entities designated by the Secretary if they also provide other services paid by Medicare and meet quality standards established by the Secretary.
- The statutory coverage requirements include a provision that a physician managing the patient's condition must certify that the services provided are needed under a comprehensive plan of care.
- Provides coverage for blood glucose monitors and testing strips for all diabetics (already covered for insulin-dependent diabetics).
- HCFA policy staff are currently consulting with appropriate organizations both inside and outside of the Federal Government about how this benefit can best provide the Medicare beneficiaries with the most appropriate knowledge, skills and behaviors that are essential to a successful diabetic education program.
- When we have completed our review of these issues, we expect to publish a notice of proposed rulemaking in the Federal Register on this some time early next year.
- Effective Date for New Coverage:
 - + January 1, 1998 for monitors and testing strips.
 - + July 1, 1998 for the other provisions.

Section 4106: Standardization of Coverage of Bone Mass Measurements

- Provides coverage for procedures to identify bone mass, detect bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results, at frequencies determined by the Secretary.
- Persons qualifying for these procedures include estrogen-deficient women at risk for osteoporosis, and persons: (1) with vertebral abnormalities, (2) receiving long-term glucocorticoid steroid therapy, (3) with primary hyperparathyroidism, and (4) being monitored to assess the response to, or efficacy of, an approved osteoporosis drug.
- This legislative amendment was enacted to ensure uniformity in Medicare coverage of medically necessary bone mineral density measurements and their interpretation by qualified practitioners.
- HCFA policy staff are currently consulting with appropriate organizations within the Federal Government and elsewhere about how this benefit can best provide Medicare beneficiaries and their attending physicians with relevant information that can be used in treating and managing the patient's medical condition.
- When we have completed our review of these issues, we expect to publish a notice of proposed rulemaking in the Federal Register on this subject sometime early next year.
- Effective Date: July 1, 1998.



HCFA BRIEFING ON BALANCED BUDGET ACT (BBA) IMPLEMENTATION

SECTION D PROSPECTIVE PAYMENT SYSTEM AND OTHER CHANGES

- o Prospective Payment System
 - Home Health
 - Hospital Outpatient Services
 - Skilled Nursing Facilities
 - Inpatient Rehabilitation Facility
- o Graduate Medical Education
 - Direct and Indirect Medical Education

Home Health Prospective Payment System

Section 4603 of the BBA requires that HCFA develop a prospective payment system for home health with a target date for implementation of 10/1/99. Recognizing the ambitious nature of this project the BBA also provides a contingency clause that there be a 15% reduction in the cost limits imposed under the interim HH payment system if the PPS system (with its required 15% reduction in expenditures) is not operational on 10/1/99.

The legislation gives HCFA a very broad mandate in the development of the PPS system. We have flexibility in determining the unit of payment, the amount of prospective payments and outliers. It does, however, require that it be based on the most current audited cost report data available; that it be case mix and wage area adjusted; that the amount paid be updated annually based on the home health market basket; that there be a proration of the payment for persons served by more than one agency and that periodic interim payments (PIP) end when PPS is implemented.

Key to our success in implementing this system is the outcome of research that is currently under way. The most important of which are the Home Health PPS Demonstration - Phase 2 and the HH Case Mix Research Study. The Phase 2 demonstration data should build a case for the appropriate unit of payment and answer a number of key operational questions about the viability of an episode-based PPS system. The Case Mix Research will provide the key weights which will be needed to produce the required case mix adjusters for the system. Interim findings of the demonstration are expected any day. The Case Mix Research Study sites began collecting data this September and an interim report is due in June 1998, with a final report in January 1999.

In other important activity, we are currently constructing an episode data base which we will use to help establish an appropriate unit of payment. Similarly, we are taking steps to assure that we have a data base with sufficient audited cost report information to build the prospective payment rate. Because the case mix adjustment is based on an agency assessment of patient condition built on the OASIS instrument (which was the subject of a proposed rule this Spring), we are moving to accelerate implementation of the OASIS.

Simultaneous with the above PPS activity, we are implementing the interim payment system specified in the BBA. This includes the recalculation of the existing home health per visit limit methodology by reducing the limits to 105% of the median versus 112% of the mean. These revised limits must be established by 1/1/98.

In addition, we are developing a new, agency specific, per beneficiary cap which is produced by dividing agency costs in a legislatively established base period (mostly 1993 and 1994) and dividing by unduplicated recipients. Because Congress selected a base year earlier than that for which we have centralized cost report files, this is requiring a special data collection on our part. Further, because the industry has reported that most agency cost reports include spurious data on unduplicated recipient counts (since it was not used in cost settlement and difficult to calculate) we are exploring other sources of data for this vital element in the calculation.

As the brief description above makes clear, this is a very ambitious agenda, given the projected implementation date. We are monitoring the various phases of this project closely and are making every effort to meet the schedule. Because most home health agencies will see their Medicare payments reduced under the interim payment system, there is tremendous interest in moving to a PPS system as soon as possible.

Hospital Outpatient Services Prospective Payment System

The Balanced Budget Act (BBA) of 1997, signed into law on August 5, 1997, authorizes HCFA to implement a prospective payment system for hospital outpatient services (and for Part B services furnished to inpatients who have no Part A coverage.) The BBA also eliminates the formula-driven overpayment (an estimated \$1B a year), effective October 1, 1997, and continues the 5.8 percent reduction in operating costs and 10 percent reduction in capital costs (which had been due to sunset) through CY 1999.

The Secretary has the authority under the BBA to determine which services are included (with the exception of ambulance services and physical, occupational, and speech therapies, for which fee schedules are being separately created). We will continue to pay for most laboratory services and for orthotics and prosthetics on their respective fee schedules, and for chronic dialysis using the composite rate. (Acute dialysis, e.g., for poisoning, will be paid under PPS.) The 9 cancer centers exempt from inpatient PPS will not come under this system until the year 2000. Other exempt facilities will be included in this system, unless impact analysis convinces us otherwise.

The PPS will consist of about 300 groups of services which are related clinically and in terms of their resource use. Currently we envision about 100 groups of significant procedures and services, such as surgery, radiation therapy and endoscopy; about 50 ancillary groups, such as radiology, EKGs and immunizations; an undetermined number of medical groups, for both clinic visits and emergency departments; several "incidental" groups, which will be bundled into the payment for the major service; and a number of unpaid groups, such as inpatient procedures and those services not covered by Medicare. Discounting of multiple significant procedures will apply. The groups are based on 3M's APGs, but tailored to Medicare. HCFA's "Ambulatory Payment Classes" will not require changes to hospitals' billing.

Payment can be made for a number of groups for a given patient on a given day (i.e., the "window" is one day.). Bundled into the payment will be costs for the operating room, recovery room, observation, pharmacy, and medical/surgical supplies. The overall expenditure target is budget neutral, based on what we would have paid in 1999 under the current system, using median hospital costs to weight the groups. Beneficiary copayments are based on national median charges for each group, frozen at 1999 rates. Both Medicare payments and coinsurance amounts will be wage-adjusted. Updates (the market basket less 1 percent for the first three years) will be made only to the Medicare payment, which will have the effect of lowering the beneficiary's coinsurance share over time. When the coinsurance falls to 20 percent of the group rate, it will no longer be frozen and will be updated yearly.

A hospital may elect to reduce its copayment to no less than 20 percent of the total Medicare payment (for any or all services), and advertise these reduced rates. This election is made yearly, and can't be changed during the year. The forgone copayment amount can't be written off as a bad debt, and deductibles can't be waived. (A special calculation applies to the coinsurance applied when a deductible also applies. The effect is that the beneficiary pays based on the usual rate, but applied to only the post-deductible amount.)

We still have to decide whether we need to recognize outliers, what volume measures are needed, and what adjustments will have to be made based on impact analysis. We are analyzing 97 million claims for 1996, matched to each hospital's most recent cost report, and will issue an NPRM in the Spring.

Skilled Nursing Facilities Prospective Payment System

Section 4432 of BBA '97 mandates the implementation of a per diem prospective payment system (PPS) for skilled nursing facilities (SNFs) covering all costs (routine, ancillary and capital) related to the services furnished to beneficiaries under Part A of the Medicare program. Major elements of the system include:

- Rates: Federal rates will be set using allowable costs from FY 1995 cost reports. Rates will also include an estimate of the cost of services for which, prior to July 1, 1998, payment had been made under Part B but furnished to SNF residents during a Part A covered stay. FY 1995 costs would be updated to FY 1998 by a SNF market basket minus 1 percentage point for each of fiscal years 1996, 1997 and 1998. Providers which received new provider exemptions in FY 1995 would be excluded from the data base. Exceptions payments would also be excluded from the data base. The data would be aggregated nationally by urban and rural area to determine standardized federal per diem rates (to which the case mix and wage adjustments would apply).
- Case Mix Adjustment: Per diem payments for each admission will be case-mix adjusted using a resident classification system (Resource Utilization Groups) based on resident assessments (MDS 2.0) and other data.
- Geographic Adjustment: The labor portion of the federal rates will be adjusted by an appropriate geographic wage index.
- Annual Updates: Payment rates will be increased annually using a SNF market basket index.
- Transition: A three year transition that blends a facility-specific payment rate with the federal case mix adjusted rate will be used. The facility-specific rate will include allowable costs (from FY 1995 cost reports) including exceptions payments. Payments associated with 'new provider' exemptions will be included but limited to 150 percent of the routine cost limit. It will also include an add-on for related Part B costs similar to the federal rate.
- Consolidated Billing: A consolidated billing provision that requires all SNFs to submit bills (Parts A and B) to Medicare for the services furnished to their residents is included in the law. The provision excludes certain services (primarily those of physicians and a few other types of medical practitioners). Consolidated billing for Part A covered residents strengthens the ability to control SNF payments under PPS, by eliminating the ability of providers and suppliers to bill Part B when payments are included in the Part A rate. It will also eliminate Part B

copayments for these residents. For all residents (including those not covered under Part A), this provision will promote high quality care by insuring that all services are incorporated in the resident's plan of care developed by the facility. It will also restrain inappropriate billing practices and utilization. This provision also includes a requirement for SNFs to use HCFA Common Procedure Coding System (HCPCS) coding on all Part B bills.

- Effective Date: The PPS system will be effective for cost reporting periods beginning on or after July 1, 1998. The consolidated billing and coding requirements will be effective for services and items furnished on or after July 1, 1998.

Inpatient Rehabilitation Facility Prospective Payment System

- Section 4421 of the Balanced Budget Act of 1997 (BBA '97) mandates the phase-in of a case mix prospective payment system for inpatient rehabilitation facilities (freestanding and units) for cost reporting periods beginning on or after October 1, 2000 and before October 1, 2002. The case mix payment system is to be fully implemented for cost reporting periods beginning on or after October 1, 2002.
- Payments will be based on the inpatient operating and capital costs of rehabilitation facilities. Payments will be adjusted for 1) case mix using patient classification groups, 2) area wages, 3) inflation, and 4) outlier and special payments.
- Total payments made under the system during fiscal years 2001 and 2002 shall be equal to 98 percent of the amount of payments that would have been made under the current TEFRA payment system. Outlier payments in a fiscal year may not exceed 5 percent of the total projected or estimated payments based on the rates for that fiscal year.
- HCFA's goal is to develop an integrated payment approach for payment of rehabilitation care across all settings (rehabilitation facilities, long-term care hospitals, SNFs, HHAs, etc.).
- A study by the RAND Corporation evaluated the use of functional-related groups (FRGs) to classify patients in developing a prospective payment system for rehabilitation facilities. Results indicate that much work would be necessary before a prospective payment system based on FRGs could be implemented. Two important implementation issues are 1) the reliability of the patient status measures, and 2) the recognition of patient complications and comorbidities. We have determined that the significant program resources necessary to develop a prospective payment system should be directed to meet HCFA's goal of an integrated payment system.
- We are currently evaluating the prospective payment system being developed for skilled nursing facilities to determine if the elements contained in the patient assessment instrument could be modified to identify the clinical needs of patients in rehabilitation facilities. The assessment elements would be used in the development of the rehabilitation facility patient classification groups. Initial field testing of a draft assessment instrument is expected to begin in early CY 1998.

- We have requested FY 1998 funding to perform staff-time measurement studies in a sample of rehabilitation facilities (similar to the studies performed in SNFs). These measurements are needed to assign an appropriate case mix weight which reflects the relative facility resources used for a patient classification group compared to patients within other groups.
- FY 1999 funding has been requested to collect medical record information to measure and track patient conditions and outcomes focusing on the appropriateness and quality of services rendered in rehabilitation facilities.
- In addition, section 4422 of BBA'97 requires the Secretary, no later than October 1, 1999, to develop and report to Congress on a legislative proposal for a case-mix adjusted prospective payment system for long-term care hospitals.

BBA Implementation: Direct and Indirect Medical Education

- o Medicare makes direct and indirect medical education payments to hospitals. Direct graduate medical education (DGME) payments are equal to the product of a per resident amount, the hospital's number of interns and residents and Medicare's share of the hospital's inpatient days. Indirect medical education payments are an adjustment to Medicare's payment per discharge under the Prospective Payment System (PPS) and are based on the hospital's ratio of interns and residents to beds (IRB).
- o The Balanced Budget Act (BBA) of 1997 makes major changes to Medicare's direct and indirect medical education payments. Some of these provisions were implemented in final regulations with comment on August 29, 1997. We expect to implement other provisions in 1998.
- o Provisions implemented in the August 29, 1997 final rule include:
 - Caps on the number of residents paid for by Medicare for both direct and indirect medical education. The caps are based on the hospital's most recent cost reporting period ending on or before December 31, 1996 and apply to hospital cost reporting periods beginning on or after October 1, 1997. There is a one year gap between the cap year and the year the cap is applied. The statute allows for exceptions for medical residency training programs created after 1/1/95 and the 8/29/97 final rule allows for the following:
 - + Programs created between 1/1/95 and 8/5/97 (the date of BBA enactment) are allowed to grow for 3 years.
 - + Hospitals which did not previously train residents would be exempt from the cap for 3 years following creation of their first program.
 - + Hospitals in rural areas would be allowed to establish new training programs which could grow for 3 years.
 - BBA allows hospitals to affiliate for purposes of establishing aggregate FTE caps. We allowed hospitals in the same geographic areas which share residents to be an affiliated group for purposes of the FTE cap. Hospitals which are not in the same geographic area can affiliate if they are recognized as "major participating institutions" in a training program by the Accreditation Council on Graduate Medical Education (the nongovernmental accrediting organization for GME programs).

- Caps the IRB. The IRB in a cost reporting period is capped based on the hospital's ratio from the prior cost reporting period rather than being capped based on a specific cost reporting period (i.e. the hospital's IRB for its FY 1996 cost reporting period). HCFA believes the statute intended a cap based on the hospital's most recent cost report ending on or before December 31, 1996 and has proposed this as a technical amendment.
 - Reduces the amount of the indirect medical education adjustment. Prior to BBA, a hospital could receive an approximately 7.7 percent increase in payments for each 1.0 percent increase in its IRB. BBA reduces the level of the adjustment from 7.7 percent to 7.0 percent in FY 1998, 6.5 percent in FY 1999, 6.0 percent in FY 2000 and 5.5 percent in FY 2001 and subsequent years.
 - Subject to the IRB cap, allows resident training time in a non-hospital site to be included in a hospital's IRB. For this provision to have any effect, the hospital would either have to rotate existing residents from inpatient to non-hospital settings or reduce the number of residents to count residents already working in nonhospital sites.
 - Makes payment for direct and indirect medical education based on a 3 year average count of interns and residents. This provides incentives for hospitals to downsize by phasing in the payment effect of reductions in residents.
 - Makes payment directly to hospitals for residency training associated with Medicare managed care discharges. This provision phases in payment for direct and indirect medical education in 20 percent increments over 5 years beginning January 1, 1998. Although HCFA implemented this provision in the August 29, 1997 final rule, we are currently considering changes to the Medicare costs reports and how teaching hospitals will need to submit data to HCFA related to their managed care discharges.
- o BBA includes provisions related to graduate medical education that we expect to implement in 1998 as follows:
- Medicare can make direct medical education payments to nonhospital providers such as federally qualified health centers, rural health clinics and managed care organizations. Prior to BBA, Medicare could only make payment to teaching hospitals. We currently anticipate publishing proposed regulations in the spring of 1998. Hospitals are currently permitted to be paid for training time residents spend in non-hospital settings. Since we

expect to develop regulations which will make payment to either the hospital or nonhospital provider but not both, this regulation may concern teaching hospitals.

- BBA requires the Secretary to develop interim final regulations which allow hospitals to participate in residency reduction plans similar to the New York Graduate Medical Education Demonstration. We currently expect to publish regulations early in 1998.
- Requires the Secretary to do a demonstration project to make direct graduate medical education payments to consortia of providers. HCFA anticipates that the final design of this demonstration will incorporate the new rules for payment of direct medical education costs to nonhospital providers, which are yet to be determined.

o TEACHING HOSPITALS HAVE MAJOR CONCERNS ABOUT THE IMPACT OF THE FTE CAPS. Among other concerns are:

- There is a one-year gap between the cap year and the year the cap is applied. Hospitals may have made commitments to new residents since 1996 that are not included in their cap. There is no provision for adjusting the cap for expansion of programs between the 1996 cap year and FY 1998 when the cap is applied.
- Teaching hospitals frequently rotate residents among multiple hospitals to provide training opportunities. The FTE caps limit hospitals flexibility in doing these rotations. Although the PPS final rule includes provisions for allowing hospitals to affiliate for purposes of establishing an aggregate cap, many hospitals may not qualify to be treated as affiliated institutions. Furthermore, there is uncertainty as to how Medicare will determine payments for institutions which are affiliated given the 3 year averaging rules and that each hospital has different per resident amount.
- Although the statute permits exceptions for training programs created after January 1, 1995, programs which began earlier do not qualify and did not have sufficient time to have a full complement of residents.
- HCFA staff has met with the AAMC and a number of hospitals to listen to their concerns about the BBA and the final regulations implementing the FTE caps. We understand that there are many situations which require further clarification and we have encouraged comments on our final rule

E

HCFA BRIEFING ON BALANCED BUDGET ACT (BBA) IMPLEMENTATION

SECTION E PROGRAM INTEGRITY

- o Surety Bond Requirements for DME and Other Suppliers
- o Barring Felons and Improvement of the Provider Enrollment Process
- o Home Health Prospective Payment System
- o Clarification of Home Health Care Definition
- o Clarification of Definition of Skilled Service for Purposes of Home Health Eligibility
- o Development of Payment Standards
- o Home Health Surety Bonds
- o Mandatory Reporting of EINs and SSNs
- o Home Health Payment Based on Site of Service
- o Hospice Payment Based on Site of Service

Program Integrity Provisions

Surety Bond Requirements for Durable Medical Equipment (DME) and Other Suppliers

This provision gives HCFA the authority to require durable medical equipment (DME) suppliers, home health agencies and other types of provider facilities to post a surety bond of at least \$50,000 before they are certified for both Medicare and Medicaid. We hope to publish a supplier standard regulation, requiring a \$50,000 surety bond for DME suppliers soon in the Federal Register. We are contemplating a graduated sliding scale based on the amount of Medicare billings, either a \$50,000 minimum or 15 percent of the amount shown on the IRS 1099 for each supplier. We are also developing a regulation, which should be published in the next six months, to implement the surety bond requirement for home health agencies and provide important programmatic protections. The home health agency moratorium will remain in effect until we strengthen these requirements. HCFA is also preparing a regulation to require a \$50,000 minimum bond for comprehensive outpatient rehabilitation facilities as required by the BBA. We may adopt a surety bond requirement for other types of providers as deemed necessary.

Barring Felons and Improvement of the Provider Enrollment Process - The BBA provides the ability to bar convicted health care felons from ever receiving Medicare and Medicaid payments again, and to exclude the family members of sanctioned providers so that such providers can't simply transfer the business to a relative and continue operation. The Office of the Inspector General has the lead on implementing this provision through regulation. HCFA will then modify its provider enrollment application and contractor manual instructions to ensure that convicted health care felons no longer bill and receive payment from the Medicare program. The authority granted by the BBA to require providers and suppliers to report their Social Security and Employer Identification Numbers is a significant factor in identifying fraudulent providers. First, the Secretary must report to the Congress on the privacy and protection of Social Security numbers. HCFA will be working closely with SSA to define the privacy and protection guidelines, which the Secretary will present to the Congress. Continued cooperation with SSA and assistance from the IRS will also be needed for successful implementation.

Home Health Prospective Payment System - This provision provides the ability to establish a prospective payment system that will pay providers a flat rate, in advance, for a patient's care, eliminating incentives for providing unnecessary care. It also will end "periodic interim payments" that are made in advance and not justified until the end of each year. The law establishes October 1, 1999 as the date by which the prospective payment system must begin, and we are working hard to meet that date with the necessary research and infrastructure development. Meanwhile, the interim system established in the Balanced Budget Act went into effect on October 1 of this year.

Clarification of Home Health Care Definition - This provision provides a clear definition specifying the hours and days that home care must be needed or provided in order to be covered by Medicare. We have just issued an instruction that announces the new requirements for this provision. Regulations and additional instructions will follow.

Clarification of the Definition of Skilled Service for the Purposes of Home Health Eligibility - Previously, venipuncture qualified as skilled nursing care and enabled a beneficiary to meet the eligibility criterion for intermittent skilled nursing services under the home health benefit. Thus, if the other criteria were met (homebound, etc.), then a beneficiary who only required venipuncture would have been entitled to all of the other covered home health services including home health aide services. Now, if venipuncture for the purpose of obtaining a blood sample is the only skilled service that is needed by the beneficiary, that individual will not qualify for home health. This provision is self-implementing and is effective for services furnished 6 months after August 5, 1997.

Development of Payment Standards - This provision gives HCFA the authority to develop normative utilization standards and deny payment to agencies that bill for services in excess of these standards. We are currently considering how most effectively to implement this critical provision.

Home Health Surety Bonds - Section 4312 of the Balanced Budget Act of 1997 (BBA) requires all home health agencies (HHAs), durable medical equipment (DME) suppliers, Comprehensive Outpatient Rehabilitation Facilities (CORFs), and Rehabilitation Agencies to obtain a surety bond of at least \$50,000 prior to enrolling in Medicare. Section 4724 requires that HHAs and DME suppliers have a bond to enroll in Medicaid. The surety bond must be obtained from an authorized surety that has been issued a Certificate of Authority by U. S. Department of Treasury. HCFA is moving forward to implement this provision on several different tracks. This measure is effective January 1, 1998.

The HHA provision is part of the overall effort to tighten the standards for HHAs in conjunction with the moratorium on new HHAs. HCFA regulations to implement this requirement are expected to be published prior to December 1, 1997. This provision will assist HCFA in its ability to recover overpayments more effectively and efficiently, and will ensure that HHAs have the financial stability to provide consistent and continuous care for beneficiaries. We believe that there is an adequate supply of HHAs throughout the country and do not expect that this requirement will adversely impact the care provided to beneficiaries.

HCFA will take several measures to ensure successful implementation of this provision. All HHAs will be required to furnish surety bonds. Additionally, as part of the enrollment process, Medicare contractors will use information service firms, such as Dun & Bradstreet and Choice Point, to assist us in assessing the overall capability and integrity of HHAs.

HCFA is also investigating the possibility of expanding the use of such services to look for patterns of bankruptcies, criminal activities and other questionable characteristics. Finally, HCFA contractors will perform additional audits and medical reviews on HHAs. These reviews may be targeted based upon the results of enrollment, verification and information services data.

Mandatory Reporting of EINs and SSNs - Under Section 4313 of the BBA, Medicare providers, with certain exceptions, will be required to report their Employer Identification Numbers (EINs) and Social Security Numbers (SSNs) of each disclosing entity, each person with an ownership interest and each subcontractor in which the entity has a direct or indirect ownership interest of 5% or more. Before implementing these provisions, the DHHS Secretary must submit a Report to Congress concerning the safeguards we will put in place to ensure the SSNs will remain confidential.

HCFA is presently working with Social Security Administration representatives to develop a detailed plan for assuring the maintenance of the SSNs' confidentiality. The Secretary's Report to Congress will be prepared upon completion of this plan. The Report will receive the concurrence of SSA and HCFA before its approval and release by the Secretary of DHHS.

Home Health Payment Based On Site of Service - Currently, home health agencies with various offices in urban and rural areas establish the parent agency in the area that would yield the highest cost limitation. Home health agencies have moved the parent office from location to location whenever new limitations were published, whereby the new location would yield higher limitations.

Section 4604 of the Balanced Budget Act of 1997 amended section 1861(v)(1)(L)(iii) of the Social Security Act to require that for cost reporting periods beginning on or after October 1, 1997, the cost limitation will be based on the geographic area in which the home health service is furnished.

By applying the cost limitations on the basis of where the home health service is furnished, home health agencies can no longer game the system by moving to areas that yield the highest cost limitation, i.e., possible higher Medicare payments.

Hospice Payment Based on Site of Service - The BBA requires that, effective October 1, 1997, hospices submit claims for payment for hospice care furnished in an individual's home (i.e., revenue codes 651 and 652) based on the geographic location at which the service is furnished (as opposed to the location of the hospice).

The purpose of revising the method for paying the home hospices rates based on the site where the service is provided as opposed to where the hospice is located is based on the fact that many hospices believe there are inequities in the payment structure. That is, a hospice with an urban office is serving a rural area and receiving a different reimbursement rate than a rural office serving the same population. We believe this has led to hospices setting up offices in urban areas and then traveling to the rural areas to provide services and receiving the higher payment rate and possibly pushing the rural hospice to provide the same services for less reimbursement and possibly causing the rural hospices to lose business.

In addition, we would only be paying for the home hospice rates based on the site where the service is provided. The inpatient rates would continue to be paid based on where the hospice is located.

A pricing system was designed for hospices so that they could bill the 2 home hospice care revenue codes by inputting the MSA code of the location of the beneficiary's address on the bill. The hospice PRICER was forwarded to the fiscal intermediaries at the end of September. In addition, instructions for this provision were included in a Program Memorandum (attached) outlining all of the BBA hospice provisions. This Program Memorandum was distributed in September.



HCFA BRIEFING ON BALANCED BUDGET ACT (BBA) IMPLEMENTATION

SECTION F

BBA IMPLEMENTATION ISSUES RAISED BY
CONGRESSIONAL STAFF

- o PPS Hospitals
- o Graduate Medical Education
- o PPS Exempt
- o Fraud and Abuse
- o Home Health
- o Rural Issues
- o DoD Subvention

BBA Implementation Issues Raised by Congressional Staff

PPS Hospitals - Transfer Policy:

Several Congressional offices, particularly those representing rural constituencies, have called with concerns about the hospital transfer policy. Rural hospitals believe that shifting patients to post acute care settings for the tail end of a hospital stay is only abused in urban hospitals and, therefore, the transfer policy should only apply to urban hospitals. Rural hospitals are concerned about the negative financial impact the transfer policy will have on their hospitals.

GME - Resident Cap:

Several Congressional offices have called with concerns related to the retroactive nature of the resident cap. The resident cap applies to a hospital's most recent cost reporting period beginning on or before December 31, 1996. If a hospital has more residents this year than they did in the base year for the cap, the hospital is not receiving payment for the additional residents.

PPS Exempt - Area Wage Adjustment on the 75th Percentile Cap:

The Greater New York Hospital Association has contacted Ways and Means Committee staff regarding the lack of an area wage adjustment on the 75th percentile cap for PPS-exempt psychiatric, rehabilitation, and long-term care hospitals and units at section 4414 of the BBA. The current statutory language for the 75th percentile cap does not include this direction. Urban hospitals in particular could be disproportionately affected by the lack of a wage adjustment. The Association believes that the BBA granted HCFA the discretion to adjust for geographic differences by directing HCFA to "estimate" the 75th percentiles. The Office of General Counsel and HCFA staff feel that, under the present statutory language at section 4414, the agency does not have this discretion unless the statute is amended.

Fraud and Abuse - Surety Bonds:

Section 4312 requires home health agencies to provide a surety bond of at least \$50,000 by January 1, 1998.

The home health agencies have approached Committees and Members of Congress concerned that HCFA will not have a rule out in time for bond agencies to issue bonds to all HHAs by January 1.

HCFA's goal is to have the rule published by December 1, 1997. HCFA has consulted with bond industry representatives who say it will take a week to 10 days to bond a legitimate HHA. However, it could take up to 8 weeks to bond HHAs with questionable histories. The purpose of the bond is to make a barrier for participation for HHAs with questionable histories.

HCFA will also take into account the tight turn-around time for HHAs to secure a bond when formulating a rule.

Home Health -

Venipuncture Provision:

Several members have expressed concern over this provision's impact on their constituents. The provision removes venipuncture for the purpose of drawing blood from the list of skilled nursing services that a Medicare beneficiary must need in order to qualify for home health. If the only skilled service that a beneficiary needs is a blood draw, he or she will be precluded from receiving home health services. The provision is effective February 1998.

Although beneficiaries who only need venipuncture for obtaining a blood sample will no longer qualify for home health, they can continue to have their blood monitored under the Part B lab benefit. The impact of this provision precludes individuals who only need custodial care from receiving the home health benefit. However, beneficiaries with serious illnesses generally will qualify for home health anyway because they need another skilled nursing service (such as observation and assessment).

Interim Payment System:

Under this system, home health agencies will be paid the lesser of 1) actual costs 2) reduced per visit limits, 3) a new agency-specific per beneficiary cost. The interim payment system will decrease expenditures on home health by significantly reducing the existing per visit cost limits, and by applying a new, agency-specific per beneficiary limit. The lower per visit cost limits provide an incentive to keep costs down while the new per beneficiary limits encourage agencies to control the number of visits provided to each beneficiary.

Several members expressed concern that the new limits, particularly the new agency-specific per beneficiary limit will force HHAs to drop very sick patients who need extensive services. Agencies will not be able to provide the needed care and meet the new cost limits. However, HCFA believes that beneficiaries who need home health services should be able to receive the care they need. The new per beneficiary cost limit is applied in the aggregate to an HHA's (unduplicated) census count. The per beneficiary limit will be implemented across the agency's caseload of patients, by multiplying the number of beneficiaries by the per beneficiary limit. This gives HHAs the flexibility to offset the cost of caring for sicker patients, who may exceed the limit, against the cost of caring for less sick patients who come under the cost limit. HHAs should be able to provide care to any beneficiary without discriminating against sicker patients.

Moreover, the new per beneficiary limits are not just arbitrary caps; they are based on home health agencies' cost experience. 75 percent of this limit will be based on an agency's own actual incurred cost in 1994 (and adjusted for inflation). [The other 25 percent is based on the average of the limits of other HHAs' located in the same census region.] By basing the

new agency specific per beneficiary limit on the agencies' actual costs, the new limit reflects the normal costs incurred by the agency in providing care to beneficiaries.

Prospective Payment System:

Some members of Congress are interested in ensuring HCFA meets the 10/1/99 deadline for PPS implementation. This schedule is ambitious; however, HCFA is committed to implementing PPS by this date. In addition, HCFA has promised Congress that we will inform them if we cannot meet the deadline.

Rural Issues -

EACH/PCH:

The BBA replaced the Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) program with the critical access hospital (CAH) program. Designation as a CAH is limited by statute to licensed hospitals; some states wish to allow non-hospital clinics to be designated as CAHs in rural areas.

Telemedicine/Telehealth: The BA requires the Secretary to make Part B payments for professional consultation via telecommunications systems; only those services associated with a physical exam or to meet other real time telemedicine consults would qualify. There is interest in allowing payment for "store and forward technologies", although these do not have live interaction with the patient and/or primary care provider.

DoD Subvention -

The Department of Defense/Medicare subvention demonstration is authorized in no more than six sites. There has been increasing interest by members to include sites in their districts/states which exceed the six authorized.

G

HCFA BRIEFING ON BALANCED BUDGET ACT (BBA) IMPLEMENTATION

SECTION G BBA IMPLEMENTATION TABLE

Unique ID	Act Section Number	Para	Topic	Provision	Interim task	Eff. Date	Lead Component	Complete	Status	Notes/Issues
BBA0020	4001	1851 (c), (e), (f)	M + C Process for exercising beneficiary choice	Enrollment / Disenrollment process for choice	instructions and conforming regs	1/1/98	CBS			This includes the establishment of the process for how an election is made changed including the form and the manner, how it is coordinated with the plans, the election forms, periods, effective dates and default rules.
BBA0070	4001	1851 (d), (e)	M+C: information	info to new eligibles		1/1/98	CBS		Background info and issue identification underway.	procedures for mailing of info 2 mos. before eligibility. Collection, accumulation, and tabulation of data; also establish procedures for data not currently collected.
BBA0120	4001	1852(d),(2)	M+C: bene protections	guidelines for standards for stabilization of care		6/1/98	OCSQ			CHPP, CBS
BBA0130	4001	1853 (b)	M+C: payment	capitation rates		1/13/98	OSP			Bill requires announcement of changes in methodology including update of 45 days prior to publication of rates on 3/1. Bill requires new capitation rates as of 1/1/98.
BBA0150	4001	1853(c)	M+C: payment	announcement of 1998 rates		9/2/97	OSP			
BBA0160	4001	1853(d)	M+C: payment	revised geographic area upon request of State chief executive		6/1/98	OSP			But at option of States; payments effective for years after 1998 and CE of State must make request 7 mos. before change year (hence date for procedures)
BBA0180	4001		M+C: ACR	ACR submissions for current contractors		3/1/98	CHPP			bill advances time frames for Act submission
BBA0190	4001		M+C: Information	Provision of information		9/1/97	CHPP			Create format for submission by plans of information required to be given to beneficiaries.
BBA0210	4001		M+C: marketing	development of marketing guidelines		6/1/98	CHPP			bill directs Secretary to develop guidelines (see 1856 of W&M) standards; one-stop approval
BBA0220	4001		M+C: payment	announcement of 1999 capitation rates		3/1/98	OSP			Bill changes the required date for announcement of capitation rates from 9/7 to 3/1

Unique ID	Act Section Number	Para	Topic	Provision	Interim task	Eff. Date	Lead Component	Complete	Status	Notes/Issues
BBA0230	4001		M+C: plan standards	various sections including beneficiary protections, premiums, contracts, establishment of standards		6/1/98	CHPP			Includes all standards except those related to enrollment, information and PSO solvency. OCSQ, CBS will participate.
BBA0240	4001		M+C: PSO	PSO solvency standards		9/19/97	CHPP			target date 4/98 applies to negotiated rulemaking for solvency standards for PSOs specifically required; specific reference to entities that must be consulted
BBA0250	4001		M+C: PSO	PSO definition		1/1/98	CHPP			bill requires issuance of regulations; date not specified, but should be as quickly as possible to effectively implement other PSO provisions with tight time frames
BBA0260	4001		M+C: PSO	PSO solvency standards		1/1/98	CHPP		Notice on negotiated rule making published 9/23; rulemaking committee meeting scheduled 10/21 - 10/22	negotiated rulemaking for solvency standards for PSOs specifically required; specific reference to entities that must be consulted
BBA0270	4001		M+C: PSO	adjusted community rate rules for PSOs		6/1/98	CHPP			
BBA0290	4001		M+C: reporting requirements	risk adjustment factors: collection of encounter data from plans		7/1/97	OSP, OCSQ, CHPP			For data standards; administration of requirement 7/1/97 for hospital data, 1/1/98 for all other. OSP, OCSQ, OIS to participate.
BBA0300	4001		M+C: reporting requirements	plan statement of capacity (all plans)		1/1/98	CHPP			processing and evaluating information
BBA0320	4001		M+C: State laws	state licensure waiver requests by PSOs		4/1/98	CHPP			

Unique ID	Act Section Number	Para	Topic	Provision	Interim task	Eff. Date	Lead Component	Complete	Status	Notes/Issues
BBA0330	4001		M+C: State laws	standards pre-empting State laws		6/1/98	CHPP			time frame assumes 4/1/98 is earliest possible existence of any new standard
BBA0340	4001		M+C: State laws	state premium tax prohibition		6/1/98	CHPP			
BBA0350	4001		M+C: Process for exercising bene choice	Process in general		1/1/98	CHPP			Secretary establishes a process for making elections including form and manner.
BBA0360	4001		Miscellaneous Affecting Medicaid	Coordinate Acute and Long-term Care Benefits under a Medicare+Choice Plan	CMSO coordinate with CHPPs	8/29/97	CMSO			
BBA0380	4002	(b)	M+C: rates	Publication of new capitation rates		9/6/97	OSP			Announcement of annual Medicare Choice capitation rates for 1988. CHPP to participate
BBA0390	4002	(f)	M+C: legislative proposal	technical and conforming amendments		2/5/98	OL			
BBA0420	4002		M+C: enrollment	HMO/CMP Part B-only enrollee grandfathering (transition) rules		6/1/98	CHPP			continued enrollment of Part B-only if enrolled as of 12/31/98
BBA0430	4002		M+C: enrollment composition	1876 50/50 waivers		9/1/97	CHPP		OPL under development	waiver or modification of 50/50 permitted if "in public interest"; p.87
BBA0440	4002		M+C: HCPP plans	elimination of HCPPs		8/5/97	CHPP			
BBA0450	4002		M+C: payment	grandfathered Part-B only payments.		1/1/98	OSP			
BBA0460	4003	(a),(b)	Medigap	Conforming Changes and Anti-duplication Provision for MSAs' Exclusion (Medigap)	CMSO will work in partnership with CBS	8/5/97	CMSO			

Unique ID	Act Section Number	Para	Topic	Provision	Interim task	Eff. Date	Lead Component	Complete	Status	Notes/Issues
BBA0490	4012		HMO Competitive Pricing	Medicare+Choice competitive pricing demonstration		10/1/97	CHPP		Memo outlining potential advisory group members is in HCFA Clearance	Advisory committee makes recommendations on areas for demonstration, design of demonstration, and advise during implementation of demonstration Memo outlining potential advisory group members is in HCFA clearance (10/9 Update).
BBA0500	4012		HMO Competitive Pricing	Medicare+Choice competitive pricing demonstration		10/1/97	CHPP			Establish area advisory committee, which advises on how to implement demo in given area. Memo outlining potential advisory group members is in HCFA clearance (10/9 Update).
BBA0520	4014		SHMO Demonstration	SHMO extension		9/1/97	CHPP			
BBA0540	4015		Medicare Subvention Demonstration Project for Military Retirees	Medicare Subvention		1/1/98	CHPP		Short list of sites received from DoD; in process of clearance within HCFA, then OS	Short list of sites received form DoD; in process of clearance within HCFA, then OS (10/9 update)
BBA0570	4017		Integrated Long-Term Care	Municipal Health Demonstration Programs: Orderly transition		3/31/98	CHPP			
BBA0580	4018	(a)	M+C: enrollment	M+C enrollment demonstration		8/5/97	CBS			Used to evaluate use of 3rd party contractor to conduct enrollment/Disenrollment activities. Prior to implementation the Secretary is required to consult with affected parties concerning design, selection criteria and performance measures
BBA0600	4021	(e)	Medicare	Bipartisan Commission Baby Boom		2/1/98	OSP			report by 3/1/99

Unique ID	Act Section Number	Para	Topic	Provision	Interim task	Eff. Date	Lead Component	Complete	Status	Notes/Issues
BBA0630	4031	(e)	Medigap	DHHS Regulatory Standards in Absence of NAIC Action (Medigap)	CMSO will work in partnership with CBS	5/5/98	CMSO			
BBA0640	4032	(a)	Medigap	Addition of High Deductible Medigap Policies (Medigap)	CMSO will work in partnership with CBS	1/1/98	CMSO			
BBA0650	4041		Medicare	tax treatment of hospitals in PSOs		9/1/97	CHPP			
BBA0660	4101	(a)	Prevention	screening mammography		1/1/98	CBS			OCSQ lead on coverage criteria
BBA0670	4101		Prevention	Screening Mammography		1/1/98	CHPP			Publish in FY 1998 physician fee schedule regulation
BBA0680	4102	(a)	Prevention	pap smear and pelvic exams		1/1/98	CBS			OCSQ lead on coverage criteria
BBA0690	4102		Prevention	Screening Pap Smear and Pelvic Exams		1/1/98	CHPP			set payment amounts; Publish in FY 1998 physician fee schedule regulation
BBA0720	4104	(a)	Prevention	colorectal screening		1/1/98	CBS			OCSQ lead on coverage criteria
BBA0740	4105	(a)	Prevention	diabetes self-management		1/1/98	CBS			OCSQ lead on coverage criteria
BBA0750	4105		Prevention	Diabetes Benefits		1/1/98	CHPP	Completed.	Instruction via ARA memo dated 9/17/97. Carriers to implement fee schedules 1/1/98.	reduce payment for testing strips by 1/1/98; Consult with Organizations in Establishing Payment under physician fee schedule by 7/1/98
BBA0770	4106	(a)	Prevention	bone mass		1/1/98	CBS			OCSQ lead on coverage criteria
BBA0820	4201		Rural Health	Medicare Rural Hospital Flexibility Program		10/1/97	CHPP			PPS Hospital Reg. Replaces EACH/RPCH. Payment for inpt/outpt on reasonable cost. States may get grants.

Unique ID	Act Section Number	Para	Topic	Provision	Interim task	Eff. Date	Lead Component	Complete	Status	Notes/Issues
BBA0830	4201		Rural Health	Medicare Rural Hospital Flexibility Program		6/1/98	CHPP		completed in 8/29/97 hospital PPS reg	Study feasibility of alternative to 96 hour limit on inpatient care in critical access hospitals (CAHs).
BBA0840	4202		Rural Health	Prohibiting Denial of Request by Rural Referral Centers for Reclassification on Basis of Comparability of Wages		10/1/97	CHPP		completed in 8/29/97 hospital PPS reg	Needs budget neutrality adjustmetn PPS Hospital Reg.
BBA0850	4202, 4511 and 4512		Nurse Practitioners, Physician Assistants	Nurse practitioners, clinical nurse specialists, and physician assistants: removal of restrictions on settings & increased payments		1/1/98	CHPP		Instruction, then regulation. OGC confirmed that change can be implemented via program memo and then codified in 98 NPRM and final	Requires mods to 2 regs under devpmt: BPD-708-P & BPD-829-P Instr, then reg. OGC conf that change can be impld via program memo and then codified in 98 NPRM and final. Rescind BPD 708 P & BPD 829 P as separate regs & bunle chgs in FY 98 phy fee sched reg.
BBA0860	4203		Rural Health	Hospital Geographic Reclassification Permitted for Purposes of Disproportionate share Payment Adjustments		10/1/97	CHPP		completed in 8/29/97 hospital PPS reg	PPS Hospital Reg.
BBA0870	4204		Rural Health	Medicare Dependent Small Rural Hospital Payment Extension		10/1/97	CHPP		completed in 8/29/97 hospital PPS reg	PPS Hospital Reg.
BBA0880	4205	(b)	Rural Health Clinics	Quality assessment		1/1/98	OCSQ		To be integrated into rural health payment reg	
BBA0890	4205		Rural Health	Per visit payment limits for rural clinics		1/1/98	CHPP			Extends limitations to rural health clinics (other than those in rural hospitals with less than 50 beds) Interim final reg 2/98 (10/6 update) Os on reg team

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Unique ID	Act Section Number	Para	Topic	Provision	Interim task	Eff. Date	Lead Component	Complete	Status	Notes/Issues
BBA0900	4205		Rural Health Clinics	Waivers of staffing limits only to clinics in program		1/1/98	CHPP			OCSQ to participate. Final reg 6/98; Consulting with OGC in issues (10/6 update).
BBA0940	4207	(a),(b),(c)	Rural Health	Informatics, Telemedicine, and Education Demonstration Project		6/1/98	OCSQ			New payment method as part of demonstration, but with \$ cap, on diabetes
BBA0950	4207	(e)	Rural Health	Informatics, Telemedicine, and Education Demonstration Project		1/1/98	OSP			Evaluation required in statute.
BBA0960	4301		Fraud & Abuse	Exclusions: Permanent Exclusion for Crimes; Authority to refuse agreements w/ convicted felons; Exclusion of Family Member of Sanctioned Individual		8/5/97	CHPP			CHPP to prepare instructions to contractors on excluded individuals/organizations. Sections 4301, 4302, 4303. IG, OIS, OFM to contribute
BBA0970	4301		Fraud & Abuse -- Family member	Exclusions: Permanent Exclusion for Crimes; Authority to refuse agreements w/ convicted felons; Exclusion of Family Member of Sanctioned Individual		9/20/97	CHPP			CHPP to prepare instructions to contractors on excluded individuals/organizations. Sections 4301, 4302, 4303. IG, OIS, OFM to contribute
BBA0980	4304	(a),(b)	Fraud & Abuse	Civil Money Penalties for Contracting with Excluded Providers and Kickbacks		8/5/97	IG			CMP of up to \$50,000 plus up to 3 times amount of remuneration for each Kickback violation
BBA0990	4311	(a)	Fraud & Abuse	Changes to handbook, toll-Free Number		1/1/98	CBS			Medicare handbook must contain additional information on Fraud

Unique ID	Act Section Number	Para	Topic	Provision	Interim task	Eff. Date	Lead Component	Complete	Status	Notes/Issues
BBA1000	4312		Fraud & Abuse	Reporting: Disclosure of Information & Surety Bonds: DME, HHA, Ambulance Services & Clinics, CORFs, Rehab. Agencies		1/1/98	CHPP		Proposed regulation that would implement the DME surety bond provision is currently in final OS clearance. Needs expedited OS/OMB clearance. OFM to participate	Proposed regulation that would implement the DME surety bond provision is currently in final OS clearance. Needs expedited OS/OMB clearance. OFM to participate
BBA1140	4314	1877 (g)(6)	Fraud & Abuse	Advisory Opinions on Physician Self-Referral		11/5/97	CHPP			Written advisory opinions on whether a referral is prohibited, based on regulations from Section 1128D(b)(5). Regulation establishes process. OS on team
BBA1160	4316		Fraud & Abuse	Factors for inherent reasonableness determination		8/5/97	CHPP			No implementation date specified -
BBA1170	4317	(b)	Fraud & Abuse	Diagnostic Information		1/1/98	CHPP			Direct physicians and other practitioners to provide diagnostic information. OCSQ will participate regarding the medical appropriateness of diagnoses. CBS to participate

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Unique ID	Act Section Number	Para	Topic	Provision	Interim task	Eff. Date	Lead Component	Complete	Status	Notes/Issues
BBA1200	4320		Fraud & Abuse	Prohibiting Payment for Certain Items		8/5/97	CHPP		Completed draft PRM instructions 10/3/97. Printing and pub. of manual revision 1/16/98 or if prior consultation needed on 2/17/98	Medicare payments are prohibited for entertainment, gifts, fines, educational expenses
BBA1210	4321	(a)	Fraud & Abuse	Post Hospital Referrals to HHA's		11/5/97	OCSQ			HHA's with financial relationship with a hospital would report number of individuals discharged from hospital requiring HH Services
BBA1220	4321	(b)	Fraud & Abuse	Maintenance and disclosure of post-hospital HHA information		11/5/97	CHPP			HHA's with financial relationship with a hospital would report number of individuals discharged from hospital requiring HH Services
BBA1230	4331	(d),(6),(A)	Fraud & Abuse	Failure to Report: Sanctions		8/5/97	HHS			Sanctions health plans for failing to report adverse action, not more than \$25,000
BBA1240	4331	(d),(6),(B)	Fraud & Abuse	Failure to report: gov't agencies		8/5/97	HHS			Secretary to issue report
BBA1250	4401		PPS Hospitals	PPS Hospital Payment Update		10/1/97	CHPP		completed in 8/29/97 hospital PPS reg	Retain current update cycle; one year freeze in fiscal 1998 (update=0); 1999 MB-1.9; 2000 MB-1.8; 2001, 2002 MB-1.1; 200 MB. Certain non teaching non DSH hospitals get two year preferential update. PPS Hospital Reg.
BBA1260	4402		PPS Hospitals	Maintaining savings from temporary reductions in capital payments for PPS hospitals		10/1/97	CHPP		completed in 8/29/97 hospital PPS reg	PPS Hospital Reg.

Unique ID	Act Section Number	Para	Topic	Provision	Interim task	Eff. Date	Lead Component	Complete	Status	Notes/Issues
BBA1280	4404		PPS Hospitals	Medicare capital asset sales price equal to book value		11/5/97	CHPP		Reg specs to OCOS/DRI 9/22/97.	
BBA1290	4405		PPS Hospitals	Elimination of IME and DSH attributable to outlier payments		10/1/97	CHPP	*	completed in 8/29/97 hospital PPS reg	PPS Hospital Reg.
BBA1300	4406		PPS Hospitals	Increase base payment rate to Puerto Rico hospitals		10/1/97	CHPP	*	completed in 8/29/97 hospital PPS reg	PPS Hospital Reg.
BBA1320	4408		PPS Hospitals	Reclassification of certain counties as large urban areas under Medicare program		10/1/97	CHPP	*	completed in 8/29/97 hospital PPS reg	PPS Hospital Reg.
BBA1330	4409		PPS Hospitals	Geographic reclassification for certain disproportionately large hospitals		10/1/97	CHPP	*	completed in 8/29/97 hospital PPS reg	PPS Hospital Reg.
BBA1350	4410	(a)	PPS Hospitals	Floor on area wage index		10/1/97	CHPP	*	completed in 8/29/97 hospital PPS reg	PPS Hospital Reg.
BBA1360	4411		PPS Exempt Facilities	FY98 update factor = 0		10/1/97	CHPP	*	completed in 8/29/97 hospital PPS reg	PPS Hospital Reg.
BBA1380	4412		PPS Exempt Facilities	15 % reduction in capital payments		10/1/97	CHPP	*	completed in 8/29/97 hospital PPS reg	PPS Hospital Reg.
BBA1390	4413		PPS Exempt Facilities	Rebasing option for certain facilities in operation before 1990		10/1/97	CHPP	*	completed in 8/29/97 hospital PPS reg	PPS Hospital Reg.
BBA1400	4414		PPS Exempt Facilities	(Most) Ceiling on target amounts (75th percentile for each category) excluding children's and cancer		10/1/97	CHPP	*	completed in 8/29/97 hospital PPS reg	PPS Hospital Reg.

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Unique ID	Act Section Number	Para	Topic	Provision	Interim task	Eff. Date	Lead Component	Complete	Status	Notes/Issues
BBA1410	4415		PPS Exempt Facilities	Reduction in bonus and relief payments		10/1/97	CHPP	*	completed in 8/29/97 hospital PPS reg	PPS Hospital Reg.
BBA1420	4416		PPS Exempt Facilities	Change in payment and target amount for new providers		10/1/97	CHPP	*	completed in 8/29/97 hospital PPS reg	PPS Hospital Reg.
BBA1430	4417		PPS Exempt Facilities	LTC hospital within a hospital		10/1/97	CHPP	*	completed in 8/29/97 hospital PPS reg	PPS Hospital Reg.
BBA1450	4419		PPS Exempt Facilities	Report to Congress on exceptions and adjustment payments		10/1/97	CHPP	*	completed in 8/29/97 hospital PPS reg	Issue report annually. PPS Hospital Reg.
BBA1460	4421		Inpatient rehabilitation	Inpatient Rehab PPS		10/1/97	CHPP			need to resolve data collection issues and begin collecting data; phase-in 10/2000 with fully implemented system in 2003; MDS Plus
BBA1510	4441		Hospice	Payment Update for Hospice Services		10/1/97	CHPP		PM released via electronic mail 9/24/97. Publish NPRM 5/1/98.	
BBA1530	4442		Hospice	Payment for Home Hospice Care Based on Location Where Furnished.		10/1/97	CHPP		PM-released-via-electronic mail 9/24/97. Publish NPRM 5/1/98.	
BBA1540	4443		Hospice	Hospice Care Benefit Periods		9/1/97	CHPP		PM released via electronic mail 9/24/97. Publish NPRM 5/1/98.	Changing the length of time hospice benefit can be used; initially implemented through instruction, with reg to follow

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Unique ID	Act Section Number	Para	Topic	Provision	Interim task	Eff. Date	Lead Component	Complete	Status	Notes/Issues
BBA1550	4444		Hospice	Other Items and services included in hospice care		4/1/98	CHPP		Initially implemented through instruction, with reg to follow. PM released via electronic mail 9/24/97.	Initially implemented through instruction, with reg to follow
BBA1560	4445		Hospice	Permit contracting with independent physician groups		9/1/97	OCSQ			Minor reg. change to conditions of participation
BBA1570	4446		Hospice	Waiver of certain staffing requirements for hospice care programs in non-urbanized areas		9/1/97	OCSQ			Minor reg. change to conditions of participation
BBA1580	4447		Hospice	Limitation on liability of beneficiaries for certain hospice coverage denials		8/5/97	CBS			Coordination with CHPP
BBA1600	4448		Hospice	Extending the period for physician certification of an individual's terminal illness		9/1/97	OCSQ			Minor change to coverage and conditions of participation; implement first through instruction followed by reg CHPP will participate
BBA1610	4451		Bad Debt	Reductions in Payments for Enrollee Bad Debt		10/1/97	CHPP		To be implemented via cost report. Later revision as part of next year's PPS.	
BBA1620	4452		Hemophilia pass through	Permanent Extension of Hemophilia Pass Through Payment		10/1/97	CHPP		completed in 8/29/97 hospital PPS reg	PPS Hospital Reg.

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Unique ID	Act Section Number	Para	Topic	Provision	Interim task	Eff. Date	Lead Component	Complete	Status	Notes/Issues
BBA1630	4453	(a)	Premium Change	Reduction in Part A Medicare Premium for Certain Public Retirees	instructions and conforming regs	1/1/98	CBS			OIS will participate
BBA1640	4454	(a)	Miscellaneous Affecting Medicaid	Coverage of Services in Religious Non-medical Health Care Institutions under the Medicare and Medicaid Programs	SMD letter, working in coordination with CHPPs	8/5/97	CMSO		SMD letter completed and released by 10/3/97	
BBA1660	4501		Physician Payment	Single conversion factor		1/1/98	CHPP			annual physician regulation
BBA1680	4503		Physician Payment	Replace VPS w/ sustainable growth rate		10/1/97	CHPP			annual physician regulation
BBA1690	4504		Physician Payment	Conversion factor for anesthesia		1/1/98	CHPP			annual physician regulation, 46% of conversion factor for other physician services
BBA1700	4505		Physician Payment	Delay in implementing practice expense component.		1/1/98	CHPP			annual physician regulation, 1 year freeze; 4 year gradual transition DPAC tech. assistance to GAO
BBA1710	4505		Physician Payment	Delay in implementing practice expense component.		2/1/98	CHPP			
BBA1720	4505		Physician Payment	Delay in implementing practice expense component.		3/1/98	CHPP			OS participation
BBA1730	4506		Physician Payment	High per discharge relative values for in-hospital physicians' services		2/1/98	CHPP			annual physician regulation, calculation and notice to hospitals applicable to 1999 and 2001. OCSQ will participate.
BBA1740	4507		Physician Payment	Use of Private Contracts by Medicare beneficiaries		1/1/98	CHPP			annual physician regulation, calculation and notice to hospitals applicable to 1999 and 2001; CBS partner from a beneficiary protection perspective Draft instructions prepared (10/9 update).

Unique ID	Act Section Number	Para	Topic	Provision	Interim task	Eff. Date	Lead Component	Complete	Status	Notes/Issues
BBA1770	4521		Hospital outpatient	Elimination of FDO		10/1/97	CHPP			ambulatory surgical procedures; radiology & diagnostic; issue program memorandum
BBA1810	4531		Ambulance services	Interim reductions in payments		10/1/97	CHPP		Instructions have been drafted by OFM/FSG/PA and approved by CHPP as of 10/2/97	set payment amounts pending fee schedule
BBA1820	4531		Ambulance services	Authorize rural advanced life support by paramedics		6/1/98	CHPP			Sec'y may include coverage
BBA1850	4532		Ambulance services	Contracts with local governments		1/1/98	CHPP			Up to 3 demos; not to exceed 3 years, evaluation due by 2000
BBA1860	4541		CORF	Payment based on fee schedule		1/1/98	CHPP		1998 Physician Regulation	1998 Physician Registration (10/9 update).
BBA1870	4541		Outpatient Rehabilitation Services	Application of standards to outpatient OT & PT services in physician offices		1/1/98	CHPP		1) Cost limits via cost report changes 1/1/98; 2) fee schedule via 98.reg.1/1/99	1.) Cost limits via cost report changes 1/1/98; 2.) fee schedule via 98 reg 1/1/99 (10/9 update).
BBA1880	4541		Outpatient Rehabilitation Services	Payment based on fee schedule		1/1/98	CHPP			Payment in 1998 blended rate; revise payment method for rehab. agencies outpatient therapy services. OCSQ Lead. PPPP/DPAC is implementing basic standards in physician reg; however, OCSQ should have lead for further clarification/instructions(10/9 update)

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Unique ID	Act Section Number	Para	Topic	Provision	Interim task	Eff. Date	Lead Component	Complete	Status	Notes/Issues
BBA1900	4551		DME	Upgraded DME		1/1/98	CHPP		To be implemented via cost report; later reg revision as part of next year's PPS.	Conditions under which upgraded DME may be purchased by beneficiaries.
BBA1910	4551		DMEPOS	Payment Provisions		1/1/98	CHPP			Limits updates for DME and P&O
BBA1920	4551 and 4552		Supplier	Other Payment Changes: DME; Oxygen & Oxygen Equipment; Reduction in Update for Clinical Diag. Lab Tests; Updates for drugs & biologicals reimbursement		1/1/98	CHPP			Freeze in update for covered DME; payment freeze for parenteral and enteral nutrients, supplies, equipment...and 10612,3,5,6. OCSQ will participate
BBA1930	4552	(c)	Oxygen Suppliers	Service standards		1/1/98	CHPP			Establish service standards for home oxygen suppliers.
BBA1950	4552		Oxygen	Payment reduction		1/1/98	CHPP		Completed. Instructions for 1998 DMEPOS fee schedules, including reduced oxygen fees, issued to carriers via ARA memo dated 9/17/97. No plans to do discretionary reg.	Reduce payment and freeze increases.

Unique ID	Act Section Number	Para	Topic	Provision	Interim task	Eff. Date	Lead Component	Complete	Status	Notes/Issues
BBA1960	4553		Clinical Labs	Payment reduction		1/1/98	CHPP		1. Cost limit provisions effective 1/1/98 via cost report changes 2. fee schedule changes effective 1/1/99 via next year's physician reg	Freeze payments; lower national payment CAP. 1. Cost limit provisions effective 1/1/98 via cost report changes 2. fee schedule changes effective 1/1/99 via next year's physician reg. (#s 1 & 2 are from 10/9/97 update).
BBA2020	4555		Ambulatory Surgical Centers	Update change		10/1/97	CHPP		Federal register notice BPD-897-N in process.	Two percentage point reduction in CPI-U update for ASCS for 1998 through 2002. Federal Register notice BPD-897-N in process.
BBA2030	4556		Supplier	Updates for Drugs & Biologicals Reimbursement		1/1/98	CHPP			In case where payment is not made on cost or prospective payment basis, payment is equal to 95% of average wholesale price
BBA2040	4557	(a)	Drugs	Anti-nausea drug coverage		1/1/98	OCSQ			Coordinate with CBS on bene. education issues OCOS will participate
BBA2050	4557	(a)	Other payment provisions	coverage of oral anti-nausea drugs		1/1/98	CBS			OCSQ lead on coverage criteria
BBA2060	4558	(a)	Renal Dialysis	Cost report audits		9/1/97	OFM			For 1996 and then every 3 years
BBA2080	4559		Portable EKG	Temporary restoration of coverage for portable EKG transportation		1/1/98	CHPP			annual physician regulation Coverage effective 1/1/98, report on 7/1/98; Qe believe recommendation to Congress belongs to OSCQ? Restores payment at 96 level.
BBA2090	4571	(a)	Part B Premium Change	Part B Premium-25% of program costs		9/1/97	OSP			Annually in September, promulgate a monthly premium rate equal to 50% of the monthly actuarial rate for enrollees 65+
BBA2100	4581	(b)	Special Enrollment Period	SEP for Disabled Workers and Waivers of Surcharge		9/1/97	CBS			CHPP will participate

Unique ID	Act Section Number	Para	Topic	Provision	Interim task	Eff. Date	Lead Component	Complete	Status	Notes/Issues
BBA2110	4582	1839 (e) (1)	Payment of Part B Surcharge Amounts	Governmental entities eligible to pay Part B Surcharges		9/1/97	CBS			
BBA2120	4601		Home Health	Recapture savings temporary payment freeze		10/1/97	CHPP		Implement as part of BPD-904-FNC. Circulate draft 10/6/97.	Federal Register notice
BBA2130	4602		Home Health	Interim system of cost limits		10/1/97	CHPP		Federal Register notice; two parts: revised cost limits and new per bene cap. Requires significant operational involvement by FIs in audit and reimbursement areas. Circulate draft 10/6/97. Publication date 11/1/97	Federal Register notice; two parts: revised cost limits and new per bene cap. Requires significant operational involvement by FIs in audit and reimbursement areas.
BBA2150	4604		Home Health	Payment based on location where services furnished		10/1/97	CHPP		Instructions completed;regs to follow	Major system changes (with cost implications) and contractor instructions needed.
BBA2170	4611	(a)	Home Health	Maintaining Seamless Administration Through Fiscal Intermediaries		1/1/98	CBS			OFM will participate
BBA2180	4611		Home Health	Modification of Part A Home Health Benefit for Individuals Enrolled under Part B		1/1/98	CHPP		Instructions with regs to follow - 11/1/97 target date for PM.	Significant change. A/B shift. OSP will participate

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Unique ID	Act Section Number	Para	Topic	Provision	Interim task	Eff. Date	Lead Component	Complete	Status	Notes/Issues
BBA2190	4611		Home Health	Post Institutional Home Health Services Defined		1/1/98	CHPP			Significant change requiring implementing instructions, operational and billing systems changes. Significant work by FIs. CBS involvement because of implications for benes (premiums).
BBA2200	4612		Home Health	Part time intermittent nursing definition		10/1/97	CHPP		PM published 9/26/97. Regs to follow.	Initially implemented through instructions
BBA2220	4614	(a),(b)	Home Health	Normative standards for HHAs		10/1/97	OCSQ			Authority to establish thresholds for physician-authorized HH visits; major work effort involved CHPP will participate
BBA2230	4615		Home Health	Home health drawing blood		1/1/98	CHPP		Self implementing, but will issue instructions. PM effective 2/5/98.	
BBA2240	4616	(a),(b)	Home Health	Home Health Containment		10/1/97	OSP			Estimates of outlays under A/B shift for FY 98-2002 to W&M, Commerce and Finance. Annual report compares actual to estimated outlays. If actual are greater, must recommend controls for HH growth (copays or other) CHPP will participate
BBA2250	4621		PPS Hospitals	Indirect graduate medical education payments		10/1/97	CHPP		completed in 8/29/97 hospital PPS reg	PPS Hospital Reg.
BBA2260	4622		GME	Payment to hospitals of indirect medical education costs for Medicare+Choice enrollees		1/1/98	CHPP		Regulation revised in 8/29 PPS rule; further details to be worked out by PPPP/DIDS and PPA/DCIP	PPS Hospital Reg. Regulation revised in 8/29 PPS rule; further details to be worked out by PPPP/DIDS and PPA/DCIP (10/9 update).

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Unique ID	Act Section Number	Para	Topic	Provision	Interim task	Eff. Date	Lead Component	Complete	Status	Notes/Issues
BBA2270	4623		GME	Limitation on number of residents and rolling average FTE count		10/1/97	CHPP			Cost report period beg. on or after 10/97
BBA2280	4624		GME	Payments to hospitals for direct costs of graduate medical education of M+C enrollees		1/1/98	CHPP			
BBA2290	4625		GME	Permitting payment to non-hospital providers		10/1/97	CHPP		Will seek input in PPS reg for future regulation.	Will seek input in PPS reg for future regulation. PPS hospital reg
BBA2300	4626		GME	Incentive payments under plans for voluntary reduction in number of residents		2/5/98	CHPP			Must issue reg within 6 months.
BBA2310	4627		GME	Medicare special reimbursement rule combined residency programs		7/1/97	CHPP		complete in 8/29/97 hospital PPS reg	PPS Hospital Reg.
BBA2350	4631	(a),(b)	MSP/ESRD Extension	Extends the Coordination period from 18 to 30 months		8/5/97				Originally assigned to CBS
BBA2360	4631		MSP	Permanent extension & revision of provisions		8/5/97	CHPP		Instruction published	disabled in large group plans; esrd; irs/ssa/hcfa data match (OFM task); MSP prepayment extends coordination period from 18 to 30 months. CBS will participate. Instruction published (10/9 update).
BBA2370	4632	(a)	MSP	Clarification time & filing limitations		8/5/97	OFM			permits recovery of incorrect payments within 3 years after date of service
BBA2380	4633	(a),(b)	MSP	Recovery third party administrative clarification bene. liability		9/1/97	OFM			CHPP will participate

Unique ID	Act Section Number	Para	Topic	Provision	Interim task	Eff. Date	Lead Component	Complete	Status	Notes/Issues
BBA2400	4642		Organ Procurement Organization	Increased certification period for OPOs		9/1/97	CHPP		instruction being prepared	
BBA2410	4643		Chief Actuary	Office of Chief Actuary		9/1/97	OSP			Establishes office of the Chief Actuary
BBA2420	4644		Date Change, Congressional Review	Conforming Amendments to comply with congressional review		1/1/98	CHPP		Hospital part completed in PPS reg 8/29/97	Change in publication dates: PPS/MGCRB
BBA2480	4702	(a)	Managed Care	PCCM Services as State Option without Waiver	SMD re: MCO contracts	10/1/97	CMSO			
BBA2490	4703	(a)	Managed Care	Elimination of 75/25 Restriction		6/20/97	CMSO			
BBA2730	4708	(b)	Managed Care	Permitting Same Copayments in HMOs as in FFS	SMD letter	10/1/97	CMSO			
BBA2800	4711	(b)	Provider Payments	Flexibility in Payment Methods for Hospital Nursing Facility, ICF/MR, and Home Health Services	NA	10/1/97	CMSO			
BBA2830	4713	(a)	Provider Payments	Elimination of Obstetrical and Pediatric Payment Rate Requirements	SMD letter	10/1/97	CMSO		SMD letter completed and released by 10/3/97	
BBA2840	4714	(a), (b)	Provider Payments	Medicaid Payment Rates for Certain Medicare Cost-sharing	QMB SMD letter	8/5/97	CMSO			
BBA2880	4722	(a), (b)	Federal Payments to States	Treatment of State Taxes Imposed on Certain Hospitals	Tax SMD letter	10/1/97	CMSO			
BBA2890	4722	(c)	Federal Payments to States	Treatment of New York Provider Taxes	NA	8/5/97	CMSO			

Unique ID	Act Section Number	Para	Topic	Provision	Interim task	Eff. Date	Lead Component	Complete	Status	Notes/Issues
BBA2950	4724	(e)	Federal Payments to States	Monitoring Dual Eligible Payments	SMD Letter (possible systems changes)	8/5/97	CMSO			
BBA2980	4725	(a)	Federal Payments to States	Increased FMAP for Alaska	Draft letter to the State	10/1/97	CMSO			Notification to Alaska completed and released by 10/3/97
BBA2990	4725	(a)	Federal Payments to States	Increased FMAP for DC	Final guidance to the States	10/1/97	CMSO			
BBA3000	4726		Federal Payments to States	Increase in Payment Limitation for Territories	Letter to the Territories	10/1/97	CMSO			Letter to the territories completed and released by 10/3/97
BBA3040	4734		Eligibility	Penalty for Fraudulent Eligibility	SMD letter	8/5/97	CMSO			
BBA3050	4734		MA - Eligibility	Penalty for fraudulent eligibility		9/1/97	Justice, with OIG			
BBA3060	4735	(a),(b)	Eligibility	Treatment of Certain Settlement Payments	Hemophilia SMD letter	8/5/97	CMSO			
BBA3080	4742		Benefits	Physician Qualification Requirements	SMD letter	8/5/97	CMSO			SMD letter completed and released by 10/3/97
BBA3090	4743	(a)	Benefits	Elimination of Requirement of Prior Institutionalization with Respect to Habilitation Services Furnished under a Waiver for Home or Community-based Services	HCBW SMD letter and revise SMM	10/1/97	CMSO			SMD letter completed and released by 10/16/97

Unique ID	Act Section Number	Para	Topic	Provision	Interim task	Eff. Date	Lead Component	Complete	Status	Notes/Issues
BBA3100	4744	(a),(b)	Benefits	Study and Report on EPSDT Benefit	Consult with States, provider and beneficiary organizations; and coordinate with OSP	8/5/97	CMSO			
BBA3120	4751	(a),(b)	Administration Miscellaneous	Elimination of Duplicative Inspection of Care Requirements for ICFs/MR and Mental Hospitals	Revise existing policy and issue an ICFs/MR SMD letter	8/29/97	CMSO			
BBA3130	4752	(a)	Administration Miscellaneous	Alternative Sanctions for Non-compliant ICFs/MR	Establish process to determine if alternative methods effective deter non-compliance	8/29/97	CMSO			
BBA3150	4754	(a)	Administration Miscellaneous	Facilitating Imposition of State Remedies on Non-compliant Nursing Facilities	Revise existing policy guidance to drop the requirement for States to repay Federal funds when a facility is non-compliant	8/5/97	CMSO			

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BBA3160	4755	(b),(c)	Administration Miscellaneous	Removal of Name from Nurse Aide Registry	Enforce States' actions in removing names, and report to Congress within 2 years on the use of registries	8/5/97	CMSO			
BBA3170	4756		Administration Miscellaneous	Medically Accepted Indication	Modify policy guidance to cite the DRUGDEX Information System as a qualified compendium, and issue a Drug SMD letter	10/1/97	CMSO		State drug rebate letter completed and released by 10/3/97	
BBA3180	4757	(a)	Administration Miscellaneous	Continuation of State-wide Section 1115 Medicaid Waivers	Establish "simplified" process to handle waiver requests, issue an 1115 SMD letter, and consult with OSP, States, Regions, DHHS and OMB	10/1/97	CMSO			

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BBA3190	4758		Administration Miscellaneous	Extension of Moratorium		8/5/97	CMSO			
BBA3200	4759		Administration Miscellaneous	Extension of Effective Date for State Law Amendment		8/5/97	CMSO			
BBA3210	4801	1894(a)	PACE	Receipt of Benefits through Enrollment in PACE Program, and Definitions for PACE Program Related Terms	CMSO/DEHP G will coordinate with CHPPs to accomplish tasks in 4802(a) through (h)	10/1/97	CMSO			
BBA3220	4801	1894(b)	PACE	Scope of Benefits and Beneficiary Safeguards	CMSO/DEHP G will coordinate with CHPPs to accomplish tasks in 4802(a) through (h)	10/1/97	CMSO			
BBA3230	4801	1894(c)	PACE	Eligibility Determinations	CMSO/DEHP G will coordinate with CHPPs to accomplish tasks in 4802(a) through (h)	10/1/97	CMSO			

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BBA3240	4801	1894(d)	PACE	Payments to PACE Providers on a Capitated Basis	CMSO/DEHP G will coordinate with CHPPs to accomplish tasks in 4802(a) through (h)	10/1/97	CMSO			
BBA3250	4801	1894(e)	PACE	PACE Program Agreement	CMSO/DEHP G will coordinate with CHPPs to accomplish tasks in 4802(a) through (h)	10/1/97	CMSO			
BBA3260	4801	1894(f)	PACE	Regulations	CMSO/DEHP G will coordinate with CHPPs to accomplish tasks in 4802(a) through (h)	10/1/97	CMSO			
BBA3270	4801	1894(g)	PACE	Waivers of Requirements	CMSO/DEHP G will coordinate with CHPPs to accomplish tasks in 4802(a) through (h)	10/1/97	CMSO			

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BBA3280	4801	1894(h)	PACE	Demonstration for For-profit Entities	CMSO/DEHP G will coordinate with CHPPs to accomplish tasks in 4802(a) through (h)	10/1/97	CMSO			
BBA3290	4801	1894 (a)	PACE: Medicare Benefit	Adds new section 1894 to Medicare statute, establishes PACE as a permanent provider.		9/1/97	CHPP		Cross-agency teams formed to develop reg specs. Publish IFC 4/30/98.	4801(a)
BBA3300	4801	1894 (d)	PACE: Capitated Payments	Prospective monthly capitated payments in the same manner as payments to a Medicare+Choice organization.		9/1/97	CHPP			4801(d) & 4802(d)
BBA3310	4801	1894 (a), (2)	PACE: Eligibility and Benefits	Outlines essential elements of the PACE model as described in the PACE protocol.		9/1/97	CHPP			4801(b), (c) & 4802(b), (c)
BBA3320	4801	1894 (h)	PACE: For-Profit Demonstrations	Authorization for up to 10 for-profit PACE demonstration sites.		9/1/97	CHPP			4801(h) & 4802(h)
BBA3330	4801	1894 (e)	PACE: Program Agreement	Number of sites limited to 40 in the first year; 20 sites each year after, sites must meet program agreement.		9/1/97	CHPP			4801(e) & 4802(e)

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BBA3350	4801	1894 (f), (2)	PACE: Waivers of Requirements	The Secretary may waive any requirements needed to effectively administer the PACE program.		9/1/97	CHPP			4801(g) & 4802(g)
BBA3410	4802	1934(f)	PACE	Regulations	Regulations for 4802(a) through (e), partner with CHPPs	10/1/97	CMSO			
BBA3430	4802	1934(h)	PACE	Demonstration Project for For-profit Entities	Consult with CHPPs, OSP, OCSP; and partner with CHPPs	10/1/97	CMSO			
BBA3440	4802	1934(i)	PACE	Post-eligibility Treatment of Income	SMD letter, partner with CHPPs	10/1/97	CMSO			
BBA3450	4802	1934(j)	PACE	Miscellaneous Provisions	SMD letter	10/1/97	CMSO			
BBA3460	4802		PACE: Miscellaneous	Nothing in sections 1924 or 1894 will prevent PACE providers from enrolling non-Medicare or Medicaid individuals in the program.		9/1/97	CHPP			4802(j)
BBA3480	4803		PACE: Transition	Timely consideration of already existing PACE and pre-PACE sites, extension of the demonstration authority available for additional 3 years.		9/1/97	CHPP			

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BBA3490	4804	(a),(b)	PACE	Study and Report		10/1/97	CMSO			
BBA3510	4901	2101	Kids-Purpose	Enable States to expand coverage to low-income, uninsured children through insurance or Medicaid		10/1/97	CMSO			New section 2101. No State is eligible for payments before 10/1/97
BBA3520	4901	2102	Kids-Child health plan	General background, eligibility, outreach and quality		10/1/97	CMSO			New section 2102
BBA3530	4901	2103	Kids-Cost-sharing	Protection for lower-income families, no cost-sharing for certain preventive benefits		10/1/97	CMSO			New section 2103
BBA3540	4901	2103	Kids-Coverage requirements	Coverage must be consistent with: benchmark; benchmark-equivalent; existing comprehensive State-based coverage; or Secretary-approved coverage		10/1/97	CMSO			New section 2103
BBA3550	4901	2103	Kids-Pre-existing conditions	Limits on pre-existing condition exclusions		10/1/97	CMSO			New section 2103
BBA3560	4901	2104	Kids-Allotments	Allotment formula		10/1/97	CMSO			New section 2104
BBA3570	4901	2105(b)	Kids-Payments	Enhanced FMAP		10/1/97	CMSO			New section 2105
BBA3580	4901	2105(c),(2)	Kids-Payments	10 percent limit on expenditures not used for Medicaid or health insurance		10/1/97	CMSO			New section 2105
BBA3590	4901	2105(c),(3)	Kids-Payments	Waivers for family coverage		10/1/97	CMSO			New section 2105

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BBA3600	4901	2105(c),(4)	Kids-Payments	No federal funds, premiums, cost-sharing used for State match		10/1/97	CMSO			New section 2105
BBA3610	4901	2105(c),(7)	Kids-Payments	No payment for abortion		10/1/97	CMSO			New section 2105
BBA3620	4901	2105(d)	Kids-Payments	Maintenance of effort		10/1/97	CMSO			New section 2105
BBA3630	4901	2105	Kids-Payments	No duplicative payments		10/1/97	CMSO			New section 2105
BBA3640	4901	2106	Kids-Child Health Plan	Process for submission, approval and amendment		10/1/97	CMSO			New section 2106
BBA3650	4901	2107	Kids-Fraud and abuse	Certain provisions of Title XIX and Title XI apply		10/1/97	CMSO			New section 2107
BBA3660	4901	2107	Kids-Performance goals	Plans must include strategic objectives, performance goals and performance measures		10/1/97	CMSO			New section 2107
BBA3670	4901	2107	Kids-Plan administration	States must collect data, maintain records and assure access for audits		10/1/97	CMSO			New section 2107
BBA3690	4901	2108	Kids-Annual reports and evaluation	States must submit annual reports and an evaluation by 3/31/2000		10/1/97	CMSO			New section 2108.
BBA3700	4901	2109	Kids-Miscellaneous provisions	Health benefits coverage provided under Title XXI will be considered creditable coverage for ERISA and HIPAA		10/1/97	CMSO			New section 2109
BBA3710	4901	2110	Kids-Definitions	Key terms are defined		10/1/97	CMSO			New section 2110

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BBA3720	4911	(a)	Expanded coverage	Optional use of State Child Health Assistance Funds for Enhanced Medicaid Match for Expanded Medicaid Eligibility	Being implemented through title XXI workgroups/steering committee	10/1/97	CMSO			
BBA3730	4911	(b)	Kids-Expanded Coverage of children under Medicaid	Optional use of Title XXI funds for enhanced Medicaid match for expanded Medicaid eligibility		10/1/97	CMSO			
BBA3740.01	4912	(a)	Expanded coverage	Medicaid Presumptive Eligibility for Low-Income Children	Being implemented through title XXI workgroups/steering committee	8/5/97	CMSO			
BBA3740.02	4912	(a)	Kids-Presumptive eligibility	Medicaid-presumptive eligibility for low-income children		9/1/97	CMSO			
BBA3770	4921		Diabetes	Special Diabetes Programs for Children with Type I Diabetes	Issue grant funds to appropriate entities	8/5/97	CMSO			
BBA3780	4922		Diabetes	Special Diabetes Programs for Indians	Issue grant funds to appropriate entities	8/5/97	CMSO			
BBA3790	4922		Diabetes-Grant program for Indians	Grants for prevention and treatment of Indians with diabetes		1/1/98	HHS			PHS?

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BBA3850	5304		Immigrants: SSI exemption very old applications	Exempts from SSI ban immigrants eligible based on apps filed before 1979.		9/1/97	SSA lead			CMSO will coordinate with SSA
BBA3890	8015		Miscellaneous Affecting Medicaid	Limitation on Pension for Certain Recipients of Medicaid-covered Nursing Home Care	See 4715 (BBA237-level 2)	8/29/97	CMSO		ARA memo completed and released by 10/3/97	
BBA3930	4102		Prevention	Screening Pap Smear and Pelvic Exams		1/1/98	OCSQ			CBS as partner for education, outreach (waiver of deductible)
BBA3950.01	4104		Prevention	Coverage of Colorectal Screening		11/4/97	OCSQ		included in physician fee schedule final reg; DS briefed 10/14	determine coverage for barium enema by 11/4/97 (may add other appropriate procedures with out time limit)
BBA3950.02	4104		Prevention	Coverage of Colorectal Screening		1/1/98	OCSQ		included in physician fee schedule final reg; DS briefed 10/14	screening fecal-occult blood test; screening flexible sigmoidoscopy; for high risk patients, screening colonoscopy; barium enema-if determined appropriate; CBS as partner for education, outreach; OCOS to participate
BBA3960.01	4105		Prevention	Diabetes Benefits		1/1/98	OCSQ			CBS as partner for education, outreach; OCOS to participate
BBA3980	4101	(a),(b)	Prevention	Screening Mammography		1/1/98	OCSQ		included in physician fee schedule final reg; DS briefed 10/14	CBS as partner for education, outreach