

April 10, 1998

**Health Care Financing Administration
Schedule for Priority Regulations
1998**

| <i>Regulation #</i> | <i>Regulation Title/Description</i> | <i>Statutory Effective Date</i> | <i>Budget Savings (S/N/C*)</i> | <i>Status</i> |
|--------------------------------------|---|---------------------------------|--------------------------------|---|
| April Critical Priorities (9) | | | | |
| HCFA-1878-F (CHPPS) | <p>Inpatient PPS Final Rule</p> <p>Desc: This is the final to the final rule with comment published August 29, 1997. The response to comments on that rule must be published. There are a number of issues that need to be clarified for the hospital community. [JANUARY]</p> | Must precede PPS FY '99 NPRM | | REGULATION UNDER DEVELOPMENT. DRAFT TO TEAM 2/18. BEING REVISED TO ADDRESS HCFA COMMENTS. OS CLEARANCE 3/11. SIGNATURE PKG TO CIRCULATION 3/20. OS CLEARANCE ON REVISED REG WAIVED 3/26. PENDING SUBMISSION TO IOS. |
| HCFA-1885-P (CHPP) | <p>ASC Rate Setting Methodology Update</p> <p>Desc: This regulation has been moved from December; it must be considered <u>critical</u> for January. The final rule for this NPRM must implement new rates before the end of calendar 1998 in order for new rates to be in effect before January 1999. The statute requires a survey of ASC costs and charges in 1999. It is crucial that we have one year of experience under the new rates to capture in this survey. We therefore must implement the new rates on October 1, 1998 to account for variations in ASC fiscal year cycles. Publication of the proposed rule is necessary no later than April 1 in order to publish the final before September 1.</p> | | | ASL CONCURRED & OS COMPLETED AND PENDING IN IOS 4/13. |
| HCFA-1001-IFC (CHPP) | <p>GME: Voluntary Incentive Plans (BBA Section 4626)</p> <p>Desc: The BBA mandates publication of this regulation by February 5, 1998. The regulation is largely self-implementing; the statutory provision leaves little room for discretion. OS staff are being solicited for participation on the regulations team, which should facilitate OS review of the final product. [JANUARY]</p> | 2/5/98 | | PREPARING SIGNATURE PACKAGE. |

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| HCFA-1011-P (CHPP) | PSO Solvency Standards (BBA-Negotiated Rulemaking, Section 4001) Desc: This regulation must be published by April 1, 1998. Timely clearance through should be expedited since this regulation will be the result of negotiated rulemaking. | 4/1/98 | | REG. NEG. REACHED CONSENSUS: REVISING REG. TEXT TO TEAM. TEAM MEETING ON PREAMBLE. PENDING SUBMISSION TO OA BUT ADVANCED A COPY TO OS & OMB ON 4/2. |
| HCFA-1913-IFC (CHPP) | Medicare Prospective Payment and Consolidated Billing for SNFs (BBA Section 4432) Desc: This rule will make fundamental changes in the reimbursement methods that Medicare employs for services furnished in skilled nursing facilities and will result in significant savings to the Medicare program. | 7/1/98 | | TEAM CLEARANCE PACKAGE TO BE FORWARDED TO OS AND HCFA TEAM MEMBERS 2/20/98. ADVANCED TO OS/OMB 3/6. TO OA 3/5. OIG COMMENTS REC'D 3/10. CHPP WORKING W/OIG TO RESOLVE ISSUES. OS COMMENTS DUE 3/18. EXPECT OIG NONCONCURRENCE. ASL COMMENTS REC'D ON 3/30. REVISED PKG TO D.C. 4/8. |
| HCFA-1152-1-F (CHPP) | Surety Bonds Desc: This final rule addresses comments on the first surety reg. | | | SIGNED BY NAMD 4/8. TO OS 4/9. PENDING SUBMISSION TO IOS |
| HCFA-1003-P (CHPP) | Inpatient Hospital PPS (Annual and BBA Section 4644(b)) Desc: March review in OS is necessary to meet new publication date mandated by the BBA. Late publication would draw intense public and congressional criticism. This rule makes annual revisions to the inpatient hospital PPS for operating costs and capital-related costs. | 4/1/98 | S | HCFA/OS COMMENTS DUE ON DRAFT 3/13. CHANGES TO OS 3/20. SECOND DRAFT TO OS/OMB 3/20. SUPPLEMENTAL PKG TO OS & OMB 4/1. OS COMMENTS DUE 4/13. CAPITAL NUMBERS TO OS 4/9. |
| HCFA-1006-P (CHPP) | Revision to Payment Policies Under the Physician Fee Schedule for CY 1999 Desc: This regulation must remain on the critical list for March in order to meet statutory requirements for publication. Late publication would draw intense public and congressional criticism. | N/A | S | REGULATION TEAM CONVENED 1/26. 3/13 HCFA/OS CIRCULATION OF DRAFT. TEAM MTG SCHEDULED 3/18. NEW ISSUES BEING ADDED 4/2. BRIEFING MATERIAL TO OS FOR BBA MTG 4/1. |

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| HCFA-2114-P (CMSO) | <p>State Child Health Initiative: State Allotments and Payments (BBA Section 4901)</p> <p>Desc: States are expected to submit a CHIP plan to have access to their FY 98 research allotments which can be utilized during a three-year period before the funds are reallocated. It is imperative that a timely regulation detail the amount of each State's reserved allotment and the percentage at which States will receive an enhanced match.</p> | | | SUBSTANTIAL DRAFT DEVELOPED WITH OR. TEAM SOLICITATION WEEK OF 3/2. FIRST TEAM MTG 3/9. MET WITH OR 3/12. OGC COMMENTS SENT TO OR 3/13. OGC SENT ADDITIONAL COMMENTS. ASMB COMMENTS REC'D 3/24. DRI PREPARING REVISED FINAL VERSION TO DISTRIBUTE TO TEAM FOR SIGN-OFF AS OF 4/9. |
| April Other Priorities (19) | | | | |
| HCFA-1104-N (CHPP) | <p>Demonstration for Congestive Heart Failure Case Management</p> <p>Desc: This solicitation is for demonstration proposals. Demonstration will reflect innovative interventions to improve clinical outcomes and quality of life under fee for service arrangements. [DECEMBER]</p> | | | OS CLEARANCE COMPLETE 1/12. OFFICIALLY TO OMB 1/13. OMB REQUESTS HCFA TO WITHDRAW THIS NOTICE 1/29. AWAITING ADMINISTRATOR DECISION. |
| HCFA-1906-P (CHPP) | <p>Telehealth (BBA Section 4206)</p> <p>Desc: The final regulation for this provision has to be published no later than December 1 for carrier implementation. OS staff have expressed interest in this regulation, and will be part of the regulations team.</p> | 1/1/99 | | ADVANCED TO OMB 2/3. SIGNED BY ADMINISTRATOR 2/8. DEPT. CLEARANCE EXPECTED. HRSA COMMENTS 2/11. OS CLEARANCE COMPLETED 3/11. CHPP TO PROVIDE LANGUAGE TO ADDRESS HRSA CONCERNS. REVISED REG. TO OS/OMB 3/17. OMB MTG 3/18. |
| HCFA-3005-F (OCSQ) | <p>Hospital Conditions of Participation - Organ Donation Provisions</p> <p>This regulation implements new hospital requirements designed to increase organ donation. The hospital must contact is OPO about every potential donor whose death occurs in the hospital, according to the OPO's protocols. Transplant hospitals are also required to report organ-transplant-related data, as requested by the Secretary. OS wants to publish this rule during Organ Donation Week (April 19-25) as part of the Secretary's National Organ and Tissue Donation Initiative.</p> | | | HCFA/OS TEAM SOLICITATION WILL BE RELEASED 3/13. FIRST TEAM MTG SCHEDULED FOR 3/18 (CANCELLED). TEAM SOLICITATION TO OS 3/16. DOCUMENT TO HCFA, OS, & OMB CLEARANCE 4/2. ANTICIPATING NONCURRENCE. |

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| HCFA-2012-N (CMSO) | DSH Payments-Institutions for Mental Diseases (BBA sec 4721(b) Desc: This regulation implements a cap on DSH payments to institutions for mental diseases. Timely publication is critical for the States to budget for payments to providers. Since this provision was effective October 1, 1997, States need guidance as soon as possible to assure adjustments to payments are made.[JANUARY] | 10/1/97 | | SIGNED BY OA 2/24. FORWARDED TO OS 2/24. ADVANCED TO OMB 2/25. COMMENTS FROM OS DUE 3/4. WAITING FOR ASMB AND IGA. CONCURRED ASPE COMMENTS 3/18. PREPARING RESPONSE TO ASPE AS OF 3/26. OS COMPLETED. MARKUP TO DRI 4/2. OMB PASSBACK 4/1. CHANGE PAGES TO OS & OMB IN RESPONSE TO ASPE 4/2. ASPE & OGC REVIEW PENDING. |
| HCFA-1005-P (CHPP) | PPS for Outpatient Hospital Services (BBA Section 4523): Desc: This rule establishes PPS for hospital outpatient services. [MARCH] | 1/1/99 | | Publication no later than May 1, to allow time for comment period, evaluation and response to comments, clearance of final rule and publication of final no later than October 1 (to allow time for Congressional review and contractor implementation prior to the effective date). ADVANCED TO OS 4/2. SOME OS COMMENTS RECEIVED (ASL & ASPE). |
| HCFA-1030-IFC (CHPP) | Medicare+Choice (BBA Section 4001) Desc: This regulation will require significant OS review time in order to assure the mandatory June 1, 1997 publication. This rule implements a new program that provides several additional ways for eligible individuals to obtain Medicare coverage. | 6/1/98 | | REGULATION UNDER DEVELOPMENT. COMPLETE DRAFT. ANTICIPATED 4/15, BUT SOME POLICIES STILL UNCLEAR. |
| HCFA-3819-FC (OCSQ) | HHA Conditions of Participation--Comprehensive Assessment (Reg Reform Initiative) Desc: The HHA conditions of participation regulations are required to further the Administration's REGO II efforts, by streamlining regulatory participation requirements and focusing on outcome rather than process requirements. | N/A | | DRAFT TO TEAM 3/9. COMMENTS DUE 3/19/98. AWAITING OASIS INFO. AND EXPANSION OF COMMENT DESCRIPTION AND RESPONSES. DOC. TO TEAM 3/10. |

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| HCFA-3XXX-F | Home Health Condition - Collection of data (OASIS) | | | PREVIOUSLY PART OF HCFA-3819-FC. BEING DEVELOPED AS SEPARATE RULE. |
| HCFA-3006-IFC (OCSQ) | OASIS The OASIS-related requirements are critical for HCFA to receive the data necessary to develop the case mix adjusters which will be part of the PPS computations. Any delay in publishing these regulations will result in the continued use of numerous regulations which impose requirements on providers with questionable benefit to the beneficiaries. | | | REGULATION UNDER DEVELOPMENT. DRAFT TO TEAM 3/10. TEAM COMMENTS REC'D REVISIONS BEING MADE. |
| HCFA-1039-N (CHPP) | Hospice Wage Index Annual Update | N/A | | REGULATION UNDER DEVELOPMENT. |
| HCFA-3003-IFC (OCSQ) | Expanded Coverage of Test Strips for Blood Monitors and Diabetes (BBA Sec. 4105) This section provides for coverage of blood glucose monitors and testing strips to non-insulin dependent diabetics. The interim final with comment must be published in June in order to meet the July 1, 1998 effective date. | 7/1/98 | | SIGNATURE DRAFT TO TEAM 4/8. NEXT MEETING SCHEDULED FOR APRIL 15 TO CLEAR DOC. BEFORE FORWARDING TO THE NAMD. |
| HCFA-3004-IFC (OCSQ) | Standardization of Medicare Coverage for Bone Mass Measurement (BBA Sec. 4106) This section provides for uniform coverage of bone mass measurements for qualified individuals who fall into at least one of five different diagnostic categories. The interim final with comment must be published in June in order to meet the July 1, 1998 effective date. | 7/1/98 | | REGULATION UNDER DEVELOPMENT BY TEAM. TEAM IS MEETING 4/9 TO CLEAR DOCUMENT. |
| DEPARTMENTAL REGS--HIPAA REGULATIONS | | | | |
| HCFA-0045-P (OLS) | Unique Identifier for Providers Desc: Administrative Simplification. [JANUARY] | 2/21/98 | | SECRETARY SIGNED 3/27. PENDING OMB APPROVAL |

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| HCFA-0047-P (OIS) | <p>Unique Identifier for Employers</p> <p>Desc: This rule is required by statute to be published in final by 2/21/98; it is an NPRM. This regulation is a Departmental document being jointly developed by HCFA, PHS and the Department of Defense. The regulation implements administrative simplification initiatives that have a national scope beyond the Medicare and Medicaid programs.</p> | 2/21/98 | | ADVANCED TO OMB. OS CLEARANCE COMPLETED 2/24. CHANGE PAGES PER DOL COMMENTS & TO OS 4/1. AWAITING SECRETARY SIGNATURE. CHANGES PAGES TO OS IN RESPONSE TO OMB, DOL, TREAS. COMMENTS. |
| HCFA-0048-NOI (OIS) | <p>Unique Identifiers for Individuals</p> <p>Desc: This rule is required by statute to be published in final by 2/21/98; it is an NPRM. This regulation is a Departmental document being jointly developed by HCFA, PHS and the Department of Defense. The regulation implements administrative simplification initiatives that have a national scope beyond the Medicare and Medicaid programs. [JANUARY]</p> | 2/21/98 | | PENDING SUBMISSION TO ADMIN. SIGNATURE PKG TO D.C. 4/10. |
| HCFA-0049-P (OIS) | <p>Security and Electronic Signature Requirements and Standards</p> <p>Desc: This rule is required by statute to be published in final by 2/21/98; it is an NPRM. This regulation is a Departmental document being jointly developed by HCFA, PHS and the Department of Defense. The regulation implements administrative simplification initiatives that have a national scope beyond the Medicare and Medicaid programs. [JANUARY]</p> | 2/21/98 | | PENDING FORMAL HCFA CLEARANCE. |
| HCFA-0149-P (OIS) | <p>Standards for Electronic Transactions</p> <p>Desc: These rules are required by statute to be published in final by 2/21/98; these are the NPRMs. These regulations are Departmental documents being jointly developed by HCFA, PHS and the Department of Defense. The regulations implement administrative simplification initiatives that have a national scope beyond the Medicare and Medicaid programs. [JANUARY]</p> | 2/21/99 | | SECRETARY SIGNED 3/27. PENDING OMB APPROVAL. |

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| HCFA-2892-IFC (CMSO) | Health Insurance Reform: Coverage for Newborns Desc: Most plans and insurers are already in compliance and many States have laws that preempt HHS regulations. However late publication would impact ERISA self-funded plans under Department of Labor jurisdiction. | Health Protection Act- 11/1/98 | | ADVANCE SIGNATURE PKG WITH UNRESOLVED ISSUES TO OS 2/23. ADVANCED TO OS 2/23. ADVANCED TO OMB 2/25. OS STAFF BRIEFED 3/9. INTERDEPARTMENTAL TEAM CONTINUES TO WORK TOWARDS RESOLUTION OF UNRESOLVED ISSUES. RECOMMEND PUBLICATION OF IFC RATHER THAN NPRM. |
| HCFA-4145-P (CBS) | Unique Identifiers for Health Plan Payers Desc: This rule is required by statute to be published in final by 2/21/98; it is an NPRM. This regulation is a Departmental document being jointly developed by HCFA, PHS and the Department of Defense. The regulation implements administrative simplification initiatives that have a national scope beyond the Medicare and Medicaid programs. [JANUARY] | 2/21/98 | | UNDER REVISION ON BASIS OF DOL, OGC, ASPE COMMENTS. |
| May (13) | | | | |
| HCFA-1026-P (CHPP) | Surety Bonds for CORFs, rehab agencies and other Providers (BBA Section 4312) Desc: This regulation parallels the HHA Surety bond regulation. All of the policy decisions are similar to the HHA regulation and it is a key element in Medicare's anti-fraud and abuse efforts. Congressional hearings by the Senate Permanent Subcommittee on Investigations will examine HCFA's efforts in this area in hearings expected in January, 1998. [JANUARY] | Discretionary (per OGC) | C | REGULATION UNDER DEVELOPMENT. WILL NOT MAKE FEBRUARY DELAY TO ADDRESS SURETY ISSUES FOR CORFS, RA CMHCS, & IDTFS. |
| HCFA-1903-IFC (CHPP/CMSO) | PACE Provisions (BBA Section 4801) Desc: This high profile regulation extends the highly successful PACE demonstration program to additional sites. This innovative Medicare/Medicaid partnership provides for the delivery of comprehensive health care services to the frail elderly and States that have implemented Medicaid-only (pre-PACE) contracts are anxious for its timely implementation. [FEBRUARY] | To allow entities to operate beginning 8/5/98 | | TEAM COMMENTS DUE 3/20. HOPE FOR FINAL CLEARANCE PKG 4/17. |
| HCFA-1909-IFC (CHPP) | Coverage of Religious Non-Medical Health Care Institutions (BBA Section 4454) This rule will remove all references in the current regulations to specific religious institutions in order to broaden coverage to include all religious <u>non-medical</u> institutions for coverage under Medicare. | 7/1/98 | | TEAM IS MEETING TO DEVELOP REG. |

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| HCFA-1910-P (CHPP) | RHC Shortage Areas (BBA Sec. 4205) This rule provides for the refinement of shortage area requirements and an RHC quality performance improvement program as a condition for participation in the Medicare/Medicaid programs. | | | TEAM IS MEETING TO DEVELOP REG. |
| HCFA-2006-IFC (CMSO) | Child Health Programs: State Plans (BBA Section 4901) Desc: This regulation establishes the policy needed to implement the State plan submissions for the Children's Health Insurance Program that was effective October 1, 1997. This regulation is critical to the implementation of the Title XXI program and is necessary before Federal funds can be disbursed to the States.[FEBRUARY] | 10/1/97 | | FIRST TEAM MTG 2/10. 5 SUB-GROUPS SUBMITTED DRAFT TO COMPONENT DIRECTOR BY 2/27. |
| HCFA-3002-P | Coverage of Diabetes Self-Management Benefit (BBA Sec. 4105) This provision provides coverage of diabetic outpatient self-management training services. These services would include educational and training services furnished to an individual with diabetes by a certified provider in an outpatient setting meeting certain quality criteria. Because of the ambiguity and complexity of the provision, this will be implemented via NPRM. Since the NPRM process will not meet the statutory effective date. OCSQ strongly believes that this regulation must be published in June. | 7/1/98 | | REGULATION UNDER DEVELOPMENT. OCSQ CURRENTLY MTG WITH INDUSTRY AND SPECIAL INTEREST GROUPS TO DISCUSS THE DIFFERENT ASPECTS OF THE REGULATION. |
| HCFA-3250-NOI (OCSQ) | Negotiated Rulemaking for Laboratories (BBA Section 4554) Desc: This provision requires the development of national coverage and administration policies for lab tests using a negotiated rule making process. The policies would be designed to promote uniformity and program integrity and reduce administrative burdens with respect to clinical diagnostic laboratory tests in connections with beneficiary information submitted with the claim. Physicians' obligations for documentation and record keeping, claims filing procedures and documentation, and frequency limitation. | 1/1/99 | | REGULATION UNDER DEVELOPMENT. REC'D CONVENING RPT FROM DAB. HCFA TEAM SOLICITATION SENT OUT 3/13. TEAM IS MEETING TO DEVELOP NOTICE OF INTENT TO NEGOTIATE. |
| HCFA-3782-N (OCSQ) | SALITRON Desc: This notice announces the noncoverage of electronstimulation of the salivary glands for the treatment of xerostomia secondary to Sjogren's syndrome and Electrostimulation devices, such as the Salitron System, under the Medicare program. | | | WITHDRAWAL OF PREVIOUS FR NOTICE PROPOSING NON-COVERAGE OF SALITRON. |
| HCFA-3XXX-N (OCSQ) | EPO and PET Desc: This notice formerly announces changes in coverage policies effective 3/12/98 and 1/1/98, respectively. | | | REGULATION UNDER DEVELOPMENT. |

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| HCFA-1023-P (CHPP) | <p>Enrollment and Re-enrollment of Medicare Providers and Suppliers</p> <p>Desc: This regulation is needed as part of the Administration's anti-fraud and abuse efforts. It would give us the authority to enroll and re-enroll providers, with timeframes for re-enrollment. [JANUARY]</p> | N/A | C | SPECIFICATIONS BEING DEVELOPED BY COMPONENT. THERE WILL BE AN ADDTL RULE LATER, WITH AN EXPANDED SET OF CONDITIONS. AWAITING REVISED MATERIAL. |
| HCFA-1813-F (CHPP) | <p>Medicare COVERAGE for Ambulance Services</p> <p>Desc: This is the residual of the proposed rule published June 1997. It will clarify a number of issues, and should definitely be finalized prior to the start of the negotiated rulemaking for the BBA ambulance provision. There has been considerable congressional interest in this regulation, and there are fraud and abuse implications. [JANUARY]</p> | | | UNRESOLVED POLICY ISSUES. |
| HCFA-6000-N (OFM) | <p>Notice of Availability of Funds for Health Care Fraud and Abuse Control.</p> <p>Desc: Solicitation of Proposals from Federal States and local government for projects or activities to combat fraud and abuse.</p> | | | DRAFT RECEIVED FROM COMPONENT 1/28. NOTICE IN HCFA CLEARANCE. ON HOLD IN OS. PER DECISION PENDING WITH DEPUTY SECRETARY. TO OA 3/5. OIG COMMENTS 3/19. ON HOLD UNTIL MID-APRIL. |
| HCFA-6144-P (OFM) | <p>Beneficiary Incentive Plan</p> <p>Desc: This regulation implements the HIPAA provision that provides for payments to beneficiaries for identifying fraud and abuse situations or for other suggestions that improve the efficiency and effectiveness of the Medicare program.</p> | | | REGULATION UNDER DEVELOPMENT. |
| June (7) | | | | |
| HCFA-1035-NC (CHPP) | <p>HHA Cost Limit Annual Update (BBA Section 4602)</p> <p>Desc: This notice with comment period announces the annual update of the Schedule of Limits on HHA Costs per Visits, and the Schedule of Per Beneficiary Limitations on HHA Costs, for cost reporting periods beginning on or after October 1, 1998.</p> | 10/1/98 (for cost reporting periods on/after 10/1/98) | | PENDING TEAM SOLICITATION. |

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| HCFA-2001-P (CMSO) | Medicaid Managed Care: State Options (BBA Section 4701(a)) Desc: This provisions involve the provision of care and services under Medicaid managed care arrangements. These provisions affect enrollee rights and responsibilities, as well as contracts between State Medicaid agencies and managed care organizations. | 10/1/97 | | TEAM SOLICITATION 2/20. SOLICITATION TO OS 2/23. HCFA/DEPARTMENT TEAM MEETING 3/12. MET W/BENE. ADVOCATE GROUPS 3/26. CMSO PLANS TO SEND REVISED PAGES TO DRI WEEK OF 3/30; FIRST DRAFT TO SOLICITATION TEAM EXPECTED 4/17. |
| HCFA-2003-P (CMSO) | Medicaid Managed Care: Quality of Care (BBA Section 4705(a)) | 10/1/97 | | TEAM SOLICITATION 2/20. SOLICITATION TO OS 2/23. FIRST TEAM MEETING 3/11. SIX WORKGROUPS WEEKLY MTG SCHEDULED. |
| HCFA-2019-IFC (CMSO) | Federal Enforcement in Group and Individual Health Insurance Markets (HIPAA) Desc: This regulation will enable HCFA to assume enforcement activities when States fail to carry out the provisions of HIPAA related to access. | N/A | | REG. SPECS. UNDER DEVELOPMENT WITH INTERDEPARTMENT DRAFTING TEAM. COMPONENT PREPARING PROJECT PLAN. REQUESTED DELAY TO DECEMBER. |
| HCFA-2007-IFC | Medicaid Program: Requirements for Surety Bonds for DME Suppliers Desc: This rule establishes DME suppliers be required to furnish Medicaid State agencies with a surety bond in order to participate in the Medicaid program. | | | CONDUCTED STATE SURVEY- RESULTS COMPILED & DISCUSSED AT 3/17 TEAM MTG. DEVELOPING DRAFT. NEXT TEAM MTG 4/7. PREPARING DRAFT REGULATION TO GO TO DRI BY 4/10. REC'D IN DRI. |
| HCFA-2060-IFC | Medicaid Program: Requirements for Inpatient Psychiatric Services for Individuals Under 21 Desc: This rule amends the CFR to remove the requirement for accreditation of hospitals and health care facilities, by the Joint Commission, for approval of Medicaid coverage of the inpatient psychiatric services benefit for individuals under 21. | | | RE-DRAFTING REGULATION. NEXT TEAM MTG 4/3 TO REVIEW DRAFT. MEETING 4/9 TO REVIEW REDRAFT. |
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| HCFA-2XXX-FC (CMSO) | CLIA Program; Clinical Laboratory Requirements--Extension of Certain Effective Dates for Clinical Laboratory Requirements Under CLIA Desc: This final rule extends certain effective dates for clinical laboratory requirements that implemented provisions of CLIA. It also extends the phase-in date of certain quality control requirements and extends the date by which an individual with a doctoral degree must possess board certification to qualify as a director of a laboratory that performs high complexity testing. | | | PENDING FIRST TEAM MEETING. |
| July (3) | | | | |
| HCFA-1002-NR (CHPP) | Ambulance Services Fee Schedule (BBA-Negotiated Rulemaking, Section 4531) Desc: This notice will be based on a convening report from the Department Appeals Board and should not require intensive review. We have moved this item from March but it must be considered a <u>critical</u> priority for July. | 1/1/00 | | |
| HCFA-1003-F (CHPP) | Inpatient Hospital PPS FY 1999 (Annual and BBA Section 4644(b)) | 8/1/98 | | |
| HCFA-1885-F (CHPP) | ASC Rate Setting Methodology Update | N/A | | |
| August (4) | | | | |
| HCFA-8001-N (OACT) | Inpatient Hospital Deductible and Hospital and Extended Care Coinsurance Amounts for CY 1999 (Annual) | Publish between Sept. 1-15 | | DRI PREPARING DRAFT. |
| HCFA-8000-N (OACT) | Part A Premium for 1999 for Uninsured Aged and Certain Disabled Individuals (Annual) | Publish in September | | DRI PREPARING DRAFT. |
| HCFA-8002-N (OACT) | Part B Premium for 1999 (Annual) | Publish by September 30 | | |
| HCFA-2014-N (CMSO) | Child Health State Allotments-FY 1999 (BBA) | Annually Updated | | AWAITS PUBLICATION OF HCFA-2114-IFC. |
| September (6) | | | | |

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| HCFA-2004-P (CMSO) | Boren Repeal (BBA Section 4711) Desc: This regulation is a critical priority because the provision is effective 10/01/97 and deletes several existing requirements and establishes new requirements for the States with respect to institutional reimbursement under Medicaid. [JANUARY] | 10/1/97 | | UNRESOLVED POLICY ISSUES. REGULATION TEAM SOLICITATION 1/27. INITIAL DRAFT DISTRIBUTED TO TEAM. REC'D COMMENTS FROM OGC ON 2/12. REC'D COMMENTS FROM DALLAS RO BEGINNING ON 2/9. |
| HCFA-1005-F (CHPP) | Physician RVUs for CY 1999 | Annual Requirement | | |
| HCFA-1XXX-FN (CHPP) | Physician Fee Schedule Update for CY 1999 (and sustainable growth rates of increase for FY 1999) | Annual Requirement | | |
| HCFA-1005-F (CHPP) | PPS for Hospital Outpatient Services (BBA Section 4523) | 1/1/99 | S | |
| HCFA-2114-F (CMSO) | State Child Health Initiative State Allotments & Payments (BBA Section 4901) Desc: States are expected to submit a CHIP plan to have access to their fiscal year 1998 reserved allotments, which can be utilized during a three-year period before the funds are reallocated. It is imperative that a timely regulation detail the amount of each State's reserved allotment and the percentages at which States will receive an enhanced match [MARCH]. | 10/1/97 | | AWAITS PUBLICATION OF HCFA-2114-IFC. |
| HCFA-3XXX-FC | Hospital Condition: CRNA Supervision Desc: This rule concerns physicians supervision of CRNAs in relations to State Laws. | | | REGULATION UNDER DEVELOPMENT. |
| First Quarter FY 99 | | | | |
| HCFA-2015-P (CMSO) | Medicaid Managed Care: External Quality Review (BBA Section 4705(a)) | 10/1/97 | | TEAM MTG 3/5. CONTRACT FOR INDEPENDENT EXTERNAL REVIEW. DRAFT OF CONTRACT PREPARED. |
| HCFA-2006-F (CMSO) | Child Health Program State Plans (BBA) | | | AWAITS PUBLICATION OF HCFA-2006-IFC. |

* S = Savings N = No Savings C = Cost Avoidance

| <i>Regulation #</i> | <i>Regulation Title/Description</i> | <i>Statutory Effective Date</i> | <i>Budget Savings (S/N/C*)</i> | <i>Status</i> |
|--|---|---------------------------------|--------------------------------|---|
| HCFA-2226-F (CMSO) | Revisions to CLIA Regulations | N/A | | MTG W/CDC WEEK OF 3/2 TO DISCUSS CONTENT AND APPROACH. NEED INTERIM NOTICE BY JULY TO CONTINUE CURRENT STANDARDS. COMPONENT REQUESTS DELAY OF REG UNTIL DECEMBER. |
| UNSCHEDULED REGS PENDING PUBLICATION OF PROPOSALS (6) | | | | |
| HCFA-2022-F (CMSO) | Application of HIPAA Group Market Nondiscrimination Rules Desc: This regulation implements sections of HIPAA that are designed to improve access to the Group Health Insurance Market. [PROPOSED FOR DECEMBER] | | | REG. SPECS. UNDER DEVELOPMENT WITH INTERDEPARTMENTAL DRAFTING TEAM. |
| HCFA-2111-IFC | Elimination of the Application of Federal Financial Participation (FFP) Limits Under 1902(r)(2). | | | AWAITING COST ESTIMATES FROM OACT - DIFFICULTY WITH BASELINE CALCULATION. REGULATION SPECS. DEVELOPED. |
| HCFA-3250-P (OCSQ) | Negotiated Rulemaking for Laboratories (BBA Section 4554) | 1/1/99 | | REG. TEAM SOLICITATION WILL GO OUT MARCH 13. FIRST TEAM MEETING SCHEDULED FOR 3/25/98. |
| Departmental Regs - Final HIPAA Rules | | | | |
| HCFA-0050-F (OIS) | Standards for Electric Transmissions | | | |
| HCFA-4145-F (CBS) | Unique Identifier for Health Plan Payers | | | |
| HCFA-0045-F (OIS) | Unique Identifiers for Providers | | | |
| HCFA-0047-F (OIS) | Unique Identifier for Employers' | | | |
| HCFA-0049-F (OIS) | Security and Electronic Signature Requirements and Standards | | | |

* S = Savings N = No Savings C = Cost Avoidance

| <i>Regulation #</i> | <i>Regulation Title/Description</i> | <i>Statutory Effective Date</i> | <i>Budget Savings (S/N/C*)</i> | <i>Status</i> |
|------------------------------|---|---|--------------------------------|---------------------------------------|
| Published Regulations | | | | |
| HCFA-1904-NC (CHPP) | HHA Per Visit Limits (BBA Sec. 4602) Desc: These limits will be retroactively applied to cost reporting periods beginning on or after 10/01/97. The statute further mandates establishment of these limits no later than 01/01/98. Hence, this rule must be published by that date. | 10/1/97 | S | PUBLISHED 1/2/98 |
| HCFA-1004-FC (CHPP) | Medicare Capital Assets (BBA sec 4404) Desc: This regulation modifies rules that will prevent certain institutional providers from gaining windfall financial benefits through the application of depreciation formulae following the transfer of capital assets. The statutory provisions were effective on 12/1 and each day of delay in publication of the rule results in significant costs to the Medicare program. | 12/1/97 | S | PUBLISHED 1/9/98. |
| HCFA-1152-FC (CHPP) | Surety Bonds and Capitalization requirements for HHAs Desc: Establishes requirements for surety bonds and fiscal soundness for HHAs. | 1/1/98 | C | PUBLISHED 1/5/98 |
| HCFA-1864-P | Additional Standards for DME Suppliers Desc: Imposes new requirements, including surety bonds, for DME suppliers. | | | TO OFR 1/9. PUBLICATION DATE 1/20/98. |
| HCFA-2000-N (CMSO) | Emergency Services for Aliens (BBA Sec.4723) Desc: This notice specifies allotments available for services furnished on or after October 1, 1997. This retroactive application gives this regulatory document an extremely high priority. [DECEMBER] | 10/1/97 | | PUBLISHED 3/3/98 |
| HCFA-2891-IFC (CMSO) | Health Insurance Reform: Mental Health Desc: This regulation is a joint effort with the Departments of Labor and Treasury and has a statutory effective date of 01/01/98. Failure to publish timely will have an adverse impact on the mental health community as health plans assert exemptions without regulatory guidance. Additionally, adverse business reaction is expected if late publication results in burdensome retroactive compliance. Adverse publicity and Congressional criticism can be expected in response to late publication. | Mental Health Parity Act-plan yrs. o/a 1/1/98 | | PUBLISHED 12/22/97 |

* S = Savings N = No Savings C = Cost Avoidance

| <i>Regulation #</i> | <i>Regulation Title/Description</i> | <i>Statutory Effective Date</i> | <i>Budget Savings (S/N/C*)</i> | <i>Status</i> |
|----------------------|--|---------------------------------|--------------------------------|--------------------|
| HCFA-1908-IFC (CHPP) | Inherent Reasonableness for Part B Services (BBA Section 4316) Desc: This regulation implements a statutory provision requested by the Administration which restores an authority that had been removed under earlier legislation. The regulation will allow carriers to apply an inherent reasonableness test to claims for Part B services, other than physician services, resulting in significant savings to the Medicare program. | 8/5/97 | S | PUBLISHED 1/7. |
| HCFA-2018-N (CMSO) | Application of HIPAA Group Market Portability Rules to Flexible Spending Accounts and Employee Assistance Programs Desc: Joint effort with Departments of Labor and Treasury; Treasury has drafting lead. Appropriate clearances and signatures will be required. This regulation clarifies applicability of April 8, 1997 interim final rules. Timely publication required by majority of health plans that operate under calendar year "plan years." | None | | PUBLISHED 12/29/97 |
| HCFA-2017-N (CMSO) | Application of HIPAA Group Market Nondiscrimination Rules to Individuals Who Were Otherwise Eligible but not Enrolled for Coverage Under the Terms of the Plan Desc: Joint effort with Departments of Labor and Treasury; Labor has drafting lead. Appropriate clearances and signatures will be required. This regulation clarifies applicability of April 8, 1997 interim final rules. Timely publication required by majority of health plans that operate under calendar year "plan years." Delay in publication would adversely affect individuals denied an opportunity to enroll in group plans due to past health status exclusion. | No Date | | PUBLISHED 12/29/97 |
| HCFA-2005-NC (CMSO) | Medicaid Payment of Part B Premium (BBA Section 4732) Desc: This provision provides \$200 million in Federal funding to be allocated on the basis of the number of qualifying individuals. This section is effective on 01/01/98 and the States may file for federal reimbursement as soon as they are notified of their allotment. Because this provision provides for federal funding of 100 % of the States allotment amount, the States are especially anxious for this publication. | 1/98 | | PUBLISHED 1/26/98. |
| HCFA-1014-N (CHPP) | Prerulemaking Solicitation of Comments on Medicare--Choice Issues (BBA Section 4001) (Potential HCFA Delegated Notice) Desc: This solicitation is discretionary, its purpose is to provide the foundation for timely completion of HCFA-1030-IFC, which must be published no later than June 1. The public is aware of this solicitation, and expects the opportunity to comment in advance of HCFA-1030-IFC. We believe this should be a HCFA delegated notice, and should not affect OS workload. This notice is critical for December: if it is not published timely, an important outreach opportunity will be missed. | IFC 6/98 | | PUBLISHED 1/20/98. |

* S = Savings N = No Savings C = Cost Avoidance

| <i>Regulation #</i> | <i>Regulation Title/Description</i> | <i>Statutory Effective Date</i> | <i>Budget Savings (S/N/C*)</i> | <i>Status</i> |
|-------------------------|--|---------------------------------|--------------------------------|---------------------------------------|
| HCFA-1808-F (CHPP) | Salary Equivalency Guidelines Desc: Payment guidelines of Participation | | S | PUBLISHED 1/30/98. |
| HCFA-3818-P | ESRD Conditions of Participation Des: New, updated requirements for ESRD facilities. | | | TO OFR 1/30. |
| HCFA-3000-N (OCSQ) | Telemedicine Diabetes Demo (BBA Section 4207) Desc: This notice must be published by the end of March to meet the statutory provisions of Section 4207 of the BBA. This demonstration is a highly visible and sensitive issue within the telemedicine industry and its successful implementation is important to maintaining a leadership role in the emerging area of telemedicine and medical informatics. | 5/5/98 | | PUBLISHED 3/18/98. |
| HCFA-7020-P (OICS) | Medicare Integrity Program (HIPAA) Desc: This regulation is an integral part of the Administration's priority initiative against fraud and abuse in the Medicare program. [JANUARY] | N/A | | PUBLISHED 3/20/98 |
| HCFA-1905-FC (CHPP) | HHA Per Beneficiary Limit (BBA Section 4602) Desc: Establishes a payment limit for home health services furnished to an individual beneficiary. | 4/1/98 | S | PUBLISHED 3/31/98 |
| HCFA-1027-IFC (CHPP) | Definition of PSOs (BBA section 4001) Desc: We consider this regulation a <u>critical</u> priority for January so that we do not compromise the negotiated rulemaking for the solvency standards. While the law does not require publication of the PSO definition prior to June 1, we strongly believe that it must be published as soon as possible to finalize the solvency standards that must be published by April 1. [JANUARY] | Must precede HCFA-1011 | | TO OFR 4/9. PUBLICATION DATE 4/14. |
| HCFA-1038-NC (CHPP) | Surety Bond & Capitalization Requirements for HHAs (BBA Section 4312) Desc: Notice announcing HCFA's plans to correct surety bond problems. | 1/1/98 | | PUBLISHED 3/4/98 |

* S = Savings N = No Savings C = Cost Avoidance

File BBA implementation

FAX TRANSMISSION

CENTER FOR BENEFICIARY SERVICES

7500 SECURITY BOULEVARD
BALTIMORE, MARYLAND 21244
PHONE: (410) 786-4280
FAX: (410) 786-5487



TO: Chris Jennings

DATE: 6/30

FAX #: (202) 456-5557

PAGES: 4, includes cover sheet

SUBJECT: M+C Information Budget

FROM: Michael McMustan
410 786-4280

COMMENTS:

Mike Marsh asked me to forward this information to you.

MEDICARE + CHOICE APPORTIONMENT

FY 1998 INCOME PLAN (BBA User Fees)*

| Second Quarter | Third Quarter | Fourth Quarter | Total |
|----------------|---------------|----------------|--------------|
| \$32,286,999 | \$32,286,999 | \$30,426,002 | \$95,000,000 |

The Balanced Budget Act of 1997 established a requirement that Medicare risk plans and Medicare + Choice plans must contribute their pro rata share of costs to fund an information campaign and Medicare counseling services for all Medicare beneficiaries. Congress further specified in appropriations legislation that HCFA could collect up to \$95 million in FY 1998 to fund these activities. HCFA published the "BBA Fee" regulation on December 2, 1997.

TWO YEAR EXPENDITURE PLAN

FISCAL YEAR 1998

| National Medicare Education Campaign | Second Quarter | Third Quarter | Fourth Quarter | Total | FY 1999 |
|---|----------------|---------------|----------------|---------------|---------------|
| BENEFICIARY MAILING | \$0 | \$22,500,000 | \$7,700,000 | \$30,200,000 | \$60,000,000 |
| User Fees | \$0 | \$20,500,000 | \$0 | \$20,500,000 | \$33,978,700 |
| Program Management | \$0 | \$2,000,000 | \$7,700,000 | \$9,700,000 | \$14,379,300 |
| PROs | \$0 | \$0 | \$0 | \$0 | \$1,642,000 |
| 1-800 TOTAL 1/ | \$0 | \$29,000,000 | \$21,200,000 | \$50,200,000 | \$68,000,000 |
| User Fees | \$0 | \$29,000,000 | \$17,200,000 | \$46,200,000 | \$68,000,000 |
| Program Management | \$0 | \$0 | \$4,000,000 | \$4,000,000 | \$0 |
| INTERNET TOTAL | \$475,000 | \$961,000 | \$64,000 | \$1,500,000 | \$2,000,000 |
| User Fees | \$475,000 | \$961,000 | \$64,000 | \$1,500,000 | \$1,400,000 |
| Program Management | \$0 | \$0 | \$0 | \$0 | \$600,000 |
| PROGRAM DEVELOPMENT TOTAL | \$2,900,000 | \$11,600,000 | \$7,875,000 | \$22,375,000 | \$24,456,000 |
| User Fees | \$2,550,000 | \$7,750,000 | \$6,575,000 | \$16,875,000 | \$18,003,500 |
| Program Management | \$0 | \$1,000,000 | \$0 | \$1,000,000 | \$0 |
| PROs | \$350,000 | \$2,850,000 | \$1,300,000 | \$4,500,000 | \$6,452,500 |
| TECHNOLOGY INVESTMENT TOTAL | \$0 | \$0 | \$0 | \$0 | \$14,997,900 |
| User Fees | \$0 | \$0 | \$0 | \$0 | \$14,997,900 |
| COMMUNITY BASE/ HEALTH FAIRS TOTAL | \$0 | \$1,000,000 | \$8,900,000 | \$9,900,000 | \$13,619,900 |
| User Fees | \$0 | \$1,000,000 | \$8,900,000 | \$9,900,000 | \$13,619,900 |
| TOTAL USER FEES 4/ | \$3,025,000 | \$59,211,000 | \$32,739,000 | \$94,975,000 | \$160,000,000 |
| TOTAL PROGRAM MANAGEMENT | \$0 | \$3,000,000 | \$11,700,000 | \$14,700,000 | \$14,979,300 |
| TOTAL PRO | \$350,000 | \$2,860,000 | \$1,300,000 | \$4,500,000 | \$8,094,500 |
| GRAND TOTAL | \$3,375,000 | \$65,061,000 | \$45,739,000 | \$114,176,000 | \$173,073,800 |

PLEASE NOTE:

Where relevant estimates for FY 1999 have been increased to reflect anticipated increases in bene. population and print volume for call center printing.

**MEDICARE PLUS CHOICE ALLOCATION OF FUNDS
FOR FISCAL YEAR 1998**

Beneficiary Mailing

User Fees

| | |
|----------------------------------|---------------------|
| Phase I States | \$4,900,000 |
| Initial enrollment package | \$900,000 |
| Newsletter | \$9,100,000 |
| Agent Support | \$1,400,000 |
| Print Support for Bene. Outreach | \$3,900,000 |
| Warehouse | <u>\$300,000</u> |
| Total User Fees | \$20,500,000 |

Program Management

| | |
|----------------------------|--------------------|
| Agent Support | \$600,000 |
| Phase I States | \$2,400,000 |
| Warehouse | \$700,000 |
| Newsletter | \$3,900,000 |
| Initial enrollment package | <u>\$2,100,000</u> |
| Total Program Mgt. | \$9,700,000 |

PROs \$0

Total Beneficiary Mailing **\$30,200,000**

1-800 Number

User Fees

1-800 Number \$46,200,000

Program Management

1-800 Number \$4,000,000

Total 1-800 Number **\$50,200,000**

Internet

User Fees

Added add'l \$961K to Medicare Compare
Interactive Comparison Database \$1,500,000

Program Management \$0

Total Internet **\$1,500,000**

**MEDICARE PLUS CHOICE ALLOCATION OF FUNDS
FOR FISCAL YEAR 1998**

Program Development

User Fees

| | |
|--------------------------------------|---------------------|
| Assessment and Surveillance | \$2,010,000 |
| Development of decision tool | \$200,000 |
| Consumer Information Framework | \$250,000 |
| CAHPS Survey and Analysis | \$2,615,000 |
| Market Research and Consumer Testing | \$50,000 |
| Content and Training | \$2,750,000 |
| HICAP | \$5,000,000 |
| M+C Project Integration Contract | \$3,500,000 |
| Requirements Analysis | <u>\$500,000</u> |
| Total User Fees | \$16,875,000 |

Program Management

| | |
|---------------------------------|--------------------|
| Requirements Analysis | <u>\$1,000,000</u> |
| Total Program Management | \$1,000,000 |

PROs

| | |
|--------------------------------------|--------------------|
| CAHPS Survey and Analysis | \$4,200,000 |
| Market Research and Consumer Testing | \$50,000 |
| Consumer Information Framework | <u>\$250,000</u> |
| Total PROs | \$4,500,000 |

Total Program Development **\$22,375,000**

Community Base/Health Fairs

User Fees

| | |
|--------------------------------------|--------------------|
| Alliance Partners Support | \$2,000,000 |
| Special Information Campaign Support | \$3,000,000 |
| Support of Aging Network | \$2,000,000 |
| Education Campaign Support | <u>\$2,900,000</u> |
| Total User Fees | \$9,900,000 |

Total Community Base/Health Fairs **\$9,900,000**

| | |
|---------------------------------|----------------------|
| Total User Fees | \$94,975,000 |
| Total Program Management | \$14,700,000 |
| Total PROs | \$4,500,000 |
| TOTAL ALL PROGRAMS | \$114,175,000 |

HHS FACT SHEET

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

June 22, 1998

Contact:

HCFA Press Office
(202) 690-6145

WWW.MEDICARE.GOV

Official U.S. Government Site for Medicare Information

***Overview:** Responding to this growing opportunity to provide beneficiaries with up-to-date information, the Health Care Financing Administration (HCFA), the agency that runs Medicare, has created a new website: www.Medicare.gov. President Clinton and Vice President Gore announced www.Medicare.gov at the seventh Family Reunion Conference in Tennessee today. Increasing numbers of Medicare beneficiaries use the Internet or have access to it through their families, friends, health care providers, and service organizations. Designed with the beneficiary in mind, www.Medicare.gov offers a variety of useful and easy-to-read information about Medicare including details of new choices available to them under the Balanced Budget Act.*

ONLINE AT WWW.MEDICARE.GOV

HCFA's new website contains the following useful information for Medicare beneficiaries and anyone involved in helping them with their health care decisions:

- **"What is Medicare?"** – In this section, visitors can get answers to their questions about Medicare, including eligibility requirements, how to enroll, and how to read a Medicare summary notice.
- **"Managed Care"** – This section is about managed care and new options that will be available in 1999. Visitors can learn more about managed care in general and the Medicare+ Choice options available to Medicare beneficiaries. This includes an extensive question-and-answer section, glossary of terms, and information about how to enroll in and disenroll from a Medicare managed care plan. From this site visitors can also access the "Medicare Compare" database to see what plans and benefits are available where they live.
- **"Who to Contact"** – This section provides state specific contact information, including phone numbers, on a variety of Medicare topics that includes: receiving Medicare, understanding your Medicare bill; Medicare rights, benefits, dealing with complaints and appeals, and managed care.
- **"Publications"** – A variety of publications (in both English and Spanish) are available for visitors to view, print and/or download.

-More-

-2-

- **“Wellness”** – Visitors can learn more about health issues that are of particular concern to them, such as peptic ulcers, pneumonia and the flu, and about new Medicare prevention benefits. This section also includes a calendar of events alerting the user to National Health Observances that are of importance to seniors. Here, seniors can learn about preventing disease or illness, preventive services covered by Medicare and how they can obtain additional information.
- **“Fraud and Abuse”** – This section describes common Medicare fraud and teaches visitors how to report suspected fraud in the Medicare system. A *Consumer Fraud Pamphlet* is available for visitors to view and/or print-out.

THE “MEDICARE COMPARE” DATABASE

“Medicare Compare” is HCFA’s new electronic database of information about accredited managed care plans that already serve nearly 6 million Medicare beneficiaries across the country. The database is designed to educate beneficiaries and others about their health care options, so they can make informed health care choices. The information is compiled by HCFA with cooperation from managed care plans, and will be updated on a quarterly basis.

“Medicare Compare” contains the following information:

- Toll-free telephone numbers and website addresses for health plans;
- Service areas listed by state, zip code, and county so beneficiaries can compare services in their own geographic areas;
- Benefit and service packages offered by each plan, including detailed information on premiums, copays/deductibles, and more;
- “Helpful hints” to help users navigate within the database;
- Guest book/E-mail link back to HCFA for users’ comments, questions, and suggestions.

Users can select the level of detail they want to know about the plans, searching either by state, county, or zip code. HCFA will update the database quarterly to provide users with the most timely and complete information.

In addition, users can:

- Display side-by-side comparisons of services offered by two health plans;
- Search for a specific type of service such as vision care or podiatry care.

-More-

-3-

SENIORS SURF THE NET

More and more Medicare beneficiaries and those who will soon be eligible for Medicare use the Internet.

- A Merrill Lynch-sponsored survey conducted in September 1997 shows that 15 percent of those 65 and older use the Internet.
- According to Packard Bell NEC Inc., customers over age 55 accounted for 14 percent of retail purchases of its personal computers in 1997.
- AARP reports that in 1997, 36 percent of Americans between ages 50 and 64 owned a personal computer.

WHO WILL USE THE WEB RESOURCES

While *www.Medicare.gov* and "Medicare Compare" are designed especially for Medicare beneficiaries and the people involved in their health care decisions; anyone with access to the Internet can use it. Material in the database may be customized and printed for local and individual needs.

Other primary users will include beneficiary advocacy groups, social and case workers, State Insurance and Assistance Program staff and volunteers, the National Association of Area Agencies on Aging network and its staff, federal and state organizations, and health care providers.

###

-More-

WWW.MEDICARE.GOV
FREQUENTLY ASKED QUESTIONS
(INTERNAL)

Q. What is *www.Medicare.gov*?

A. *Www.Medicare.gov* is the official U.S. Government Internet site for Medicare information. It is designed to meet the consumer information needs of Medicare beneficiaries. It offers a variety of useful and easy to read information about Medicare.

Q. *Who will use www.Medicare.gov*?

A. While *www.Medicare.gov* and the information included there are designed especially for Medicare beneficiaries and the people involved in their health care decisions, anyone with access to the Internet can use it. Material in the database may be customized and printed for local and individual needs.

Other primary users will include:

- beneficiary advocacy groups
- social and case workers
- State Insurance Advisory Program staff and volunteers
- staff in the National Association of Area Agencies on Aging network
- Federal and State organizations
- health care providers

Q. *Why use www.Medicare.gov*?

A. Increasing numbers of Medicare beneficiaries use the Internet or have access to it through their families, friends, health care providers and service organizations. Responding to this growing opportunity to provide beneficiaries with up-to-date information, the Health Care Financing Administration (HCFA), the agency that runs Medicare, has created this new web site. Beneficiaries can use the site to access various kinds of Medicare information.

Q. *What kind of information can visitors find on the Internet site?*

A. *Www.Medicare.gov* contains the following useful information for Medicare and anyone involved in helping them with their health care decisions:

- ◆ **“What is Medicare?”** - In this section, visitors can get answers to their questions about Medicare, including eligibility requirements, how to enroll and how to read a Medicare summary notice.

- ◆ **“Managed Care”** - This section is about managed care and the new options that will be available to beneficiaries in 1999. Visitors can learn more about managed care and the Medicare + Choice options available to beneficiaries. This includes an extensive question and answer section, glossary of terms, and information about how to enroll in and disenroll from a Medicare managed care plan. From this site, visitors can also access the “Medicare Compare” database to see what plans and benefits are available where they live.
- ◆ **“Who to Contact”** - This section provides state specific contact information, including phone numbers on a variety of Medicare topics broken down into five broad categories:
 - Your Medicare Bill
 - Getting Medicare, other health insurance, other benefits
 - Complaints, appeals and other Medicare rights
 - Your health plan choices
 - Railroad Retirement Board
- ◆ **“Publications”** - A variety of publications (in both English and Spanish) are available for visitors to view, print and/or download.
- ◆ **“Wellness”** - Visitors can learn more about health issues that are of particular concern to them, such as peptic ulcers, pneumonia and the flu and about new Medicare prevention benefits. This section also includes a calendar of events alerting the user to National Health Observances that are of interest to seniors. Here, seniors can learn about preventing disease or illness, preventive services covered by Medicare and how they can obtain additional information.
- ◆ **“Fraud and Abuse”** - This section describes common Medicare fraud and tells visitors how to report suspected fraud in the Medicare system. A *Consumer Fraud Pamphlet* is available for visitors to view and/or print out.

Q. How can visitors access the site?

A. Visitors can visit their local library, school, home or any computer with access to the Internet. Visitors can use Netscape or Internet Explorer and any web browser or search engine will work. Type in *http://www.Medicare.gov* to access the home page. The site can be accessed 24 hours a day, 7 days a week.

Q.: Is the site worthwhile? How many seniors actually use the Internet?

A. More and more, Medicare beneficiaries and those who will soon be eligible for Medicare use the Internet. The following research indicates Internet access growth:

- A Merrill Lynch sponsored survey conducted in September 1997 shows that 15 percent

-More-

of those 65 and older use the Internet.

- According to Packard Bell NEC inc., customers over age 55 accounted for 14 percent of retail purchases of its personal computers in 1997.
- AARP reports that in 1997, 36 percent of Americans between ages 50 and 64 own a personal computer.

Q. What is the "Medicare Compare" database?

- A.** "Medicare Compare" is HCFA's new electronic database of information about accredited managed care plans that are available to 26 million Medicare beneficiaries across the country. Currently 6 million Medicare beneficiaries are members of managed care plans. The database is designed to educate beneficiaries (and others including beneficiaries' family members, advocates and social workers) about their health care options so they can make informed health care choices. The information is compiled by HCFA with cooperation from managed care plans and will be updated on a quarterly basis.

Q. What kind of information does the "Medicare Compare" database contain?

- A.** The "Medicare Compare" database contains the following information:
- Toll-free telephone numbers and web site addresses for health plans.
 - Service areas listed by state, zip code and county so beneficiaries can compare services in their own geographic areas.
 - Benefit and service packaged offered by each plan including detailed information on premiums, copays/deductibles and more.
 - Helpful hints to help users navigate within the database.
 - Guest book/E-mail link back to HCFA for users comments, questions and suggestions.

Q. How do visitors use "Medicare Compare"?

- A.** Users can select the level of detail they want to know about the plans, searching either by state, county or zip code. (While the database contains a broad range of information on the plans, certain areas of interest to Medicare beneficiaries may not be documented.) HCFA will update the database quarterly to provide users with the most timely and complete information. In addition, users can:
- Display side-by-side comparisons of services offered by two health plans
 - Search for a specific type of service such as vision care, podiatry care or Pap tests.

Q. What are future plans for the site?

A. Future plans include the development of additional consumer information resources targeted to meet the immediate and ongoing needs of Medicare beneficiaries and those who work with them. We will develop the additional resources in response to market research and to ongoing surveillance of customer service needs.

Q. Are there plans to include more plan comparison information on the web site in the future?

A. Yes. Plan information will be updated at least quarterly to reflect new plans that are available to Medicare beneficiaries. In addition, there are plans to expand the comparison information to include new information as it becomes available. The first expansion will include quality and satisfaction information in late Fall 1998. Quality information will be obtained from 1996 data reported on measures that comprise the Health Plan Employer Data and Information Set (HEDIS). These data are reported by health plans that contract with Medicare, and will be useful in comparing health plans. Satisfaction information will be obtained from 1997 data reported by Medicare beneficiaries from questions that comprise the Consumer Assessment of Health Plans Survey (CAHPS). Finally, disenrollment rates will be available on the web site in late spring of 1999.

HHS FACT SHEET

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
June 22, 1998

Contact: HCFA Press Office
(202) 690-6145

MEDICARE EXPANDS COVERAGE FOR BONE DENSITY MEASUREMENT AND DIABETES SELF-MANAGEMENT

Overview: Starting July 1, 1998, Medicare will expand coverage of preventive benefits for beneficiaries at risk for osteoporosis and other bone abnormalities and for people with diabetes. Medical experts agree early detection and management of disease can lead to substantial reductions in life-threatening and serious illness.

The Clinton Administration is committed to making sure Medicare beneficiaries get recommended preventive screening tests. That is why the President worked with Congress to expand the preventive benefits available to Medicare beneficiaries in the Balanced Budget Act of 1997. As of January 1, 1998, Medicare expanded coverage of mammograms, pap smears, and colorectal cancer screening. Today, President Clinton highlighted these exciting preventive tests at the seventh Family Reunion Conference, hosted by Vice President and Mrs. Gore, in Tennessee.

Bone Mass Measurement. The National Osteoporosis Foundation estimates that more than 10 million people in the United States have this disease and another 18 million are at risk for it. As of July 1, 1998, Medicare will cover bone density measurement for beneficiaries at risk for osteoporosis and other bone abnormalities. Through earlier detection of low bone mass and the use of appropriate prevention and treatment measures, the ravaging effects of this disease will be reduced.

Eligible beneficiaries will be able to have their bone mass measured once every two years, or more often, if medically necessary. Doctors will be able to use all of the FDA-approved or cleared bone densitometry and sonometry devices that are currently available in the United States. Beneficiaries should consult with their doctors about whether and when they might need one of these tests.

In the past, bone mass measurement coverage was decided by the many regional contractors that process Medicare claims, resulting in wide variations across the country. The new law makes sure that all beneficiaries who need this testing, no matter where they live, will be covered.

Diabetes Self-Management Benefits. More than 16 million Americans have diabetes and nearly 750,000 new cases are reported every year. Minorities make up a disproportionate share of those suffering from diabetes -- especially African Americans, Native Americans, and Latinos. As of July 1, 1998, more Medicare benefits will be available to diabetics. These newly expanded benefits will help provide people with the skills and resources that most diabetics need to control their diabetes.

Glucose Monitoring for Diabetics. All Medicare beneficiaries with diabetes, whether or not they use insulin, will have coverage for blood glucose monitors and testing strips so they can monitor their own blood glucose levels. Diabetics who keep their blood glucose levels within the normal range reduce the risk of complications, such as blindness and amputations that often are associated with uncontrolled diabetes. In the past, Medicare covered blood glucose monitors and testing strips only for insulin-dependent diabetics.

Diabetes Education. Medicare will cover a wider range of education and training programs to help teach diabetics to control their blood glucose levels. These training programs do not have to be based in hospitals. Physicians and certain other physician practitioners can provide diabetes self-management and training services to their patients if their programs are recognized by the American Diabetes Association. A physician must certify that a patient needs the service under a comprehensive plan of care. In the past, Medicare covered only education and training furnished by hospital-based programs.

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Qs & As on Bone Density Measurement (INTERNAL)

Q. How many more people will be eligible for this expanded benefit?

A. Because virtually all elderly women are at risk of osteoporosis almost all female Medicare beneficiaries would be eligible to receive this benefit. About 21 million women (including disabled and elderly) would be eligible but those beneficiaries with visible signs of osteoporosis are already covered. According to the National Osteoporosis Foundation, 2 million men suffer from osteoporosis and 3.1 million are at risk for the disease.

Q. What is a bone mass measurement?

A. It is a simple, painless test used to measure the density or thickness of the bones, and it should help to determine whether an individual has osteoporosis or is at risk for the disease.

Q. How often will Medicare cover a bone mass test?

A. Once every 2 years, or more frequently if medically necessary.

Q. Which Medicare beneficiaries will be eligible to receive a covered bone mass test?

A. The law identifies five categories of people. These include (1) estrogen-deficient women at clinical risk for osteoporosis, (2) those with vertebral abnormalities, (3) those with primary hyperparathyroidism, (4) those receiving long-term (more than 3 months) steroid therapy, and (5) those being monitored to assess the response to, or efficacy of, an approved osteoporosis drug therapy.

Q. What bone mass measurements are going to be covered under the new Medicare benefit?

A. The benefit will cover all FDA-approved bone mass measurements in clinical use in the United States.

Q. What benefits will the new bone mass measurement provision allow for under Medicare that were not available before enactment?

A. In the past, bone mass measurement coverage was decided by the many contractors that process Medicare claims, resulting in wide variations across the country. The Balanced Budget Act makes sure that all beneficiaries who need this testing, no matter where they live, will be covered.

Q. Should women in menopause seek coverage of a bone mass measurement under the new benefit?

A. Yes, menopause is an estrogen-deficient condition and women should check with their physicians about having the test done.

Q. What is osteoporosis?

A. It is a bone-thinning disease in which bones may become fragile and break. It is estimated that 10 million individuals in the United States have osteoporosis and that another 18 million are at risk for the disease because of a high rate of bone loss.

**Qs and As for Diabetes Self-Management
(INTERNAL)**

Q: What is HCFA doing to implement the blood glucose monitor provision by July 1, 1998?

A: The Balanced Budget Act expanded Medicare coverage to pay for blood glucose monitors and testing strips for all diabetic beneficiaries, whether they take insulin or not, effective July 1, 1998.

Q: What should a beneficiary do in order to have a blood glucose monitor and test strips covered by Medicare?

A: Beneficiaries should ask their doctor if the beneficiary's diabetes could be better controlled by testing their blood glucose. If the physician thinks that better control is necessary the doctor should write a prescription that explains in detail how many times a day or week the beneficiary should test his or her blood sugar and how many test strips the pharmacy or supplier should dispense. The physician will be required to renew this prescription periodically.

Q: I understand that Medicare is not providing the same amount of test strips to non-insulin treated diabetics as insulin treated diabetics can you explain the reasons for this?

A. Medicare will cover the amount that the physician orders. So, these numbers are not limits but will be used as benchmarks to look for potential fraud and abuse in the system. On average medical evidence suggests that the typical non-insulin treated Medicare diabetic beneficiary would use less than 25 test strips per month and the insulin treated Medicare beneficiary would use less than 100 per month. We recognize that there are certain medical conditions that would require the beneficiary to monitor more often, for example, when they are put on a new medication or other medical reasons.

Q: Can you tell us the status of the implementation of the diabetes self-management and training provision?

A: We have a two-phased implementation strategy for diabetes education and training benefits:

By July 1, 1998, HCFA will issue a carrier instruction allowing physicians and certain non-physician practitioners (and services provided incident to their services), who meet the National Diabetes Advisory Board (NDAB) standards to begin providing diabetes self-management training.

HCFA also will develop a Notice of Proposed Rulemaking to enable others who may be eligible to provide diabetes self-management training, and to include quality standards set by the Secretary. It will require a proposed rule with comment period, followed by a final rule. This regulation will identify others who can be reimbursed for this training such as nurse practitioners, physician assistants, clinical nurse specialists, nurse-midwives, clinical psychologists and clinical social workers.

We have taken this two-phased approach because the legislation clearly specifies physicians as eligible to provide diabetes education if they meet NDAB standards. Certain other practitioners are also authorized by law to provide services that would be physician services if they were furnished by a physician.

Q: How does a beneficiary get enrolled in a diabetes self-management and training program?

A: A beneficiary's physician must establish a comprehensive plan of care to ensure therapy compliance or to provide the individual with necessary skills and knowledge (including the self-administration of injectable drugs). Self referral into a program will not be covered.

Q. What are the advantages of a self-management and training program?

A. With better control of their diabetes, beneficiaries will have better health and less medical complications as a result of their diabetes. Diabetes outpatient self-management and training services help beneficiaries manage their diabetes. The program includes education about self-monitoring of blood glucose, diet and exercise, an insulin treatment plan developed specifically for the patient who is insulin dependent, and assistance in developing skills for more effective self-management.

Q: Are all diabetics eligible to attend a self-management training program or only those diabetics who are treated with insulin?

A. Both insulin and non-insulin patients will be eligible to attend a self-management training program as long as they are referred to such a program by the physician who is treating their diabetes.

MEDICARE PATIENT CHOICE AND ACCESS ACT OF 1997, S. 107

Introduced by Senators Grassley (R-IA), Conrad (D-ND), D'Amato (R-NY), Durbin (D-IL) and Helms (R-NC)

ACCESS

- **Provision.** Beneficiaries enrolled in managed care plans must have timely access to primary care and speciality providers who are appropriate for the enrollee's condition. Enrollees must have access to specialized treatment, when medically necessary. The plan's use of case management cannot create an "undue burden" for enrollees. A plan must ensure direct access to specialists for on-going care as determined by the case manager in consultation the speciality care provider. This requirement may be satisfied for enrollees with chronic care conditions through the use of a specialist serving as a case manager.
- **HCFA Comment.** Managed care plans are already required under current law to ensure the availability and accessibility of providers by including an adequate number, mix and geographic distribution of primary care and specialty providers in its network and to provide all covered services. HCFA believes that enrollees with chronic conditions could benefit from a specialist serving as the case manager. However, we would we not want to micro manage plans by requiring them to do so.

Don't want to micromanage

POINT-OF-SERVICE OPTION

- **Provision.** At the time of enrollment, beneficiaries must be given the option of choosing a point-of-service option.
- **HCFA Comment.** Beneficiaries already have access to POS options since many managed care plans already offer such an option, and we expect the number to increase in the future. If a beneficiary desires fewer restrictions when accessing providers, the beneficiary has the choice of enrolling in a managed care plan that has a POS option or remaining in traditional Medicare. In addition, HCFA would not want to require all plans POS options since some plans may not have the administrative capability to do so. In addition, it seems unreasonable to require staff model HMOs, which salary their physicians and other providers, to establish the necessary contractual arrangements for the POS option.

GRIEVANCE PROCESS

- **Provision.** Plans must establish an expedited appeals process. The Secretary would determine the time frames for the expedited process; all other appeals must be resolved within 30 days. A hearing board comprised of representatives from the plan, consumers not enrolled in the plan and providers not under contract with the plan would reconsider the plan's initial determination.

- **HCFA Comment.** We already have the authority under current law to require plans to establish an expedited review process and on April 30, 1997, HCFA published a regulation to that effect. The regulation, however, did not require that plans establish a hearing board and specify its membership.

We have several concerns regarding the bill's requirement to establish an appeals board. First, a requirement to conduct all appeals through one statutorily-set mechanism will result in needless inefficiency and is will likely delay the issuance of decisions to beneficiaries in many instances. Second, the inclusion of doctors and other persons from outside of the HMO will require the HMO to reveal proprietary information and processes. Currently, HMOs are required to use physicians and other health professionals who have not been party to the initial denial. If the review at the health plan level results in continued denial of care, the case is automatically referred to an independent HCFA reconsideration contractor that expedites all pre-service denials and disputes over terminations of care. The existing process is considered the best in the country and the addition of an untested mechanism is unwarranted. Third, we do not support micro management of how plans conduct reconsideration. Further, this would prevent the evolution of alternative dispute mechanisms for beneficiaries in HMOs, a concept that is gaining interest and support.

Under current law, plans have a 60-day time frame to process non-expedited appeals. We plan to publish a second regulation which would modify the time frames for the general appeals process including the time frame for that process. We prefer that such modifications are made in regulation rather than statute.

COMPARATIVE INFORMATION

- **Provision.** Plans would be required to provide to beneficiaries at the time of enrollment and at least annually an explanation of the enrollees rights to benefits, payment and coverage restrictions on out-of-network services, out-of-area coverage, coverage of emergency and urgently needed services, appeal rights and grievance procedures and other rights as established by the Secretary.

The Secretary would be required to provide comparative information charts to beneficiaries and update the charts at least annually. The information included in the charts would include the identity, location, qualifications and availability of network providers; the number of enrollees who disenrolled from the plan within three months of enrollment; procedures the plan uses to control utilization and costs, including financial incentives; quality assurance procedures; the rate at which plans deny certain medical services; the number of times HCFA reversed a plan's determination on appeal; and payment and coverage restrictions on out-of-network services.

- **HCFA Comments.** The information that the plan is required to provide beneficiaries is already required under current law. In addition, HCFA already has an initiative under way to provide beneficiaries with comparative information on managed care plans via HCFA's

home page on the Internet. The cost of producing and mailing the comparative charts to all 37 million beneficiaries was prohibitive. Placing the information on the Internet is a cost effective way to disseminate the information to beneficiary advocates groups, State insurance counseling and assistance (ICA) programs and others who in turn will make the information available to beneficiaries. The comparability charts will be available in mid-1997 and will include information on each plan's benefits, premiums, copayments, and coverage rules, as well local and toll-free phone numbers and geographic service areas for each plan. Future iterations of the charts will include information on HEDIS performance measures and the results of a standardized consumer satisfaction survey.

The President's FY 1998 budget proposal requires that the Secretary develop and disseminate comparative information to beneficiaries. The proposal, however, gives the Secretary the discretion to determine what types of comparative materials would be most useful to beneficiaries. Equally important, the proposal permits the Secretary to collect fees from plans to finance the development and dissemination of the comparative information.

We do not believe that some of the types of information required to be provided would be meaningful to beneficiaries, especially disenrollment and appeals information. Without proper adjustments, the information could unfairly characterize as a plan as delivering poor quality care. HCFA's comparability chart would include information on standardized performance and beneficiary satisfaction measures.

FINANCIAL INCENTIVE PLANS

- **Provision.** Current requirements for incentive plans would be expanded beyond physicians to include all providers.
- **HCFA Comment:** HCFA would not support the application of the physician incentive plan requirements to other providers at this time. Although there is some support for such an expansion among network health plan providers, HCFA is finding that the reporting burden for the physician incentives is tremendous. At this point, we will review the existing information reporting requirements to determine the appropriateness of expanding the incentives provisions.

Physicians assume much of the risk in most cases for direct provision of services in managed care plans. In addition, network doctors tend to be paid on a capitated basis, and have the most influence on patient referrals. Therefore, we believe that at this time the incentive requirements should remain limited to physicians.

GAG CLAUSES

- **Provision.** Plans would be prohibited from restricting any medical communication as part of a contract, a written statement or an oral communication. Medical communication is defined broadly to include communications beyond those covered in HCFA's recent Operational Policy Letter which only prohibits limits on physicians' counsel or advice to beneficiaries regarding their treatment options. Medical communications could include discussions between the provider and patient regarding utilization review procedures and

the basis for specific UR decisions, how participating physicians are paid, whether a drug is on the plan's formulary, how the organization decides whether a treatment is experimental.

- **HCFA Comment:** Under current law, the plan must provide information regarding physician incentive plans to the beneficiary upon request. Several of the types of medical communication listed in the bill could be considered proprietary information (e.g., what drugs are on the formulary, how UR decisions are made, how the plan determines what treatments are experimental).