

President's FY 1998 Budget:

Medicare Savings and Investment Proposals

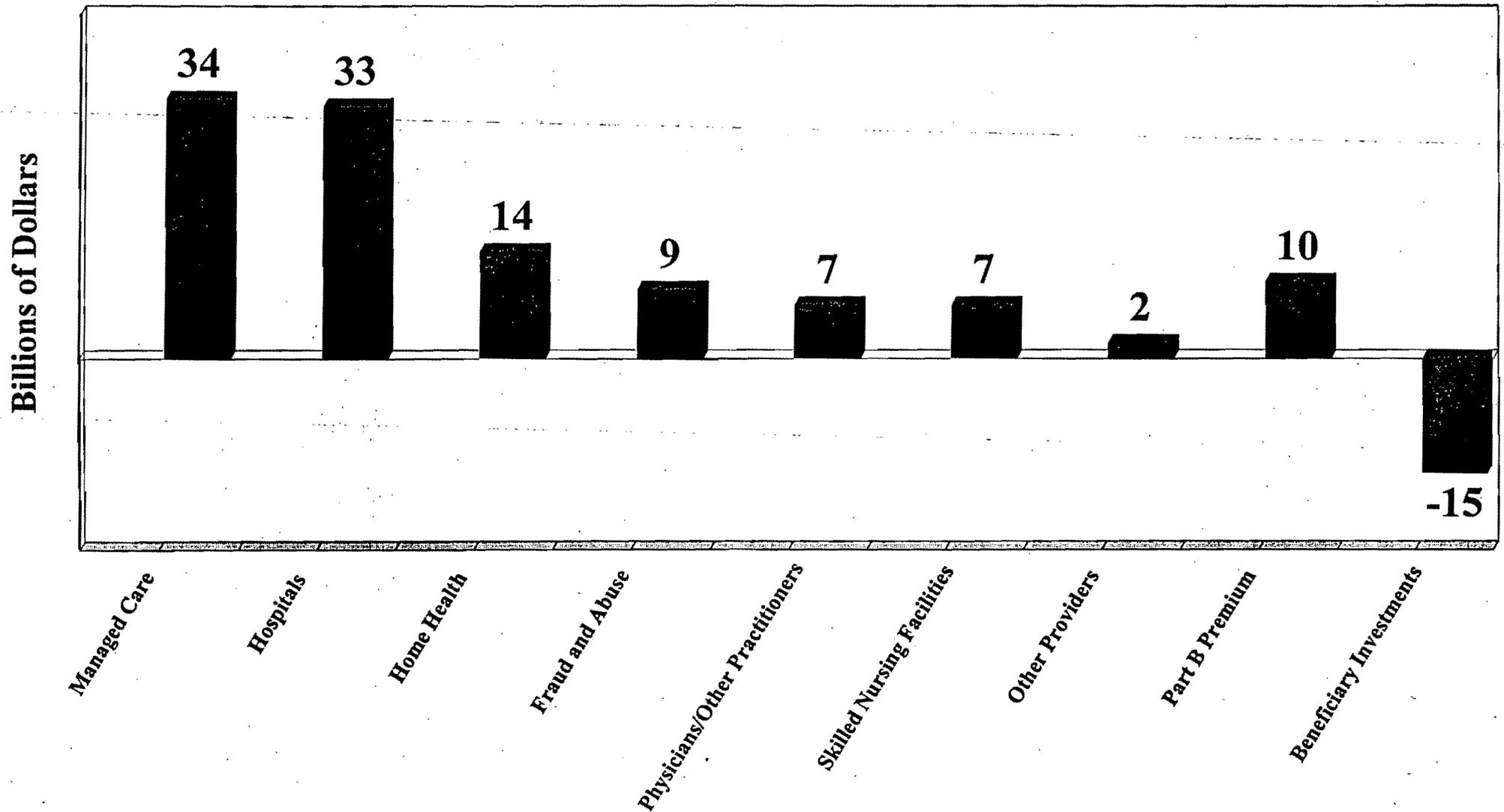
Background Materials

February, 1997

The President's FY 1998 Budget

Medicare Savings and Investment Proposals

FY 1998 - FY 2002, Total Savings = \$100 billion



The President's FY 1998 Budget: Medicare Savings and Investment Proposals

(FY, \$'s in billions, positive numbers are savings, negative numbers are costs, sums may not add due to rounding)

	1998	1999	2000	2001	2002	98-02
PART A PROPOSALS						
Managed Care	1.2	3.2	6.5	8.3	9.9	29.2
Hospitals	2.7	3.3	4.6	5.9	8.0	24.5
Reduce Hospital PPS Update	0.7	1.4	2.2	3.1	4.0	11.4
Extend PPS Capital Reduction	1.2	1.2	1.3	1.3	1.4	6.4
Reduce PPS-Exempt Update w/ Rebasing	0.3	0.4	0.6	0.8	1.0	3.2
Reduce PPS-Exempt Capital Payments	0.1	0.2	0.2	0.2	0.2	0.8
Reform Base Puerto Rico Payment	0.0	0.0	0.0	0.0	0.0	-0.1
Moratorium on Long-Term Care Hospitals	0.0	0.0	0.1	0.1	0.1	0.4
Expand Centers of Excellence	0.0	0.1	0.1	0.1	0.1	0.2
Lower IME	0.2	0.4	0.7	0.9	2.0	4.2
GME Reform	0.2	0.4	0.7	0.9	1.2	3.4
Eliminate Add-Ons for Outliers	0.5	0.5	0.5	0.6	0.6	2.6
PPS Redefined Discharges	0.7	0.8	0.8	0.9	1.0	4.1
SCH Rebasing	-0.1	-0.1	-0.1	-0.1	-0.1	-0.6
RPCH expansion	0.0	0.0	0.0	0.0	0.0	-0.1
Medicare dependent hospitals	0.0	0.0	-0.1	0.0	0.0	-0.1
Remove GME, IME, and DSH from AAPCC	-1.1	-1.9	-2.1	-2.6	-3.0	-10.7
Interactions Among Hospital Proposals	0.0	0.0	-0.1	-0.2	-0.4	-0.7
Home Health	1.1	1.6	3.3	3.7	4.2	13.7
HH Freeze Extension	0.1	0.3	0.3	0.3	0.3	1.3
HH Interim System	0.9	1.3	1.5	1.8	2.1	7.7
HH PPS	0.0	0.0	1.5	1.6	1.7	4.7
Fraud and Abuse	0.1	0.9	2.0	1.5	1.7	6.2
Clarify and Enhance MSP Authority	0.1	0.2	0.2	0.3	0.3	1.0
Extend Expiring MSP Provisions	0.0	0.7	0.9	1.1	1.3	4.0
Repeal Objectionable Provisions	0.0	0.0	0.1	0.1	0.1	0.2
Pay Home Health on Location of Service	0.1	0.1	0.1	0.1	0.1	0.4
Require SNF Consolidated Billing	-0.1	-0.1	-0.1	-0.1	-0.1	-0.3
Eliminate Home Health PIP	0.0	0.0	0.8	0.1	0.1	1.0
Skilled Nursing Facilities	0.0	1.0	1.8	2.1	2.1	7.1
Extend Savings from OBRA 93 Freeze	0.0	0.2	0.3	0.4	0.4	1.3
Establish SNF PPS	0.0	0.9	1.5	1.7	1.7	5.8
Beneficiary Investments	-0.3	-0.4	-0.6	-0.7	-0.8	-2.7
Colorectal Screening	-0.1	-0.2	-0.2	-0.3	-0.3	-1.1
HI Premium Free Working Disabled	0.0	0.0	0.0	0.0	0.0	-0.1
Part A Premium Offset	-0.2	-0.2	-0.3	-0.4	-0.4	-1.5
TOTAL PART A	4.8	9.6	17.7	20.8	25.0	77.9

The President's FY 1998 Budget: Medicare Savings and Investment Proposals

(FY, \$'s in billions, positive numbers are savings, negative numbers are costs, sums may not add due to rounding)

	1998	1999	2000	2001	2002	98-02
PART B PROPOSALS						
Managed Care	-0.1	0.2	1.1	1.5	1.8	4.5
Hospitals	0.0	1.8	1.8	2.1	2.5	8.2
Outpatient PPS	0.0	1.8	1.8	2.1	2.5	8.1
Outpatient GME Reform	0.0	0.0	0.0	0.0	0.0	0.0
Expand Centers of Excellence	0.0	0.0	0.0	0.0	0.0	0.1
Physicians and Other Practitioners	0.2	0.8	1.6	2.1	2.6	7.2
Single Conversion Factor, Reform Update	0.1	0.7	1.2	1.5	1.8	5.3
Single Fee For Surgery	0.0	0.1	0.1	0.1	0.1	0.4
Incentives for In-hospital MD Services	0.0	0.0	0.3	0.5	0.7	1.5
Direct Payment to PA, NP, CNS	-0.1	-0.1	-0.1	-0.1	-0.2	-0.6
Pay Acquisition Cost for Drugs	0.1	0.2	0.2	0.2	0.2	0.8
Increase Access to Chiropractors	0.0	0.0	0.0	-0.1	-0.1	-0.2
Interaction among Physician Proposals	0.0	0.0	0.0	0.0	0.0	-0.1
Fraud and Abuse	0.1	0.5	0.6	0.7	0.9	2.9
Clarify and Enhance MSP Authority	0.1	0.1	0.1	0.2	0.2	0.6
Expiring MSP Provisions	0.0	0.3	0.4	0.5	0.6	1.9
Require SNF Consolidated Billing	0.1	0.1	0.1	0.1	0.1	0.3
Repeal Objectionable Provisions	0.0	0.0	0.0	0.0	0.0	0.1
Other Providers	0.0	0.0	0.1	0.6	1.0	1.8
Competitive Bidding	0.0	0.0	0.0	0.5	0.8	1.4
Reduce ASC update	0.0	0.0	0.1	0.1	0.1	0.3
Reform Lab Payments	0.0	0.0	0.0	0.0	0.0	0.1
Part B Premium	0.0	0.7	1.8	3.0	4.7	10.2
Extend 25% Premium Beyond 1998	0.0	1.0	2.5	4.1	5.9	13.6
Premium Offset	0.0	-0.3	-0.7	-1.1	-1.2	-3.4
Beneficiary Investments	-0.8	-2.2	-2.4	-3.1	-3.9	-12.4
Waive Mammography Costsharing	0.0	-0.1	-0.1	-0.1	-0.1	-0.3
Annual Mammogram	0.0	-0.1	-0.1	-0.1	-0.1	-0.4
Respite Care	-0.4	-0.4	-0.4	-0.4	-0.4	-1.8
Colorectal Screening	0.0	-0.1	-0.1	-0.2	-0.2	-0.7
Diabetic Screening	-0.2	-0.3	-0.3	-0.3	-0.3	-1.5
Blood Glucose Monitor Strips	0.0	0.0	0.0	0.0	0.0	0.1
HI Premium Free Working Disabled	0.0	0.0	0.0	0.0	0.0	0.0
Preventive Injections	0.0	-0.1	-0.1	-0.1	-0.1	-0.4
Actuarially Determined Premium Surcharge	-0.1	-0.2	-0.2	-0.2	-0.2	-0.8
Appropriate Outpatient Coinsurance	0.0	-1.1	-1.3	-1.8	-2.6	-6.8
TOTAL PART B	-0.5	1.8	4.5	7.0	9.5	22.3
NET SAVINGS FROM TOTAL PACKAGE	4.3	11.4	22.2	27.8	34.6	100.2

THE PRESIDENT'S FY 1998 BUDGET MEDICARE SAVINGS AND INVESTMENT PROPOSALS

The President's plan achieves \$100 billion in net Medicare savings over five years by making a variety of reforms to the program and extends the life of the Part A Trust Fund to 2007.

MANAGED CARE

The President's plan includes \$34 billion in managed care savings over five years. In addition to the savings components of the policy, there are several other proposals that address inequities in the current payment methodology and introduce important structural changes in the administration of the program.

- Address the Wide Geographic Disparity in Managed Care Payment Rates. Certain areas of the country receive much higher managed care payment rates than others. This proposal would raise payment levels for current low-payment counties, potentially encouraging managed care plans to enter new markets and thus providing more beneficiaries with a choice of plans. It also would limit payments for counties whose rates have been inflated by high service utilization in the fee-for-service sector. **This proposal is budget neutral; i.e., by limiting payments for certain higher-payment areas, funds can be redirected to lower-payment areas.**
- Indirect Savings from Fee-For-Service Reductions. The majority of managed care savings, **about \$18 billion over five years, are an indirect effect of reductions in fee-for-service spending.** Because increases in managed care payments are based upon the growth in fee-for-service payments, reductions in fee-for-service payments also produce managed care savings. In the last two years Medicare managed care payments have increased by about 13 percent, while private sector managed care payments have remained relatively flat.
- Carve Out GME, IME and DSH Payments From Managed Care Rates. These payments would be distributed directly to teaching and disproportionate share hospitals for managed care enrollees and to academic medical centers and managed care plans that run their own residency programs. **This proposal reduces payments by about \$10 billion over five years.**
- Reduce Medicare Reimbursement to Managed Care Plans From Its Current Rate of 95 Percent of Fee-For-Service Rates to 90 Percent Beginning in 2000. This proposal responds to substantial evidence that Medicare overpays managed care plans as a result of "favorable selection." The delay in the effective date of this provision is intended to

provide health plans the opportunity to prepare for the new methodology. **This proposal achieves about \$6 billion in savings over five years.**

- Consumer Information, Medigap Reforms and Increased Choice. Because many beneficiaries are unaware of their current options and would like greater choice among plans, the Administration proposes to increase managed care options, improve beneficiary awareness of the options, and improve access to Medigap coverage. First, the budget proposes to allow provider-sponsored organizations and preferred provider organizations that meet certain standards to participate as Medicare managed care plans. Second, the budget proposes to distribute comparative information on plan options to beneficiaries, ensuring that all are aware of the advantages and additional benefits that many managed care plans offer. Third, the budget guarantees that beneficiaries have the opportunity to enroll in community-rated Medigap plans annually without being subject to pre-existing condition exclusions. This provision would ensure that beneficiaries who try managed care, and are dissatisfied, can return to the Medigap plan of their choice. These policies are expected to increase enrollment in Medicare managed care plans.

HOSPITALS

The President's plan achieves \$33 billion in hospital savings over five years.

- Reduce Annual Updates to Hospitals. This policy would reduce the annual update by 1.0 percent for PPS hospitals for each year from 1998-2002 (**achieving about \$11 billion in savings over five years**). Similarly, the market basket for hospitals that are exempt from Medicare's hospital prospective payment system (i.e., psychiatric, rehabilitation, long-term care, cancer, and children's hospitals) would be reduced by 1.5 percentage points for each year from 1998-2002 (**achieving about \$3 billion in savings over five years**). The larger reduction in the PPS-exempt update is needed to bring the projected double-digit growth in payments to PPS-exempt facilities under control.

Under current law, inpatient hospital prospective payment rates are updated annually by a "market basket index" that reflects inflation in the prices of operating an inpatient facility. An update of less than the full market basket is given to reflect anticipated productivity gains and provide an incentive for hospitals to increase efficiency. For 1998, a hospital paid under the prospective payment system would receive about a 1.8 percent increase rather than the projected increase in the market basket of 2.8 percent.

- Reduce Hospital Capital Payments. Hospitals receive payments for their capital-related costs (e.g., construction, maintenance) based on the number of Medicare patients they treat. This proposal would reduce the 1998 hospital capital payment rate by 15.7 percent. In effect, this proposal permanently captures the savings from the OBRA 1990 capital provision, which limited payments for capital under PPS to 90 percent of what they

would have been under a reasonable cost system. **This proposal achieves about \$6 billion in savings over five years.**

In addition, this proposal would pay 85 percent of capital costs for PPS-exempt hospitals and units for FY 1998-2002, **resulting in about \$0.8 billion in savings over five years.**

- **Redefine Hospital "Transfer."** Currently, hospitals that move patients to PPS-exempt facilities and SNFs "discharge" the patient and receive a full DRG payment. This policy overpays hospitals and contributes to higher post-acute expenditure growth rates because these sites end up caring for more acutely ill patients. Under this proposal, moving a patient would be considered a hospital "transfer" rather than a discharge and payment would be on a per diem basis, not the DRG. **This proposal achieves about \$4 billion in savings over five years.**
- **Rural Health Provisions.** The President's plan invests about \$0.8 billion over five years to safeguard access to health care for rural beneficiaries. It: (1) extends the Rural Referral Center program; (2) improves the Sole Community Hospital program; (3) expands the Rural Primary Care Hospital program; and (4) extends the Medicare Dependent Hospitals program.
- **Give Hospitals Equal Subsidies for Teaching and "Disproportionate Share Hospital" (DSH) Costs for Medicare Fee-for-Service (FFS) and Managed Care Beneficiaries.** This proposal would give teaching and DSH hospitals additional payments, outside of their negotiated rates, when they treat Medicare beneficiaries in managed care plans. Currently, Medicare gives special payment adjustments to hospitals that run graduate medical education programs and/or serve a disproportionate share of low-income persons. These subsidies are only available when a hospital treats a Medicare FFS beneficiary. The President's plan would redirect the money for teaching and DSH that is being removed from managed care payments and pay it directly to eligible hospitals that provide services to Medicare managed care enrollees. Moreover, Medicare managed care plans that run their own teaching programs would also be eligible for payments to cover teaching costs. **This proposal returns about \$11 billion over five years to hospitals and eligible Medicare managed care plans.**
- **Graduate Medical Education Payments.** Medicare pays teaching hospitals for a share of the direct and indirect costs they incur in providing graduate medical education. Direct graduate medical education (GME) payments are based on a hospital's per resident costs (i.e., resident salaries and fringe benefits, overhead costs) and the number of full-time equivalent residents the hospital employs. The indirect costs are reimbursed through the indirect medical education (IME) adjustment to Medicare's hospital payments. **The graduate medical education proposals save about \$8 billion over five years.** These proposals would make the following changes in Medicare's graduate medical education payments:

- Graduate Medical Education Reform. This proposal actually contains three individual proposals, including two program expansions. The three proposals would: (1) cap the total number and the number of non-primary care residency positions reimbursed under Medicare at the current level; (2) count work in non-hospital settings for IME; and (3) allow GME payments to non-hospitals (e.g., Federally Qualified Health Centers) for primary care residents in those settings, when a hospital is not paying for the resident's salary in that setting. Most experts agree that the current GME and IME payment methodologies are flawed because they provide incentives to hospitals to increase their numbers of residents and to focus on specialty training at the expense of primary care training. This proposal is designed to slow the growth in Medicare spending on graduate medical education while encouraging more primary care training.

- Reduce IME Adjustment to 5.5 Percent. Through the IME adjustment, Medicare recognizes the higher indirect costs that teaching hospitals incur in running a teaching program (e.g., additional tests and procedures that residents may order as part of their training). Currently, the IME adjustment is based on a teaching hospital's ratio of interns and residents to beds (IRB), with payments increasing by about 7.7 percent for each 10 percent increase in a hospital's IRB. ProPAC recommends initially reducing the adjustment to 7 percent. However, ProPAC's research indicates that an IME adjustment of 4.1 percent corresponds more closely to the actual relationship between teaching intensity and costs. This proposal would reduce the IME adjustment to 7.4 percent in FY 1998, 7.1 percent in FY 1999, 6.8 percent in FY 2000, 6.6 percent in FY 2001, and 5.5 percent in FY 2002 and thereafter.

- Hospital Outpatient Departments (OPDs). Spending for OPD services is projected to nearly double between FY 1997 and FY 2002, from \$18 billion to \$31 billion. These services are still paid in part on the basis of a hospital's reported costs. The President's plan would move to a prospective payment system for these services effective January 1, 1999. Rates would initially be established so that total payments to hospitals for OPD services would be equal to projected FY 1999 hospital revenue (made up of Medicare's payments and beneficiary coinsurance payments), less savings from eliminating a flaw in the current payment methodology and assuming extension of certain policies set to expire at the end of 1998. **These proposals achieve about \$8 billion in savings over five years.**

- Expand "Centers of Excellence" Demonstration. Currently, HCFA is conducting a demonstration that pays 10 facilities, considered "centers of excellence," a flat fee to provide cataract or coronary artery bypass graft (CABG) surgery. The facilities were selected on the basis of their outstanding experience, outcomes, and efficiency in performing these procedures. This proposal would expand centers of excellence demonstrations to all urban areas by allowing Medicare to pay select facilities a single

rate for all services associated with CABG surgery or other heart procedures, knee surgery, hip replacement surgery, and other procedures that the HHS Secretary determines appropriate. This approach gives facilities incentives to provide high quality care more efficiently. Beneficiaries would not be required to receive services at these centers. **This proposal achieves about \$0.3 billion in savings over five years.**

- **Other Proposals that Achieve Net Savings of about \$3 billion over five years.**
 - Make new long-term care hospitals subject to the prospective payment system.
 - Eliminate increased IME and DSH payments that are attributable to so-called "outlier payments," but allow hospitals to count IME and DSH as part of costs that trigger outlier payments, effective FY 1998.
 - Adjust the Puerto Rico payment rate to more appropriately reflect the costs of providing hospital care.

HOME HEALTH AGENCIES

The President's plan achieves about \$14 billion in home health savings over five years.

Home health care is one of the fastest growing areas of Medicare expenditures, with a projected average annual growth rate of 10.6 percent over the period FY 1997-2002. This high growth is driven primarily by increased volume. The average number of home health visits per user increased by over 40 percent between FY 1992 and FY 1997, rising from 52 visits per user to 74 visits per user. The average payment per visit has also increased, rising from \$57 per visit in FY 1992 to an estimated \$68 per visit by FY 1997. There is widespread consensus that the high rate of growth in home health expenditures needs to be addressed. These proposals would reform the home health payment methodology by making the following changes:

- **Reform Home Health Payment.** Medicare reimburses home health agencies on a cost basis, subject to limits. However, Medicare's retrospective reimbursement rates often contribute to increased expenditures by failing to control volume. This proposal would constrain growth in expenditures through lower cost limits over the short run and implement a prospective payment system (PPS) for an appropriate unit of service for home health in 1999. Budget-neutral rates under the PPS would be calculated after reducing expenditures that exist on the last day prior to implementation by 15 percent.

Prior to PPS, this proposal would implement an interim payment system to help reduce home health costs and control volume. Beginning in FY 1998, home health agencies would be paid the lesser of: (1) the actual costs (defined as Medicare allowable costs paid on a reasonable cost basis); (2) the per visit cost limits (which would be based on 105 percent of national median costs); or (3) a new agency-specific per beneficiary annual limit calculated from 1994 reasonable costs.

- Reallocate Financing of Part of the Home Health Benefit to Part B. This proposal divides the financing of the Medicare home health benefit between Part A and Part B -- without imposing any additional beneficiary cost sharing. Under this proposal, effective in FY 1998, the first 100 visits following a three-day hospital stay would be reimbursed under Part A. All other visits, including those not following hospitalization, would be reimbursed under Part B. (Part B visits would not be subject to the Part B coinsurance or deductible; this shift also would not affect the Part B premium.) By re-creating a post-hospital home health benefit under Part A, this proposal recognizes that Part A covers services associated with inpatient hospitalization and that Part B finances the remaining home health services. Re-allocating the home health benefit in this way also extends the solvency of the Part A Trust Fund.
- Extend Savings from OBRA 1993 Home Health Cost Limits Freeze. Medicare pays for covered home health services on a cost basis, subject to limits that are updated annually. OBRA 1993 eliminated the update for the home health cost limits from July 1, 1994 to July 1, 1996. Although this proposal would not extend the freeze, future home health payments would be decreased by an amount necessary to recapture these savings as though the freeze had been extended.

FRAUD AND ABUSE

The President's plan achieves about \$9 billion in fraud and abuse savings over five years.

- Medicare as Secondary Payer (MSP). Some Medicare beneficiaries have health coverage through an employer group health plan, workers' compensation, or automobile and liability insurance. In these cases, Medicare pays after a beneficiary's primary insurer, subject to certain restrictions and conditions. The MSP provisions in the President's plan permanently extends three expiring MSP provisions, requires a beneficiary's other insurance plan to tell Medicare when that beneficiary is covered and clarifies Medicare's authority to recover certain overpayments. **These provisions save about \$8 billion over five years.**
- Close Payment Loopholes. The President's plan proposes to close a number of "payment loopholes" that lead to wasteful and abusive spending.
 - Require Consolidated Billing for SNFs, Beginning in FY 1998. The HHS Office of Inspector General and others have reported that some Part B suppliers bill Medicare for supplies that were never delivered to nursing home residents. This proposal would require SNFs to bill Medicare for almost all services their residents receive, prohibiting payment to any entity other than SNFs for services or supplies furnished to Medicare-covered beneficiaries. This proposal will reduce double billing for some supplies and services and reduce beneficiary Part

B copayments for services covered under Part A. These two proposals would cost about \$0.04 billion over five years.

-- Base Home Health Payments on Location of Service Delivery. Home health agencies (HHAs) are often established with a home office in an urban area and branches in rural areas. When HHAs bill Medicare, payment is based on the higher wage rate for the urban area, even though the service delivery occurred in a rural area. Under this proposal, payments would be based on the location where the services are *rendered*, not where the services are *billed*, beginning January 1, 1998. This proposal achieves about \$0.4 billion in savings over five years.

-- Eliminate Periodic Interim Payments (PIP) for Home Health. PIP was established to help simplify cash flow for new home health providers by paying them a set amount on a bi-weekly basis. Then, at the end of the year, PIP is reconciled with actual expenditures. But, with about 100 new HHAs joining Medicare each month, access to home health care is no longer a problem, and new providers no longer need PIP to encourage them to participate in Medicare. Further, the HHS Office of Inspector General has found that Medicare tends to overpay providers who receive PIP and has a hard time recovering the money. This proposal would eliminate PIP for home health agencies simultaneous with PPS implementation in 1999 and achieves about \$1 billion in savings over five years.

• Repeal Objectionable Fraud and Abuse Laws. The President's plan proposes to repeal current law provisions enacted as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that weaken fraud and abuse enforcement efforts. **Repealing these objectionable provisions achieves about \$0.3 billion in savings over five years.**

-- Repeal the Managed Care Exception to the Medicare and Medicaid Anti-kickback Statute. HIPAA included an exception to the Medicare and Medicaid anti-kickback statute for risk sharing arrangements (i.e., managed care plans). The HHS IG believes that this exception threatens the integrity of the Medicare program because it could allow "sham" risk sharing arrangements to meet the exception and thereby offer kickbacks for referrals.

-- Eliminate Advisory Opinions. HIPAA requires HHS and the Department of Justice (DoJ) to issue advisory opinions to providers on whether a proposed business venture violates the Medicare and Medicaid anti-kickback statute. We believe this process hinders the ability of the HHS IG and DoJ to prosecute providers who have obtained advisory opinions and who actually end up violating the anti-kickback statute (e.g., providers might obtain an advisory opinion under false pretext and then hide behind it to defraud the Medicare program).

- Reinstate Provider Requirement for Reasonable Diligence. HIPAA changed the standard that prosecutors must meet to enforce a Medicare or Medicaid civil monetary penalty (CMP). This provision makes it more difficult to impose a CMP in the Medicare program by increasing the government's burden of proof in CMP cases. The provision leads to costs because anticipated CMP recoveries assumed in the baseline will not be achieved in certain cases where the government cannot meet the new burden of proof.

PHYSICIANS AND OTHER PRACTITIONERS

The President's plan achieves about \$7 billion in net savings over five years from physicians and other practitioners.

- Establish Single Conversion Factor and Reform Method for Updating Physician Fees. When Medicare implemented physician payment reform in 1992, there was one category of physicians and one annual fee update. Congress has since created three categories of services, and each category has its own standard payment amount and annual fee update. In 1997, the standard payment amount is \$35.77 for primary care services, \$40.96 for surgical services, and \$33.85 for all other services. The Physician Payment Review Commission (PPRC) has recommended that three different standard payment amounts -- and the statutory spending target and update formulas that created them -- are inconsistent with the basic principles of the 1992 physician payment reforms.

This proposal would implement several changes consistent with the PPRC's recommendations to improve the physician payment system. First, a single standard payment amount (or "conversion factor") would go into effect on January 1, 1998. Second, the 1998 single conversion factor will be equal to the 1997 conversion factor for primary care services, updated for 1998 by a single, average fee update. Third, the formula that is used to set spending growth targets would be changed to a "sustainable growth rate" based on real GDP per capita growth plus one percentage point. The sustainable growth rate would begin affecting updates to the single conversion factor beginning in 1999. Fourth, a ceiling of 3 percentage points above medical inflation would be put on annual fee increases, and the floor on annual fee decreases would be increased from 5 percentage points to 8.25 percentage points. **This proposal achieves about \$5 billion in savings over five years.**

- Make Single Payment for Surgery. Under certain conditions, Medicare will make an extra payment for each physician or other practitioner who assists the primary surgeon during an operation. These "assistants-at-surgery" are paid a percentage of the total fee paid to the primary surgeon. In view of evidence that this practice may lead to higher costs without better outcomes, this policy will make the same payment for a surgery

regardless of whether the primary surgeon elects to use an assistant-at-surgery. **This proposal achieves about \$0.4 billion in savings over five years.**

- Create Incentives to Control High-Volume Inpatient Physician Services. Urban Institute research has found wide variation among hospitals in the volume of physician services per admission, even after adjusting for case severity, teaching hospital status, and disproportionate-share status. This proposal would create incentives to encourage physicians with high-volume inpatient practice styles to become more efficient. Effective January 1, 2000, this proposal would limit payments to groups of physicians practicing in hospitals whose volume and intensity of services per admission exceeded 125 percent of the national median for urban hospitals (125 percent in 2002 and thereafter) and 140 percent for rural hospitals. For each physician practicing in hospitals above those limits, 15 percent of each payment would be withheld during the year. If the physicians collaborate to efficiently manage the volume and intensity of the services they provide during the year, the physicians would receive the withheld payments, plus interest at the end of the year. **This proposal achieves about \$2 billion in savings over five years.**
- Direct Payment to Physician Assistants, Nurse Practitioners, and Clinical Nurse Specialists in Home and Ambulatory Care Settings. Medicare currently pays for services provided by physician assistants, nurse practitioners and clinical nurse specialists -- but only in limited settings (primarily rural areas and nursing facilities). Effective January 1, 1998, this proposal would expand coverage to include home and ambulatory care settings in which a separate facility or provider fee is not charged. **The five-year investment for this proposal is about \$0.6 billion.**
- Pay Based on Acquisition Costs Subject to a Limit for Outpatient Drugs Prescribed in Physicians' Offices. While Medicare does not have an expansive outpatient drug benefit, it does cover certain kinds of outpatient drugs, e.g., certain specific drugs that are used with home infusion or inhalation equipment and drugs that are prescribed for dialysis and organ transplant patients. Medicare typically pays for these drugs based on the charge submitted by providers, usually physicians or pharmacies. The HHS IG estimates that Medicare currently pays 15 to 30 percent more than what the provider paid for the drug. Effective January 1, 1998, this proposal would eliminate that mark-up by basing Medicare's payment on the provider's acquisition cost of the drug. As a back-stop, payments for a particular drug would not be allowed to exceed the national median cost of that drug. **This policy achieves about \$0.8 billion in savings over five years.**
- Improve Access to Chiropractic Services. If a beneficiary chooses to see a chiropractor for Medicare-covered services, Medicare currently requires that the beneficiary get an x-ray demonstrating spinal subluxation (i.e., misalignment) before beginning chiropractic spinal manipulation services. In some cases, this x-ray requirement may hinder a beneficiary's access to chiropractic services. Effective January 1, 1998, this proposal

would eliminate the pre-treatment x-ray requirement. The five-year investment for this proposal is about \$0.2 billion.

SKILLED NURSING FACILITIES

The President's plan achieves about \$7 billion in skilled nursing facility savings over five years. The SNF program is one of the fastest growing benefits, with a projected average annual growth rate of 10.5 percent over the period FY 1997-FY 2002. This high growth is driven primarily by increases in intensity of service. While the average number of days per user is fairly stable, SNF patients are receiving an increasing amount of therapy services; SNF patients incurring at least \$2,000 in therapy charges per stay increased from 12 percent in 1989 to 26 percent in 1992. Overall, reimbursement per SNF day is projected to more than double between FY 1992 and FY 1997, rising from \$151 per day to \$314 per day. Medicare SNFs are reimbursed on a cost basis, subject to certain limits. For SNFs, limits are applied only to the routine services (i.e., room and board, nursing, administration, and other overhead); ancillary (e.g., drugs, physical therapy, speech therapy) and capital-related costs are not subject to any limits. Medicare's current retrospective reimbursement rates contribute to rising expenditures by providing incentives to increase costs. The SNF proposals make the following changes in reimbursement:

- Extend Savings from OBRA 1993 SNF Cost Limits Freeze. OBRA 1993 eliminated the annual update to the SNF routine cost limits for FY 1994 and FY 1995. Although this proposal would not extend the freeze, future SNF payments would be decreased by an amount necessary to recapture these savings as though the freeze had been extended.
- Establish Per-Diem SNF PPS, Beginning in FY 1998. The prospective rate would be designed to cover all three (i.e., routine, ancillary, and capital-related) SNF costs and would be case-mix adjusted. The PPS rates would also be set in a manner that reflects the permanent capture of the savings from the OBRA 1993 freeze on SNF cost limits.

OTHER PROVIDERS

The President's plan achieves about \$2 billion in savings over five years by making a number of changes in reimbursement for a variety of other Medicare providers.

- Establish Competitive Bidding for Laboratories, Durable Medical Equipment and Other Items. The General Accounting Office and the HHS Inspector General have recommended that Medicare use more competitive strategies in managing payment for durable medical equipment and other items and supplies. Numerous reports over the past five years have indicated that private payers using competitive acquisition strategies paid 17 to 48 percent less than Medicare for certain nutritional supplements, that Medicare pays \$2.32 for surgical dressings that wholesale at 19 cents and for which VA pays 4

cents, and that Medicare pays 176 percent more than physicians for certain panels of laboratory tests. This proposal allows the Secretary to competitively bid for these and other items. **This proposal saves about \$1 billion over five years.**

- **Reduce Updates for Ambulatory Surgical Center Fees Through 2002.** Medicare pays for ambulatory surgical center (ASC) services on the basis of prospectively determined rates. These rates are updated annually for inflation using the CPI-U. OBRA 1993 eliminated updates for ASCs for FY 1994 and FY 1995. Utilization of ASC services has escalated rapidly since the mid-1980s. In addition, the number of ASC facilities has increased dramatically over the same period, suggesting that Medicare's payment rates are more than adequate to cover facility costs. This proposal would reduce the annual CPI update for ASC fees by 2 percentage points for each year between FY 1998 and 2002. **This proposal achieves about \$0.3 billion in savings over five years.**
- **Reform Payment for Certain Automated Laboratory Tests.** Medicare currently pays individually for several common laboratory tests that are typically performed as a group (or "panel" of tests) on automated equipment. This means that Medicare pays more for common tests than most private insurers pay. This proposal would add several chemistry tests to the existing list of tests that are classified and paid as automated tests. **This proposal achieves about \$0.1 billion in savings over five years.**

BENEFICIARY PREMIUMS

- **Extend Part B Premium at 25% of Program Costs.** Premiums for Part B of Medicare are specified in the Medicare law for years 1991-1995. OBRA 1993 set the Part B premium at 25 percent of SMI program costs for 1996-1998. This provision would extend the OBRA 1993 provision and permanently set Part B premiums at 25 percent of Part B program costs. **Five-year net savings from this proposal are about \$10 billion.**

BENEFICIARY INVESTMENTS

The President's plan makes a \$15 billion investment over five years to protect beneficiaries from unusually high coinsurance payment for certain services and to increase preventive health care to improve senior's health status.

- **Set an Appropriate Level of Beneficiary Coinsurance for Hospital Outpatient Department Services.** Another flaw in the reimbursement methodology for outpatient department services involves how beneficiary coinsurance payments are calculated. Because many outpatient services -- such as clinic visits, surgery, and physical therapy -- are reimbursed by Medicare based on cost, and cost is not known at the time of service delivery, copayments are calculated as 20 percent of *charges*. Because charges are significantly higher than the outpatient costs that Medicare recognizes, beneficiary coinsurance for

these services amounts to significantly more than 20 percent of the hospital's costs. In fact, beneficiaries currently make copayments of 46 percent on these outpatient services, and the percentage is rising as charges increase faster than costs. As part of the proposal to implement an OPD PPS, the President's plan proposes to "buy-down" beneficiary coinsurance to 20 percent by 2007. **The five-year investment for this proposal is about \$7 billion.**

- **Expand Preventive Benefits.** The President's plan strengthens the Medicare benefit package by expanding coverage for important preventive care, and it takes steps to encourage families to keep beneficiaries in the community and simultaneously avoid institutional costs for Medicare and Medicaid.
 - **Waive Cost-Sharing for Mammography Services.** Although Medicare's coverage of screening mammography services began in 1991, only 14 percent of eligible beneficiaries without supplemental insurance received mammograms during the first two years of the benefit. One factor is the required 20 percent coinsurance. To remove financial barriers to women seeking preventive mammograms, this proposal waives the Medicare coinsurance and the deductible, effective January 1, 1998. **The five-year investment for this proposal is about \$0.3 billion.**
 - **Expand Screening Mammography Coverage for Beneficiaries Age 65 and Over.** OBRA 1990 mandated coverage of annual screening mammography for Medicare beneficiaries age 50-64, but only biennial mammograms for those 65 and over. This proposal would cover annual screening mammograms for beneficiaries age 65 and over, effective January 1, 1998. **The five-year investment for this proposal is about \$0.4 billion.**
 - **Cover Colorectal Screening.** Effective January 1, 1998, this proposal would cover four common preventive screening procedures -- barium enemas, colonoscopy, sigmoidoscopy, and fecal-occult blood tests -- for detection of colorectal cancers. Current law provides for these procedures only as diagnostic services. Normal coinsurance and deductibles would apply. **The five-year investment for this proposal is about \$2 billion.**
 - **Increase Payments to Providers for Preventive Injections.** Effective January 1, 1998, this proposal would increase the payment for administration of Medicare-covered preventive injections, which include pneumonia, influenza, and hepatitis B vaccines. It is expected that enhanced payment will increase utilization of these vital preventive services. In addition, the Part B deductible and coinsurance would be waived for hepatitis B injections, just as it is waived currently for other injections. **The five-year investment for this proposal is about \$0.4 billion.**

The President's FY 1998 Budget: Proposals To Improve Medicare For Beneficiaries

The President's Budget includes a number of proposals that would improve the Medicare program for beneficiaries. These proposals would: expand preventive care, create a respite care benefit, make coinsurance in hospital outpatient departments affordable, improve enrollment procedures, assist disabled beneficiaries, increase Medigap options, and strengthen financial protections for managed care enrollees.

IMPROVED BENEFITS FOR PREVENTION, RESPITE CARE, AND THE FRAIL ELDERLY

o Cover Colorectal Screening

Proposal: Expand Medicare coverage to include common screening procedures for detection of colorectal cancer, subject to certain frequency limits, effective for services provided on or after January 1, 1998. Covered procedures would include barium enemas, colonoscopies, flexible sigmoidoscopies, fecal-occult blood tests, and other procedures determined appropriate by the HHS Secretary.

Rationale: Current law provides coverage of these procedures only as diagnostic services, not as routine screening purposes. This proposal would improve access to colorectal screening, thereby increasing early detection and treatment of colorectal cancer and other conditions.

o Waive Cost-Sharing for Mammography Services

Proposal: Waive payment of coinsurance and applicability of the Part B deductible for both screening and diagnostic mammograms, effective for services provided on or after January 1, 1998.

Rationale: Waiving cost-sharing would improve access to mammography, thereby increasing early detection and treatment of breast cancer and other breast conditions. Although Medicare has covered screening mammography since 1991, only 14 percent of eligible beneficiaries without supplemental insurance receive mammograms.

o Expand Screening Mammography Coverage for Beneficiaries Age 65 and Over

Proposal: Cover annual screening mammograms for beneficiaries age 65 and over, effective for services provided on or after January 1, 1998.

Rationale: Current law already provides coverage of annual screening mammograms for women ages 50-64, and those at high risk, ages 40-49. Screening mammograms for

women age 65 and over are now covered only biennially, even though breast cancer mortality increases with age. This proposal would remove this anomaly in current law and make coverage consistent with the frequency recommendations of most major breast cancer authorities.

o **Expanded Benefits for Diabetes Outpatient Self-management Training and Blood Glucose Monitoring**

Proposal: Expand coverage of diabetes outpatient self-management training to non-hospital-based programs, and expand coverage of blood glucose monitoring (including testing strips) to all diabetics, effective January 1, 1998.

Rationale: Under current law, Medicare covers diabetes outpatient self-management training only in hospital-based programs, and covers blood glucose monitoring (including testing strips) only for insulin-dependent diabetics. This proposal would expand these benefits to enable many more diabetic beneficiaries to utilize services that are crucial to managing their chronic disease.

o **Increase Payments to Providers for Preventive Injections**

Proposal: Increase payment amounts for the administration of pneumonia, influenza, and hepatitis B vaccines, and waive payment of coinsurance and applicability of the Part B deductible for hepatitis B vaccine, effective for services provided on or after January 1, 1998.

Rationale: Current law provides payment for the administration of pneumonia, influenza, and hepatitis B vaccines, and already waives payment of coinsurance and the Part B deductible for pneumonia and influenza vaccines. This proposal would improve access to adult vaccinations and make the cost-sharing waiver consistent for all types of covered vaccines.

o **Respite Benefit**

Proposal: Provide for a Medicare respite benefit for beneficiaries with Alzheimer's disease or other irreversible dementia beginning in fiscal 1998. The benefit would cover up to 32 hours of care per beneficiary per year and would be administered through home health agencies or other entities, as determined by the HHS Secretary. Services would be provided in the home or in a day care setting.

Rationale: This new benefit is not only needed, it is potentially cost-effective, since it could improve a families' ability to provide care at home rather than in an institution.

- o **PACE Demonstrations**

Proposal: Grant full permanent provider status for Program of All-inclusive Care for the Elderly (PACE) demonstration sites that currently meet the PACE protocol.

Rationale: PACE is a unique service delivery system designed to prevent the institutionalization of frail elderly.

COINSURANCE REFORM AND ENROLLMENT IMPROVEMENTS

- o **Reform Beneficiary Coinsurance for Hospital Outpatient Department Services**

Proposal: Reduce beneficiary coinsurance to 20 percent by 2007.

Rationale: Coinsurance for Part B services is generally based on Medicare's payment amount. However, for certain OPD services, coinsurance is a function of hospital charges, which are significantly higher. Combined with a flaw in the statutory formula determining Medicare's payment, this practice now makes the effective coinsurance rate for these OPD services nearly 50 percent rather than 20 percent. This proposal would address this inequitable situation, reducing the coinsurance rate to 20 percent by 2007.

- o **Part B Enrollment and Premium Surcharge**

Proposal: Replace the general enrollment period for Part B (and Part A for those beneficiaries who pay a premium) with a continuous open enrollment period. Beneficiaries could enroll in the program at any time, and coverage would begin six months after enrollment. Also, base the Part B premium surcharge for late enrollees on the actuarially determined cost of late enrollment.

Rationale: This proposal would simplify the enrollment process and eliminate the onerous nature of the current rules where some beneficiaries have to wait as long as 15 months prior to receiving coverage. The surcharge revision, while still encouraging timely enrollment, would provide particular relief to individuals who do not enroll initially in Part B. Some beneficiaries come late into Medicare, such as military retirees who receive health care from a military treatment facility that subsequently closes, and retirees whose employer group coverage is reduced or eliminated.

PROPOSALS ASSISTING DISABLED BENEFICIARIES

o Demonstration to Extend Premium-Free Part A to Working Disabled

Proposal: Establish a four-year demonstration to encourage Social Security Disability Insurance (SSDI) beneficiaries to work. During the demonstration period, certain SSDI beneficiaries would be provided premium-free Part A Medicare coverage for additional years. SSDI beneficiaries would be eligible after completion of the trial work period and extended period of eligibility.

Rationale: Despite existing work incentives in the SSDI program, fewer than one-half of one percent of beneficiaries return to substantial gainful employment annually. The fear of losing medical benefits has been identified as one of the potential barriers to SSDI beneficiaries returning to work. This demonstration is intended to test whether strengthening the existing work incentives by providing additional years of premium-free Part A Medicare coverage would encourage more SSDI beneficiaries to work.

o Definition of Durable Medical Equipment (DME)

Proposal: Modify the definition of durable medical equipment (DME) to include items needed "for essential community activities." The HHS Secretary would have the authority to limit the benefit to assure the efficient provision of items needed by the beneficiary (e.g. through the use of prior authorization of equipment).

Rationale: Under current law, DME is limited to those items appropriate for use in the home. This definition was developed in 1965, when Medicare only applied to the elderly, and beneficiaries who used DME were not expected to function outside the home. The expanded definition would encourage independent activity by permitting beneficiaries to obtain equipment necessary for them to participate in activities outside the home.

PROPOSALS RELATED TO MEDIGAP AND MANAGED CARE OPTIONS

o Pre-Existing Condition Exclusion

Proposal: Eliminate the Medigap insurer's option of imposing a six-month pre-existing condition exclusion period for initial enrollment and maintain this prohibition for as long as coverage (Medigap, managed care, or employer coverage) is maintained (with no break in coverage of 63 days).

Rationale: As a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the use of pre-existing condition exclusion periods is now limited as long as coverage is maintained. Individuals becoming eligible for Medicare and purchasing a

Medigap policy should not be subject to a pre-existing condition exclusion period. Similarly, a beneficiary changing supplemental coverage should not have to face a pre-existing condition exclusion period.

o **Open Enrollment Expansions**

Proposal: Expand open enrollment opportunities for Medigap and Medicare managed care options. All beneficiaries would have an open enrollment period when they first become eligible for Medicare. They also would have an open enrollment opportunity during an annual 30-day coordinated open enrollment period and under certain specified circumstances (for example, for beneficiaries who move).

Rationale: These expanded open enrollment opportunities would ensure that all beneficiaries have the choice of the full range of coverage options.

o **Permit Managed Care Enrollment of End-Stage Renal Disease (ESRD) Beneficiaries**

Proposal: Permit beneficiaries with ESRD to enroll in a managed care plan.

Rationale: ESRD beneficiaries should not have their coverage options limited because of their health status.

o **Managed Care Coverage for Out-of-Area Dialysis Services**

Proposal: Require managed care plans to pay for out-of-area dialysis services when an enrollee is temporarily out of the plan's service area.

Rationale: Under current law, plans are only obligated to pay for out-of-area services in two instances: emergency care and unforeseen urgent care. Since dialysis services are foreseeable, plans have no obligation to pay for them outside of their network. As a result, managed care enrollees receiving dialysis services are effectively barred from ever leaving their home town.

o **Limit Beneficiary Liability for Out-of-Network Services**

Proposal: Apply normal fee-for-service limits to the amount that non-contracting entities may charge a Medicare managed care enrollee for unauthorized out-of-network services.

Rationale: Providers should not receive a windfall from charges to beneficiaries for providing an unauthorized service outside of their managed care plan. Beneficiaries who decide to receive unauthorized services should have the same protections as beneficiaries who remain in fee-for-service Medicare.

THE PRESIDENT'S FY 1998 BUDGET: HOME HEALTH CARE REFORM

The President's budget proposes a number of initiatives to control spending in home health expenditures. It implements a prospective payment system and also takes steps to reduce fraud and abuse on home health services. Both of these proposals achieve significant savings. Finally, the budget proposes to reallocate all home health expenditures to the Part B side of program, with the exception of the post-acute portion of the benefit.

- ▶ **Expenditures for Home Health Services are Increasing Faster than for Any Other Medicare Service.**
 - ▶ **Home health care utilization has risen.** The average number of home health visits per user has grown from 26 visits in 1984 to 69 visits in 1994.
 - ▶ **Highest growth in home health services in excess of 100 visits.** The 10 percent of beneficiaries who use more than 200 home health visits per year account for over 40 percent of home health spending.
- ▶ **Implements a Prospective Payment System.** The President's budget implements payment reforms, which would modify costs and lead to separate prospective payment system for home health services. Prospective payments would reduce incentives for overutilization, save billions of dollars, and begin to bring the current double-digit rise in spending on these services under control. **This proposal would save \$14 billion over five years.**
- ▶ **Combats Fraud and Abuse in Home Health Services.** A March, 1996 GAO report on Medicare home health growth recommended that the Congress provide additional resources to HCFA to enhance enforcement controls against fraud and abuse. **The President's Fraud and Abuse initiatives would achieve approximately \$1.4 billion over five years.**
 - ▶ **Home Health Payments on Location of Service.** This proposal would require that payment be determined by the location of the service, rather than the location of the billing office. (Billing offices tend to be in urban areas where rates are higher).
 - ▶ **Eliminate Periodic Interim Payments (PIP) for Home Health.** This proposal would eliminate PIP and simultaneously phase-in a prospective payment system. PIP was initially established to help simplify cash flow for new home health providers by paying them a set amount, and reconciling PIP with actual expenditures at the end of the year.

- o However, with 100 new HHAs joining Medicare each month, access to home health is no longer a problem.
- o Further, the Office of Inspector General has found that Medicare continually overpays PIP and has a hard time recovering the money. This proposal achieves \$1 billion over five years.

▶ **Home Health Expenditure Reallocation.** Under the President's budget, the post-acute part of the budget would remain in Medicare Part A and all other home care services would be transferred from Medicare Part A to Medicare Part B. This proposal would protect Medicare beneficiaries from additional out-of-pocket costs because Part B home care services would not be subject to the 20 percent Part B coinsurance and would not be included in the Part B premium. This shift does not count towards any of the \$100 billion savings in the President's Medicare proposal.

▶ **Restores original intent of the policy.** Prior to 1980, the home health benefit was originally designed as a post-acute care service under Part A for beneficiaries who had been hospitalized. Home health care benefits were limited to 100 visits per year and could only be provided after a hospital stay of three or more days.

In 1980, Congress altered the home care benefit by eliminating the 100-visit and the 3-day hospital stay requirement. As a result of these changes, home health care has increasingly become a chronic care not linked to hospitalization. Part A now absorbs about 99 percent of the rapidly growing home health costs.

The President's proposal restores the original intent of the policy so that payments for more than 100 visits are not in Part A of the program, the part of Medicare that pays for acute -- not long-term care services. Under the proposal, the post-acute care portion of the home health benefit would remain in Part A and all other home care services would be transferred from Part A to Part B.

▶ **Protects Medicare, Without Excessive Program Cuts**

- ▶ This policy avoids the need for excessive reductions in Medicare payments to hospitals, physicians, and other health care providers, and protects beneficiaries from unjustifiable increases in premiums and other out-of-pocket expenses.
- ▶ Without this policy, Medicare's total growth for Part A would have to be constrained to 3.4 percent per year (2.2 percent per capita), according to CBO -- below the rate of inflation.
- ▶ This proposal is an integral part of the President's Medicare plan which extends the life of the Medicare Trust Fund to 2007 without imposing any new costs on beneficiaries or undermining the high quality services.

The President's FY 1998 Budget Health Care Reform Proposals

Preserving and Strengthening Medicare

- ▶ Saves approximately \$100 billion over 5 years (\$138 billion over six years), modernizes the program, and extends the life of the Trust Fund to 2007.

Restraining Growth in the Program

- ▶ Constrains payments to health plans and providers, such as managed care, hospitals, nursing homes, home health care.
- ▶ Extends current law that sets Part B premium at 25 percent of program costs.
- ▶ Combats fraud and abuse by enacting new program integrity provisions and by repealing the provisions Congress enacted last year that weaken fraud and abuse enforcement.

Improving Benefits

- ▶ Invests in preventive health care such as diabetes management, colorectal screening, annual mammograms without copayments, and increases reimbursement rates for certain immunizations to protect seniors from pneumonia, influenza, and hepatitis.
- ▶ Establishes a new respite care benefit to assist families of Medicare beneficiaries with Alzheimer's and related diseases.
- ▶ Phases down excessive outpatient copayments to the traditional 20 percent level.
- ▶ Adds Medigap protections to increase the security of Medicare beneficiaries.

Modernizing Medicare

- ▶ Provides more choices by establishing new private health plans options (such as preferred provider organizations and provider sponsored organizations).
- ▶ Establishes market-oriented purchasing for Medicare including: new prospective payment systems for home health care, nursing home care, and outpatient services; competitive pricing authority; and expanded "centers of excellence" to improve quality and reduce costs.
- ▶ Addresses flaws in Medicare's current payment methodology for managed care, which combined with a new national minimum floor, will reduce geographical variation in rates.

Protecting and Preserving Medicaid

- ▶ **Savings and Investments.** The President's proposal saves, on net, about \$9 billion over five years. It would save about \$22 billion over five years, but at the same time, it makes about \$13 billion in investments in Medicaid, including proposals to expand coverage for eligible children, and changes to last year's welfare reform law.

- ▶ **Per Capita Cap.** To stabilize Medicaid growth, the plan includes a “per capita cap,” which would constrain the rate of increase in Federal matching payments per beneficiary.
- ▶ **DSH.** Under the President’s plan, Federal payments for disproportionate share hospitals (DSH) would be tightened and States would have the flexibility to target these payments to a range of essential community providers.
- ▶ **Improved State Flexibility.** The plan contains a number of reforms, including: repealing the “Boren amendment” for hospitals and nursing homes; eliminating the Federal waiver process for States opting for managed care; and eliminating a Federal waiver for States moving populations needing long-term care from nursing homes to home- and community-based care.
- ▶ **Medicaid and Medicare for Workers with Disabilities.** The plan enables SSI beneficiaries with disabilities to keep their Medicaid when they return to work. It also includes a demonstration program that allows certain SSDI beneficiaries receiving Medicare benefits to maintain their coverage when they return to work.

Expanding Coverage for Workers Who Are In-Between Jobs

- ▶ The President’s plan includes an initiative to help provide health care coverage for workers who are in-between jobs and their families. This initiative would help an estimated 3.3 million Americans, including 700,000 children. This initiative invests \$9.8 billion over five years.
- ▶ The plan helps working families continue health insurance coverage, building on Kassebaum-Kennedy’s protections against pre-existing conditions.
- ▶ The plan gives States the flexibility to provide coverage in the way that best meets the needs of their populations.

Expanding Health Care Coverage for Children

- ▶ **Children Whose Parents are In-Between Jobs.** This initiative will provide health care coverage for 700,000 children whose parents are in-between jobs.
- ▶ **Grants to States to Expand Childrens’ Coverage.** The President’s budget provides \$750 million a year (\$3.75 billion over five years) to States to develop innovative programs to provide coverage to children.
- ▶ **Investments in Medicaid to Expand Coverage.** The plan expands coverage for children by investing in Medicaid. It:
 - Gives States the option to extend one year of continuous Medicaid coverage to all children who are determined eligible for Medicaid.
 - Proposes to work with States and the private sector to reach out to the three million children who are eligible but not enrolled for Medicaid.

HIGHLIGHTS OF THE PRESIDENT'S MEDICARE REFORM PLAN

Medicare Savings

Approximately \$100 billion over 5 years; \$138 billion over 6 years.

Medicare Trust Fund

Extends the solvency of the Trust Fund to 2007 through a combination of scorable savings and programmatic and structural changes.

Beneficiary Provisions

Extends current law that sets Part B premium at 25 percent of program costs. This policy achieves \$10 billion in savings over 5 years. The Part B premium would go below this percentage without this change after 1998; the expenditures associated with the reallocation of some home health expenditures are excluded from this calculation.

Invests in preventive health care to improve seniors' health status and reduce the incidence and costs of disease. The plan covers colorectal screening, diabetics management, and annual mammograms without copayments, and it increases reimbursement rates for certain immunizations to ensure that seniors are protected from pneumonia, influenza, and hepatitis.

Establishes a new Alzheimer's respite benefit starting in 1998 to assist families of Medicare beneficiaries with Alzheimer's and related diseases.

Buys down excessive outpatient copayments to the traditional 20 percent level. Because of a flaw in reimbursement methodology, beneficiaries now in effect contribute a 46 percent copayment. Our policy will prevent further increases in copayments and reduce the copayment to 20 percent by 2007.

Adds Medigap protections (such as new open enrollment requirements and prohibitions against the use of pre-existing condition exclusions) to increase the security of Medicare beneficiaries who wish to opt for managed care but fear they will be unable to access the Medigap policy of their choice if they decide to return to the fee-for-service plan. (This provision is consistent with bipartisan legislation pending before Congress.)

Provides new private plan choices (through new PPO and Provider Service Organization choices) for beneficiaries.

Provider Impact

Hospitals

Through a series of traditional savings (reductions in hospital updates, capital payments, etc.), achieves about \$33 billion in savings over 5 years.

Establishes new provider service organization (PSOs), which will allow hospitals (and other providers) to establish their own health care plans to compete with current Medicare HMOs.

Establishes a new pool of funding, about \$11 billion over 5 years for direct payment to academic health centers to ensure that academic health centers are compensated for teaching costs. This is funded by carving out medical education and disproportionate share (DSH) payments from the current Medicare HMO reimbursement formula.

Managed Care

Through a series of policy changes, the plan will address the flaws in Medicare's current payment methodology for managed care. Specifically the reforms will create a national floor to better assure that managed care products can be offered in low payment areas, which are predominantly rural communities. In addition, the proposal includes a blended payment methodology, which combined with the national minimum floor, will dramatically reduce geographical variations in current payment rates. Medicare will reduce reimbursement to managed care plans by approximately \$34 billion over 5 years. Savings will come from three sources:

(1) Because HMO payments are updated based on projections of national Medicare per-capita growth, when the traditional fee-for-service side of the program is reduced, HMO payments are reduced. The savings from this is \$18 billion over five years;

(2) The elimination of the medical education and DSH payments from the HMO reimbursement formula (these funds will be paid directly to academic health centers). Savings from this proposal are \$9 billion over five years; and

(3) A phased-in reduction in HMO payment rates from the current 95 percent of fee-for-service payments to 90 percent. A number of recent studies have validated earlier evidence that Medicare significantly overcompensates HMOs. The reduction does not start until 2000 and it accounts for a relatively modest \$6 billion in savings over 5 years.

Home Health Care

Saves about \$14 billion over 5 years through the transition to and establishment of a new prospective payment system.

Home Health Expenditure Reallocation

Home health care has become one of the fastest growing components of the Medicare program, growing at double digit rates. Originally designed as a post-acute care service under Part A for beneficiaries who had been hospitalized, home health care has increasingly become a chronic care benefit not linked to hospitalization. The President's proposal restores the original split of home health care payments between Parts A and B of Medicare. The first 100 home health visits following a 3-day hospitalization would be reimbursed by Part A. All other visits -- including those not following a hospitalization -- would be reimbursed by Part B.

The restoration of the original policy will not count toward the \$100 billion in savings in the President's plan. The policy avoids the need for excessive reductions in payments to hospitals, physicians, HMOs, and other health care providers while helping to extend the solvency of the Part A Trust Fund.

See additional provisions under Fraud and Abuse which save \$1.3 billion over five years.

Physicians

Saves about \$7 billion over 5 years through a modification of physician updates. This reduction is relatively small because Medicare has been relatively effective in constraining growth in reimbursement to physicians.

Skilled Nursing Facilities

Saves about \$7 billion over 5 years through the establishment of a prospective payment system.

Fraud and Abuse

Saves about \$9 billion over 5 years through a series of provisions to combat fraud and abuse in areas such as home health care, by requiring insurers to provide information about insurance coverage of beneficiaries, and by repealing the provisions Congress enacted last year that weaken fraud and abuse enforcement.

Structural Reform

Brings the Medicare program into the 21st century by:

- (1) Establishing new private health plan options (such as PPOs and Provider Service Networks) for the program;
- (2) Establishing annual open enrollment for all Medicare plans within independent third-party consumer consulting.
- (3) Establishing market-oriented purchasing for Medicare including the new prospective payment systems for home health care, nursing home care, and outpatient hospital services, as well as competitive bidding authority and the use of centers of excellence to improve quality and cut back on costs;
- (4) Adding new Medigap protections to make it possible for beneficiaries to switch back from a managed care plan to traditional Medicare without being underwritten by insurers for private supplemental insurance coverage. This should encourage more beneficiaries to opt for managed care because it addresses the fear that such a choice would lock them in forever.

Rural Health Care

The plan will have a very strong package of rural health care initiatives, including continuation and improvement of sole community hospital, Medicare dependent hospital, and rural referral center protections. the expansion of the Rural Primary Care Hospital program that allow for designation of and reimbursement to facilities that are not full-service hospitals, and the modification of managed care payments to ensure they are adequate for rural settings. The rural hospital investment alone is \$1 billion over 5 years.

**Medicare for Workers'
with Disabilities**

The President's budget authorizes a demonstration which enables SSDI beneficiaries to return to work without losing their health care coverage. Under the demonstration, certain SSDI beneficiaries who return to work would be able to maintain their Part A coverage.

HIGHLIGHTS OF THE PRESIDENT'S MEDICAID REFORM PLAN

Medicaid Savings and Investments

The President's plan saves approximately \$9 billion net of new investments over 5 years.

Through a combination of policies to reduce and target spending on disproportionate share hospitals (DSH) more effectively and establish a per-beneficiary limit on future Medicaid growth, the plan would save \$22 billion over five years.

Roughly two-thirds of the savings comes from a reduction in Disproportionate Share Hospital (DSH) payments and roughly one-third from the per capita cap.

In addition, the President's plan invests \$13 billion in improvements to Medicaid, including health initiatives to expand coverage for children, changes to last year's welfare reform law, and new policies to help people with disabilities return to work.

Guarantee of Coverage

The 37 million children, pregnant women, people with disabilities, and older Americans who are currently covered by Medicaid would retain their Federal guarantee of health care coverage for a meaningful set of benefits.

Per Capita Cap

Even though the overall Medicaid baseline has fallen over the past few years, Medicaid spending growth is still expected to increase by over 8 percent annually after the year 2000. To stabilize Medicaid growth, the President's budget would set a per capita cap on Medicaid spending. The cap would constrain the rate of increase in Federal matching payments per beneficiary.

The per capita cap protects States facing population growth or economic downturns because it ensures that Federal dollars are linked with beneficiaries.

DSH Payments

Federal DSH payments would be tightened without undermining the important role these funds play for providers that serve a disproportionate number of low-income and Medicaid beneficiaries.

Improved State Flexibility

The President's plan incorporates the highest-priority State flexibility requests advocated by the National Governors' Association. It:

- Repeals the "Boren amendment" for hospitals and nursing homes, to allow States more flexibility to negotiate provider payment rates;
- Eliminates Federal waiver process for States opting for managed care; and
- Allows States to serve people needing long-term care in home- and community-based settings without Federal waivers, and a number of other initiatives.

Improves Quality Standards

The President's plan maintains existing Federal standards and enforcement for nursing homes and institutions for people with mental retardation and developmental disabilities. Quality standards for managed care systems would be updated and enhanced.

Expanded Coverage for Children

The President's plan includes measures to enhance coverage for Medicaid-eligible children. It:

- Provides continuous coverage for children: The President's budget provides States with the option to extend 12 months of continuous Medicaid coverage, guaranteeing more stable coverage for children and reducing the administrative burden on Medicaid officials, providers, and families.
- Encourages outreach to help more children receive Medicaid: The Administration will work with States to develop innovative ways to reach and sign up for Medicaid some of the 3 million children who are eligible for Medicaid but are not currently enrolled.

Modifications to Welfare Reform Law

The President's plan includes provisions to ameliorate some of the effects of the welfare reform law, including:

- Exempting disabled immigrants from the ban on SSI benefits to ensure they retain their Medicaid benefits.
- Exempting immigrant children and disabled immigrants from the bans on Medicaid benefits for immigrants, and from the new “deeming” requirements that mandated that the income and resources of an immigrant’s sponsor be counted when determining program eligibility.
- Extending from 5 to 7 years the exemption from the Medicaid bans and deeming requirements for refugees and asylees.
- Retaining Medicaid coverage for disabled children currently receiving Medicaid who lose their Supplemental Security Income (SSI) benefit because of changes in the definition of childhood disability.

Provision to Help Workers with Disabilities

The President’s plan recognizes that many people with disabilities want to work but they face significant barriers. The plan would help people with disabilities return to work risking their health care coverage. As a State option, SSI beneficiaries with disabilities who earn more than certain amounts could keep Medicaid. They would contribute to the cost of coverage on their income rises.

HIGHLIGHTS OF THE PRESIDENT'S INITIATIVES TO MAINTAIN AND EXPAND WORKERS' COVERAGE

Because most Americans have employment-based health insurance, health care coverage is often jeopardized for workers who change jobs. In fact, over 50 percent of the uninsured lost their health insurance due to a job change. Many of these uninsured Americans are the spouses and children of workers. The President's initiative will provide temporary premium assistance to families with workers who are in-between jobs. For millions of these workers and their families this assistance could make it possible for them to maintain their health care coverage while looking for another job. This initiative is fully paid for within the President's FY 1998 balanced budget plan. In addition, to assist small businesses - which often have more difficulty providing and maintaining health care coverage for their workers -- the President has proposed to help States create voluntary purchasing cooperatives.

Funding

Invests \$9.8 billion over the budget window and is paid for in the President's FY1998 balanced budget.

Eligibility

Helps an estimated 3.3 million Americans in 1998, including about 700,000 children.

- A full subsidy would be provided up to 100% of the poverty level for and would be phased out at 240% of the poverty level.
- To assure that limited federal dollars are cost-effectively targeted, individuals who are eligible for Medicare, Medicaid or who have an employed spouse with coverage, are not eligible for this program.
- While low-income workers would certainly be helped by this benefit, over half of participants would come from families who previously had incomes over \$30,000, for a family of four.

Coverage for Families of Workers Who Are In-Between Jobs

Helps to assure that Kassebaum-Kennedy protections against pre-existing conditions are not placed at risk because of breaks in insurance coverage. It achieves this goal by helping working families retain their health coverage through premium assistance during a time in which they lose much of their income.

Gives States the flexibility to provide coverage in ways that best meets the needs of their populations. States would have flexibility to administer their own programs, (e.g., COBRA, a private insurance product, Medicaid, or an alternative means of coverage).

Voluntary Purchasing Cooperatives

Small businesses have more difficulty providing health care coverage for their workers because they have higher per capita costs due to increased risk and because of extraordinarily high administrative costs.

The President's budget will make it easier for small businesses to provide health care coverage for their employees, by allowing them to band together to reduce their risks, lower administrative costs, and improve their purchasing power with insurance companies.

His budget proposes to empower small businesses to access and purchase more affordable health insurance through the use of voluntary health purchasing cooperatives. This will be accomplished by providing \$25 million a year in grants that States can use for technical assistance, by setting up voluntary purchasing cooperatives, and by allowing these purchasing cooperatives to access to Federal Employees Health Benefit Plans.

HIGHLIGHTS OF THE PRESIDENT'S CHILDREN'S HEALTH INITIATIVES

In 1995, more than 10 million American children had no health insurance. Eighty percent (8 million) of the ten million uninsured children have a parent who is a worker. Many uninsured children have parents who earn too much for Medicaid but too little to afford private coverage, and an estimated three million children are eligible, but not enrolled in Medicaid. The President's plan helps these groups of uninsured children by working with States, communities, advocacy groups, providers, and businesses to expand coverage. Combined with the scheduled Medicaid phase-in of older children, HHS estimates that the President's plan would provide coverage for as many as five million children by the year 2000.

Assistance for Children Whose Parents Are In-Between Jobs

The President's plan includes an initiative to assist workers who are in-between jobs and their families maintain health coverage. The program will cost \$9.8 billion over five years, and will help an estimated 3.3 million Americans, including 700,000 children.

This initiative provides funding to States to cover the children of workers who are temporarily in-between jobs. The program would help those families who had employer-based coverage in their prior jobs.

The plan would give States flexibility to administer their own programs (e.g., through Medicaid, COBRA, or an independent program).

Grants to States to Expand Children's Coverage

The President's plan provides \$750 million a year in grants to States (\$3.8 billion over FY 1998-2002) that will build on successful State children's programs like those in Pennsylvania, Washington, Minnesota, and Florida, to identify and provide coverage for uninsured children.

Under the President's plan, States could work with insurers, providers, employers, schools, and others to develop innovative programs to provide coverage to children.

In addition to covering children who fall through the gaps, these new State grants may help identify and enroll children eligible for Medicaid.

Investments to Expand Medicaid Coverage

The President's plan invests in Medicaid to provide better coverage for eligible children. It:

Provides one year of continuous Medicaid coverage to children. The President's budget give States the option to extend 12 months of continuous Medicaid coverage to all children who are determined eligible for Medicaid.

Currently, many children receive Medicaid protection for only part of the year. This is because Federal law requires that a family that has a change in income or some other factor affecting eligibility report it immediately, possibly making them ineligible for Medicaid.

This provision will benefit families who will have the security of knowing that their children will be covered by Medicaid for a full year. It will also help States by reducing administrative costs, and managed care plans, by enabling them to better coordinate care.

Encourages outreach. The President's plan proposes to work with the States, communities, advocacy groups, providers, and businesses to extend Medicaid coverage to the three million children who are eligible for Medicaid but are not currently enrolled.

The President's FY 1998 Budget: Medicare Structural Reforms in the President's Budget

The President's Budget modernizes Medicare and brings it into the 21st century through a number of major structural changes.

FEE-FOR-SERVICE PAYMENT REFORM

- **Building on the success of prospective payment for inpatient hospital, the President's Budget would move to prospective payment systems for:**
 - **Skilled nursing facilities (SNFs).** Driven primarily by increases in intensity of services, SNF care is one of the fastest growing Medicare benefits. The budget would establish a per-diem SNF prospective payment system beginning in 1998, which would reimburse for all costs (routine, ancillary, and capital).
 - **Home health services.** Medicare's current reimbursement system does not help control volume, contributing to the increasingly high expenditures in this area. The President's budget implements a prospective payment system in 1999, which pays home health agencies based on characteristics of the patients, not on how many services agencies provide. In the mean time, while the prospective payment system is being developed the President's budget improves the current system to reduce overutilization.
 - **Hospital outpatient departments (OPDs).**
 - Implements prospective payment system.** OPDs are still paid, in part, on a cost basis. The President's budget would move to a prospective payment system for these services starting in 1999, which for the first time, would create incentives for efficiencies not present in a cost-based system.
 - Addresses the current inequity in coinsurance for hospital outpatient fees.** There is a significant flaw in the reimbursement methodology for OPDs involving the calculation of beneficiary coinsurance. Since coinsurance is a function of hospital charges and since charges are significantly greater than Medicare's payment rates, beneficiaries pay nearly a 50-percent copayment for outpatient department services, as oppose to the 20-percent rate beneficiaries typically pay for other Part B services. The President's proposal assures that by 2007, coinsurance will be reduced to the traditional 20-percent level.

IMPLEMENT SUCCESSFUL PURCHASING APPROACHES

- **Adopts approaches to purchasing health care services that have proved successful in other areas.** The following approaches to purchasing health care services have been used successfully by the private sector and other Federal and State purchasers and have been tested under Medicare's demonstration authority.
 - **Centers of Excellence.** Since 1991, the Health Care Financing Administration has been conducting a demonstration that pays facilities a single flat fee to provide all diagnostic and physician services associated with coronary artery bypass graft (CABG) surgery. Medicare has achieved an average of 12 percent savings for the CABG. Using this proposal would make the "centers of excellence" a permanent part of Medicare expanding it to include other heart procedures, knee surgery, and hip replacement surgery.
 - **Competitive Bidding.** To help implement more competitive strategies in managing payment for durable medical equipment, laboratories, and other items and supplies, the President's proposal would establish competitive bidding for these items.
 - **Purchasing Through Global Payments.** This enables the Secretary to selectively contract with providers and suppliers to receive global payments for a package of services for a specific condition or need of an individual. Providers would be selected on the basis of their ability to provide high quality services, to improve coordination of care, and to offer additional benefits. Beneficiaries would voluntarily elect on a month-to-month basis to participate in such an arrangement.
 - **Flexible Purchasing Authority.** This authorizes the Secretary to negotiate alternative administrative arrangements, excluding changes in quality standards or conditions of participation, with providers who agree to provide price discounts to Medicare. Savings from these arrangements could be given directly to the beneficiaries who use them, e.g. through reduced deductibles and copays.

MANAGED CARE PAYMENT REFORMS

The President's Budget would reform the payment methodology for managed care plans.

- **Addresses flaws in payment methodology for managed care.** The reforms will create a national floor to better assure that managed care products can be offered in low payment areas, which are predominantly in rural communities. In addition, the proposal includes a blended payment methodology, which combined with the national minimum floor, will reduce geographical variation in current payment rates.

- **Carves out GME, IME, and DSH payments from managed care.** Eliminates medical education and disproportionate share hospital payments from the HMO reimbursement formula and provides this money directly to teaching and disproportionate share hospitals for managed care enrollees.
- **Adjusts payment rates to reduce Medicare's current overpayment to managed care plans.** Currently, this overpayment exists because managed care enrollees are typically healthier than Medicare beneficiaries who remain in fee-for-service. This is a temporary adjustment until we implement a risk-adjusted payment system which is expected to be in place by no later than 2002.

NEW CHOICES FOR BENEFICIARIES

- **Establishes new private health plan options.** The budget increases the number of plans -- including Preferred Provider Organizations and Provider Sponsored Organizations -- available to seniors and people with disabilities. These options will meet strong quality standards and include consumer protections. The plans would be required to compete on cost and quality, not on the health status of enrollees.
- **Replaces 50/50 rule with quality measurement system.** The Secretary, in consultation with consumers and the industry, will develop a system for quality measurement. Once this system is in place, the current requirement for managed care plans to maintain a level of private enrollment at least equal to the public program enrollment will be eliminated.
- **Provides beneficiaries with comparative information to help them choose the plan that best meets their needs.** Similar to information provided under FEHBP, this proposal would enable beneficiaries to examine and compare all of the information about their coverage options.
- **Develops a process with the National Association of Insurance Commissioners to better standardize benefits.** This proposal creates a process to standardize some of the additional benefits provided by managed care plans and revises standard Medigap packages so that Medicare beneficiaries can make an "apples to apples" comparison when evaluating their coverage options.
- **Guarantees that beneficiaries can enroll in community-rated Medigap plans annually without being subject to preexisting condition exclusions.** These new Medigap protections would make it possible for beneficiaries to switch back from a managed care plan to traditional Medicare without being underwritten by insurers for private supplemental insurance coverage. This should encourage more beneficiaries to choose managed care plans because they would be assured that they could always go back to fee-for-service.

The President's FY 1998 Budget: Proposals To Improve Medicare For Beneficiaries

The President's Budget includes a number of proposals that would improve the Medicare program for beneficiaries. These proposals would: expand preventive care, create a respite care benefit, make coinsurance in hospital outpatient departments affordable, improve enrollment procedures, assist disabled beneficiaries, increase Medigap options, and strengthen financial protections for managed care enrollees.

IMPROVED BENEFITS FOR PREVENTION, RESPITE CARE, AND THE FRAIL ELDERLY

o Cover Colorectal Screening

Proposal: Expand Medicare coverage to include common screening procedures for detection of colorectal cancer, subject to certain frequency limits, effective for services provided on or after January 1, 1998. Covered procedures would include barium enemas, colonoscopies, flexible sigmoidoscopies, fecal-occult blood tests, and other procedures determined appropriate by the HHS Secretary.

Rationale: Current law provides coverage of these procedures only as diagnostic services, not as routine screening purposes. This proposal would improve access to colorectal screening, thereby increasing early detection and treatment of colorectal cancer and other conditions.

o Waive Cost-Sharing for Mammography Services

Proposal: Waive payment of coinsurance and applicability of the Part B deductible for both screening and diagnostic mammograms, effective for services provided on or after January 1, 1998.

Rationale: Waiving cost-sharing would improve access to mammography, thereby increasing early detection and treatment of breast cancer and other breast conditions. Although Medicare has covered screening mammography since 1991, only 14 percent of eligible beneficiaries without supplemental insurance receive mammograms.

o Expand Screening Mammography Coverage for Beneficiaries Age 65 and Over

Proposal: Cover annual screening mammograms for beneficiaries age 65 and over, effective for services provided on or after January 1, 1998.

Rationale: Current law already provides coverage of annual screening mammograms for women ages 50-64, and those at high risk, ages 40-49. Screening mammograms for

women age 65 and over are now covered only biennially, even though breast cancer mortality increases with age. This proposal would remove this anomaly in current law and make coverage consistent with the frequency recommendations of most major breast cancer authorities.

o **Expanded Benefits for Diabetes Outpatient Self-management Training and Blood Glucose Monitoring**

Proposal: Expand coverage of diabetes outpatient self-management training to non-hospital-based programs, and expand coverage of blood glucose monitoring (including testing strips) to all diabetics, effective January 1, 1998.

Rationale: Under current law, Medicare covers diabetes outpatient self-management training only in hospital-based programs, and covers blood glucose monitoring (including testing strips) only for insulin-dependent diabetics. This proposal would expand these benefits to enable many more diabetic beneficiaries to utilize services that are crucial to managing their chronic disease.

o **Increase Payments to Providers for Preventive Injections**

Proposal: Increase payment amounts for the administration of pneumonia, influenza, and hepatitis B vaccines, and waive payment of coinsurance and applicability of the Part B deductible for hepatitis B vaccine, effective for services provided on or after January 1, 1998.

Rationale: Current law provides payment for the administration of pneumonia, influenza, and hepatitis B vaccines, and already waives payment of coinsurance and the Part B deductible for pneumonia and influenza vaccines. This proposal would improve access to adult vaccinations and make the cost-sharing waiver consistent for all types of covered vaccines.

o **Respite Benefit**

Proposal: Provide for a Medicare respite benefit for beneficiaries with Alzheimer's disease or other irreversible dementia beginning in fiscal 1998. The benefit would cover up to 32 hours of care per beneficiary per year and would be administered through home health agencies or other entities, as determined by the HHS Secretary. Services would be provided in the home or in a day care setting.

Rationale: This new benefit is not only needed, it is potentially cost-effective, since it could improve a families' ability to provide care at home rather than in an institution.

o **PACE Demonstrations**

Proposal: Grant full permanent provider status for Program of All-inclusive Care for the Elderly (PACE) demonstration sites that currently meet the PACE protocol.

Rationale: PACE is a unique service delivery system designed to prevent the institutionalization of frail elderly.

COINSURANCE REFORM AND ENROLLMENT IMPROVEMENTS

o **Reform Beneficiary Coinsurance for Hospital Outpatient Department Services**

Proposal: Reduce beneficiary coinsurance to 20 percent by 2007.

Rationale: Coinsurance for Part B services is generally based on Medicare's payment amount. However, for certain OPD services, coinsurance is a function of hospital charges, which are significantly higher. Combined with a flaw in the statutory formula determining Medicare's payment, this practice now makes the effective coinsurance rate for these OPD services nearly 50 percent rather than 20 percent. This proposal would address this inequitable situation, reducing the coinsurance rate to 20 percent by 2007.

o **Part B Enrollment and Premium Surcharge**

Proposal: Replace the general enrollment period for Part B (and Part A for those beneficiaries who pay a premium) with a continuous open enrollment period. Beneficiaries could enroll in the program at any time, and coverage would begin six months after enrollment. Also, base the Part B premium surcharge for late enrollees on the actuarially determined cost of late enrollment.

Rationale: This proposal would simplify the enrollment process and eliminate the onerous nature of the current rules where some beneficiaries have to wait as long as 15 months prior to receiving coverage. The surcharge revision, while still encouraging timely enrollment, would provide particular relief to individuals who do not enroll initially in Part B. Some beneficiaries come late into Medicare, such as military retirees who receive health care from a military treatment facility that subsequently closes, and retirees whose employer group coverage is reduced or eliminated.

PROPOSALS ASSISTING DISABLED BENEFICIARIES

o Demonstration to Extend Premium-Free Part A to Working Disabled

Proposal: Establish a four-year demonstration to encourage Social Security Disability Insurance (SSDI) beneficiaries to work. During the demonstration period, certain SSDI beneficiaries would be provided premium-free Part A Medicare coverage for additional years. SSDI beneficiaries would be eligible after completion of the trial work period and extended period of eligibility.

Rationale: Despite existing work incentives in the SSDI program, fewer than one-half of one percent of beneficiaries return to substantial gainful employment annually. The fear of losing medical benefits has been identified as one of the potential barriers to SSDI beneficiaries returning to work. This demonstration is intended to test whether strengthening the existing work incentives by providing additional years of premium-free Part A Medicare coverage would encourage more SSDI beneficiaries to work.

o Definition of Durable Medical Equipment (DME)

Proposal: Modify the definition of durable medical equipment (DME) to include items needed "for essential community activities." The HHS Secretary would have the authority to limit the benefit to assure the efficient provision of items needed by the beneficiary (e.g. through the use of prior authorization of equipment).

Rationale: Under current law, DME is limited to those items appropriate for use in the home. This definition was developed in 1965, when Medicare only applied to the elderly, and beneficiaries who used DME were not expected to function outside the home. The expanded definition would encourage independent activity by permitting beneficiaries to obtain equipment necessary for them to participate in activities outside the home.

PROPOSALS RELATED TO MEDIGAP AND MANAGED CARE OPTIONS

o Pre-Existing Condition Exclusion

Proposal: Eliminate the Medigap insurer's option of imposing a six-month pre-existing condition exclusion period for initial enrollment and maintain this prohibition for as long as coverage (Medigap, managed care, or employer coverage) is maintained (with no break in coverage of 63 days).

Rationale: As a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the use of pre-existing condition exclusion periods is now limited as long as coverage is maintained. Individuals becoming eligible for Medicare and purchasing a

Medigap policy should not be subject to a pre-existing condition exclusion period. Similarly, a beneficiary changing supplemental coverage should not have to face a pre-existing condition exclusion period.

o **Open Enrollment Expansions**

Proposal: Expand open enrollment opportunities for Medigap and Medicare managed care options. All beneficiaries would have an open enrollment period when they first become eligible for Medicare. They also would have an open enrollment opportunity during an annual 30-day coordinated open enrollment period and under certain specified circumstances (for example, for beneficiaries who move).

Rationale: These expanded open enrollment opportunities would ensure that all beneficiaries have the choice of the full range of coverage options.

o **Permit Managed Care Enrollment of End-Stage Renal Disease (ESRD) Beneficiaries**

Proposal: Permit beneficiaries with ESRD to enroll in a managed care plan.

Rationale: ESRD beneficiaries should not have their coverage options limited because of their health status.

o **Managed Care Coverage for Out-of-Area Dialysis Services**

Proposal: Require managed care plans to pay for out-of-area dialysis services when an enrollee is temporarily out of the plan's service area.

Rationale: Under current law, plans are only obligated to pay for out-of-area services in two instances: emergency care and unforeseen urgent care. Since dialysis services are foreseeable, plans have no obligation to pay for them outside of their network. As a result, managed care enrollees receiving dialysis services are effectively barred from ever leaving their home town.

o **Limit Beneficiary Liability for Out-of-Network Services**

Proposal: Apply normal fee-for-service limits to the amount that non-contracting entities may charge a Medicare managed care enrollee for unauthorized out-of-network services.

Rationale: Providers should not receive a windfall from charges to beneficiaries for providing an unauthorized service outside of their managed care plan. Beneficiaries who decide to receive unauthorized services should have the same protections as beneficiaries who remain in fee-for-service Medicare.

THE PRESIDENT'S FY 1998 BUDGET: HOME HEALTH CARE REFORM

The President's budget proposes a number of initiatives to control spending in home health expenditures. It implements a prospective payment system and also takes steps to reduce fraud and abuse on home health services. Both of these proposals achieve significant savings. Finally, the budget proposes to reallocate all home health expenditures to the Part B side of program, with the exception of the post-acute portion of the benefit.

- ▶ **Expenditures for Home Health Services are Increasing Faster than for Any Other Medicare Service.**
 - ▶ **Home health care utilization has risen.** The average number of home health visits per user has grown from 26 visits in 1984 to 69 visits in 1994.
 - ▶ **Highest growth in home health services in excess of 100 visits.** The 10 percent of beneficiaries who use more than 200 home health visits per year account for over 40 percent of home health spending.
- ▶ **Implements a Prospective Payment System.** The President's budget implements payment reforms, which would modify costs and lead to separate prospective payment system for home health services. Prospective payments would reduce incentives for overutilization, save billions of dollars, and begin to bring the current double-digit rise in spending on these services under control. **This proposal would save \$14 billion over five years.**
- ▶ **Combats Fraud and Abuse in Home Health Services.** A March, 1996 GAO report on Medicare home health growth recommended that the Congress provide additional resources to HCFA to enhance enforcement controls against fraud and abuse. **The President's Fraud and Abuse initiatives would achieve approximately \$1.4 billion over five years.**
 - ▶ **Home Health Payments on Location of Service.** This proposal would require that payment be determined by the location of the service, rather than the location of the billing office. (Billing offices tend to be in urban areas where rates are higher).
 - ▶ **Eliminate Periodic Interim Payments (PIP) for Home Health.** This proposal would eliminate PIP and simultaneously phase-in a prospective payment system. PIP was initially established to help simplify cash flow for new home health providers by paying them a set amount, and reconciling PIP with actual expenditures at the end of the year.

- o However, with 100 new HHAs joining Medicare each month, access to home health is no longer a problem.
- o Further, the Office of Inspector General has found that Medicare continually overpays PIP and has a hard time recovering the money. This proposal achieves \$1 billion over five years.

▶ **Home Health Expenditure Reallocation.** Under the President's budget, the post-acute part of the budget would remain in Medicare Part A and all other home care services would be transferred from Medicare Part A to Medicare Part B. This proposal would protect Medicare beneficiaries from additional out-of-pocket costs because Part B home care services would not be subject to the 20 percent Part B coinsurance and would not be included in the Part B premium. This shift does not count towards any of the \$100 billion savings in the President's Medicare proposal.

- ▶ **Restores original intent of the policy.** Prior to 1980, the home health benefit was originally designed as a post-acute care service under Part A for beneficiaries who had been hospitalized. Home health care benefits were limited to 100 visits per year and could only be provided after a hospital stay of three or more days.

In 1980, Congress altered the home care benefit by eliminating the 100-visit and the 3-day hospital stay requirement. As a result of these changes, home health care has increasingly become a chronic care not linked to hospitalization. Part A now absorbs about 99 percent of the rapidly growing home health costs.

The President's proposal restores the original intent of the policy so that payments for more than 100 visits are not in Part A of the program, the part of Medicare that pays for acute -- not long-term care services. Under the proposal, the post-acute care portion of the home health benefit would remain in Part A and all other home care services would be transferred from Part A to Part B.

- ▶ **Protects Medicare, Without Excessive Program Cuts**

- ▶ This policy avoids the need for excessive reductions in Medicare payments to hospitals, physicians, and other health care providers, and protects beneficiaries from unjustifiable increases in premiums and other out-of-pocket expenses.
- ▶ Without this policy, Medicare's total growth for Part A would have to be constrained to 3.4 percent per year (2.2 percent per capita), according to CBO -- below the rate of inflation.
- ▶ This proposal is an integral part of the President's Medicare plan which extends the life of the Medicare Trust Fund to 2007 without imposing any new costs on beneficiaries or undermining the high quality services.

**PRESIDENT'S FY 98 BUDGET
LEGISLATIVE PROPOSALS**

**MEDICARE PROPOSALS FOR BENEFICIARY IMPROVEMENTS,
MODERNIZING MEDICARE, AND FRAUD AND ABUSE
(Proposals With No Budget Impact)**

AND

**MEDICAID PROPOSALS FOR STATE FLEXIBILITY
AND NEW INVESTMENTS**

FEBRUARY 11, 1997

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- o PACE Demonstrations
- o Extend Social HMO for Three Years

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- o Limits on Charges for Out-of-Network Services
- o Coverage for Out-of -Area Dialysis Services
- o Clarification of Coverage for Emergency Services
- o Permit States with Programs Approved by the Secretary to Have Primary Oversight Responsibility
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- o Permit Collection of Fees from Entities Requesting Initial Participation in Medicare
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- o Modify upper payment limit for capitation rates
- o Convert managed care waivers (1915(b)) to State Plan Amendments
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- o Allow nominal copayments for HMO enrollees

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- o Convert Home and Community Based Waivers (1915(c)) to State Plan Amendments
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- o Permit waiver of prohibition of nurse aide training programs in certain facilities
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- o Allow SSI beneficiaries who earn more than the 1619(b) thresholds to buy into Medicaid -
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(Proposals with no Budgetary Impact)

February 11, 1997

Beneficiary Improvements

Program Improvements

o Definition of DME

Modify the definition of DME to include items needed "for essential community activities". The Secretary would have the authority to limit the benefit to assure the efficient provision of items needed by the beneficiary (e.g. through the use of prior authorization of equipment). Under current law, durable medical equipment (DME) is limited to those items appropriate for use in the home. This definition was developed in 1965, when Medicare only applied to the elderly, and beneficiaries who used DME were not expected to function outside the home. The expanded definition will encourage independent activity by disabled beneficiaries.

o PACE Demonstrations

Grant full permanent provider status for Program of All-inclusive Care for the Elderly (PACE) demonstration sites that currently meet the PACE protocol. PACE has proven to be a successful model for a unique service delivery system for frail-elderly persons who live in the community.

o Extend Social Health Maintenance Organization (SHMO) Demonstrations

Extend both the first and second generation of SHMO demonstrations until December 31, 2000. SHMOs enroll a cross-section of the elderly living in community and provide standard Medicare benefits, together with limited long-term care benefits. These congressionally-mandated demonstrations are currently set to expire on December 31, 1997. A three-year extension would provide additional time to evaluate this delivery model.

Choice

Medicare Managed Care

o **Permit Enrollment of ESRD Beneficiaries**

Permit beneficiaries with ESRD to enroll in a managed care plan. Currently, while beneficiaries who develop ESRD can stay enrolled in a plan, beneficiaries with ESRD are prohibited from enrolling. ESRD beneficiaries should not have their coverage options limited because of their health status.

o **Limits on Charges for Out-of-Network Services**

Expand current limits on charges to plans by non-contracting entities for authorized services. Limits which now apply in the case of inpatient hospital, SNF, physician and dialysis services would apply in regard to all services for which there is a fee schedule or limit under fee-for-service Medicare. Apply these same limits to unauthorized, out-of-network services. Providers should not have a windfall payment as a result of providing an authorized or unauthorized service to a Medicare beneficiary enrolled in a managed care plan. Beneficiaries who decide to receive unauthorized services should have the same protections as beneficiaries who remain in fee-for-service Medicare.

o **Coverage for Out-of-Area Dialysis Services**

Require plans to pay for out-of-area dialysis services when an enrollee is temporarily out of the plan's service area. Under current law, plans are only obligated to pay for out-of-area services in two instances: emergency care and urgent care. Since services such as dialysis are foreseeable, plans have no obligation to pay for them. As a result, managed care enrollees with ESRD are effectively barred from ever leaving their home town.

o **Clarification of Coverage for Emergency Services**

Clarify the obligation of managed care plans to pay for emergency services provided to their plan's enrollees (whether through the plan or by a non-plan provider) by defining "emergency services" as services that a "prudent layperson" would, from his or her perspective, reasonably believe were needed immediately to prevent serious harm to his or her health. This clarification of Medicare policy will be helpful to states as they determine what requirements should apply in regard to emergency services provided to commercial managed care enrollees.

o **Permit States with Programs Approved by the Secretary to Have Primary Oversight Responsibility**

Authorize States, with programs approved by the Secretary, to certify whether a plan is eligible to contract with Medicare and to monitor certain aspects of plan performance. Such certification and monitoring would be subject to Federal standards. The Secretary would retain final authority in regard to contracting and compliance actions. User fees would be collected from plans for both the certification and monitoring activities. Effective 1/1/98. The proposal would eliminate certain duplication of effort that exists between States' traditional licencing role and HCFA oversight of managed care contractors.

o **Modify Termination and Sanction Authority**

Authorize the Secretary to terminate a contract prior to a hearing in cases where the health and safety of Medicare beneficiaries are at-risk. Delete requirement for corrective action plans and for hearing and appeals prior to imposing intermediate sanctions. Conform sanctions options add by the existing sanction authority. When the health and safety of beneficiaries is at risk, HCFA should not be required to hold a hearing prior to terminating a contract. In regard to intermediate sanctions, HCFA already provides plans with the opportunity to respond to findings that the plan has committed an act subject to an intermediate sanction. Requiring a hearing and an appeal in all instances, however, would unnecessarily hinder enforcement actions.

Improved Quality

Accreditation

o **Modify the "Deemed Status" Provisions for Hospitals to Require that the JCAHO Demonstrate that All of the Applicable Hospital Conditions are Met or Exceeded and to Enhance Monitoring and Enforcement of Compliance**

This would require the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) to demonstrate that, under its accreditation process and standards, accredited hospitals meet or exceed all federal health and safety standards (called the Medicare "conditions of participation"). Further, the JCAHO would be required to enforce compliance with the standards and monitor those entities that are found out of compliance. Under current law, hospitals that receive JCAHO accreditation are automatically deemed to have met Medicare conditions of participation and the Secretary has no statutory authority to require the JCAHO to monitor compliance. The Omnibus Consolidated Rescissions and Appropriations Act of 1996 raised the standards for deemed status of other (non-hospital) providers by authorizing the Secretary to grant Medicare deemed status to providers if the accrediting body has demonstrated to the

Secretary that a provider category meets or exceeds all of the Medicare conditions and requirements. This proposal would bring hospital "deemed status" requirements in line with deeming requirements for other providers.

o **Permit the Secretary to Disclose Accreditation Survey Data from Accrediting Organizations for Purposes Other than Enforcement**

This would broaden the instances when the Secretary may disclose accreditation survey information to include instances where the Secretary deems disclosure to be in the interests of beneficiary safety, quality of care, and program integrity. Under current law, the Secretary may not publicly disclose any accreditation survey result unless the information relates to an enforcement action taken by the Secretary. Such limited authority restricts the Secretary from fully safeguarding quality.

Survey and Certification

o **Permit Collection of Fees from Entities Requesting Initial Participation in Medicare**

This would permit the Secretary to charge entities (including dually-participating Medicare/Medicaid providers but excluding clinical labs under CLIA) a fee for the initial survey required for participation in the Medicare program. Under this new authority, HCFA would charge fees through its agreements with State survey agencies. As HCFA's agents, States would collect and retain these fees and apply them to their survey costs. HCFA's survey and certification budget has been held constant since 1993, while the number of entities seeking to enter the Medicare program has grown dramatically each year. This under-funding has forced HCFA to prioritize State survey workloads and has resulted in extensive delays of initial certification surveys. This proposal would allow a greater number of providers to enter the Medicare program in a timely fashion, thereby enhancing beneficiary access to, and choice of, providers. In addition, program certification allows providers to derive a financial benefit from participating in Medicare and Medicaid. Charging for initial program participation surveys is consistent with the fee-based approach for other government services.

o **Create Authority for an Integrated Quality Management System Across HCFA Programs (Medicare and Medicaid)**

This proposal would provide for a uniform authority for all Medicare and Medicaid quality management activities. A re-engineered, integrated quality management approach would include, but not be limited to: authorities for data collection, quality conditions, enforcement, publication of provider-level data, user fees, deeming flexibility, and designated accountability. Prior to full implementation of an integrated quality management system, HCFA would test out various models through demonstrations. For the last five years, HCFA has been building the foundations of a truly re-engineered

approach to survey and certification activities, which creates a new conceptual framework and reshapes many operational features of the current system and breaks through current limitations. HCFA would like to test this re-engineering concept through a demonstration.

Managed Care

o Privately Accredited Plans Deemed to Meet Internal Quality Assurance Standards

Authorize the Secretary to deem plans with private accreditation as meeting internal quality assurance requirement. This proposal, without reducing Federal standards, would eliminate certain duplication of effort that exists between private accrediting organizations' review of plans internal quality assurance programs and HCFA's own efforts.

o Replace 50/50 Rule with Quality Measurement System

Eliminate the current requirement that managed care plans maintain a level of commercial enrollment at least equal to public program enrollment, once the Secretary, in consultation with the consumers and the industry, develops a system for quality measurement. Authorize the Secretary to terminate plans that do not meet standards under the quality measurement system. Until the quality measurement system is in place, expand the Secretary's waiver authority for 50/50 (e.g., plans with good track records). The Administration believes that the 50/50 rule should be retained until an adequate quality measurement system is in place. This system, once in place, should drive contracting decisions.

Nurse Aide Training

o Permit Waiver of Prohibition of Nurse Aide Training and Competency Evaluation Programs in Certain Facilities and Clarify that the Trigger for Disapproval of Nurse Aide or Home Health Aide Training and Competency Evaluation Programs is Substandard Quality of Care (Medicare and Medicaid)

This would allow States to waive the prohibition on nurse aide training and competency evaluation programs offered in (but not by) a SNF or Medicaid NF if the State: (1) determines that there is no other such program offered within a reasonable distance of the facility; (2) assures, through an oversight effort, that an adequate environment exists for operating the program in the facility; and (3) provides notice of such determination and assurances to the State long-term care ombudsman. The proposal would also make clear that a survey finding substandard quality of care, rather than the mere occurrence of an extended or partial extended survey is what triggers the sanction of the training program. The current prohibition on nurse aide training and competency evaluation programs causes a special problem for rural nursing home where a community college or other training

facility may be inaccessible to nurse aides. This proposal would safeguard the availability of nursing homes which might otherwise stop participation in Medicare and Medicaid as a result of losing a training program's approval. This proposal is also a part of the Vice-President's "Reinventing Government" initiative. A clarification of the circumstances under which a program must be sanctioned is needed because the fact that an extended or partial extended survey is conducted is not, in itself, an indication that substandard quality of care exists in the SNF, NF, or HHA.

STRUCTURAL REFORM – MODERNIZING MEDICARE

Prudent Purchasing

Post-Acute Payment Reform

o Secretarial Authority to Create Integrated Post Acute Care Payment System, and to Collect Assessment Data

This would signal the Administration's intention to develop, in the future, a fully integrated payment system for all post-acute care services (including SNFs, HHAs, rehabilitation and long-term care hospitals). It would give the Secretary the authority to implement, through regulations, a single payment system that includes (at a minimum) a case-mix adjustment mechanism predicated on a standard core patient assessment instrument; equitable payment among provider types; budget neutrality to post-acute payments in some base year; and geographic adjustments. The uniform payment system would be built upon the prospective payment system for home health and an expanded PPS for SNF that more appropriately reflects costs across all post-acute inpatient settings, including the higher intensity of service in rehabilitation and long-term care hospitals. It would authorize the Secretary to collect any and all data, on a national basis, that would be necessary to implement such a system. There is considerable overlap in the types of services provided and the types of beneficiaries that are treated in each of the post-acute settings. Despite this overlap, Medicare's current payment and coverage rules vary by setting and may create perverse incentives to treat patients in one setting rather than another in order to maximize reimbursement. A "site-neutral" integrated post-acute care payment would help to ensure that beneficiaries receive high quality care in the appropriate settings. This system would ensure that reimbursement is sufficient for all patient types, including high intensity patients who in the current environment are cared for in rehabilitation hospitals. In addition, any transfers among settings occur only when medically appropriate and not in an effort to generate additional revenues. A consistent patient classification system would allow meaningful comparisons of the diagnoses, severity, and functional limitations of patients in all these settings; permit case-mix adjustment for payment purposes; and permit greater coordination of care. ProPAC has cited the perverse incentives that currently operate under separate and distinct payment methods for post-acute care services.

Beneficiary-Centered Purchasing

In general, provide the Secretary with authority to pay on the basis of special arrangements as opposed to statutorily-determined, administered prices. This proposal has five components which are fully described below: Centers of Excellence; Competitive Bidding; Global Payments; Flexible Purchasing Authority; and Inherent Reasonableness Authority. Two years after enactment, and annually thereafter for the next three years, the Secretary would report to Congress by March 1st on the use of these new authorities, including the impacts on program expenditures and on the access and quality of services received by beneficiaries.

- + **Centers of Excellence** - Authorize the Secretary to pay selected facilities a single rate for all services (including potentially post-acute services) associated with a surgical procedure or hospital admission related to a medical condition, specified by the Secretary (The Secretary would be required by January 1, 1999 to establish Centers of Excellence for CABG surgery, other cardiac procedures and for hip and knee replacements across the country). Selected facilities would have to meet special quality standards. The single rate paid to a Center would have to represent a savings to the program. There would be no requirement for beneficiaries to receive services at Centers. However, Centers would be allowed, subject to approval by the Secretary, to provide additional services (such as private room) or other incentives (waiver of cost-sharing) to attract beneficiaries.
- + **Competitive Bidding Authority** - Authorize the Secretary to set payment rates for Part B services (excluding physician services) specified by the Secretary based on competitive bidding. The items included in a bidding process and the geographic areas selected for bidding would be determined by the Secretary based on the availability of entities able to furnish the item or services and the potential for achieving savings. Bids would be accepted from entities only if they met quality standards specified by the Secretary. The Secretary would have the authority to exclude suppliers whose bid was above the cut off bid determined sufficient to maintain access. Automatic reductions in rates for would be triggered for clinical laboratory services and DMEPOS (excluding oxygen services) if by 2001 a 20 percent reduction had not been achieved.
- + **Purchasing Through Global Payments** - Authorize the Secretary to selectively contract with providers and suppliers to receive global payments for a package of services directed at a specific condition or need of an individual (e.g. diabetes, congestive heart failure, frail elderly, cognitively or functionally impaired, need for DME). The Secretary would select providers on the basis of their ability to provide high quality services efficiently, to improve coordination of care (e.g. disease management, case management), and to offer additional benefits to beneficiaries (e.g. prescription drugs, respite, nutritional counseling, adaptive and assistive

equipment, transportation.) Within the global payment, providers would have flexibility in how services are provided, and they may, subject to approval by the Secretary, offer additional, non-covered benefits financed through the global payment. The global rate would have to represent a savings to the program. Beneficiaries would voluntarily elect on a month-to-month basis to participate in such arrangements and during that period would be "locked-in" for the services covered under the arrangement.

- + **Flexible Purchasing Authority** - Authorize the Secretary, after rulemaking, to negotiate alternative administrative arrangements with providers, suppliers and physicians who agree to provide price discounts to Medicare. These discounts could be based on current fee schedules or payment rates or could involve alternative payment methods. The alternative administrative arrangements could not include any changes to quality standards or conditions of participation. The Secretary would have the authority to permit sharing of these savings with beneficiaries who use these entities - - for example, through a reduced deductible in the case of hospital services or lower coinsurance payments in the case of other services.
- + **Inherent Reasonableness Authority** - Restore Medicare's carriers authority to make "inherent reasonableness" payment changes for durable medical equipment, prosthetics and orthotics (DMEPOS) as well as surgical dressings.

Medicare's statutory framework was based on a Blue Cross/Blue Shield model from the 60's. Although payment methodologies have improved over time, current payment authority is too rigid for the fee-for-service program to meet the challenges of the 21st century. Each component of this initiative represents an approach that has been used successfully by the private sector, other government program or under Medicare's demonstration authority.

Contracting Reform

o Reform Contracting for FIs and Carriers

This proposal would end the requirement that all Medicare contractors perform all Medicare administrative activities, and would allow Medicare to contract with entities other than insurance companies. New contractors would be awarded contracts using the same competitive requirements that apply throughout the government. The proposal would give HCFA the tools to take advantage of innovations and efficiencies in the private sector when it comes to beneficiary and provider services, and claims processing. It builds on the Medicare Integrity Program contracting changes established in HIPAA.

Improving Efficiency and Eliminating Overpayments

Hospitals

o Hold-Harmless for DSH

Freeze hospital-specific disproportionate share hospital (DSH) adjustments at current levels, for a period of 2 years. Require the Secretary to submit a legislative proposal to Congress by 18 months after enactment for revised qualifying criteria and payment methodology for hospitals that incur higher Medicare costs because they serve a disproportionate share of low-income patients. Without action by FY 2000, the old (current) formula would be reinstated. The current formula for identifying DSH hospitals relies on counting the number of days the hospital serves Medicare/SSI beneficiaries (as a proportion of total Medicare days) and the number of days it serves Medicaid beneficiaries (as a proportion of total days). The resulting "DSH percentage" is plugged into a formula that computes the increase in Medicare payments for DSH hospitals.

However, this measure is becoming increasingly unreliable. The recently enacted welfare reform law will have an impact both on the number of people eligible for SSI and the number of people eligible for Medicaid but not necessarily on the number of low-income individuals seeking hospital care. Furthermore, as the number of uninsured Americans increases, the reliability of this measure to reflect the a hospital's level of uncompensated care decreases. Concurrently, HCFA has lost a series of court cases on the DSH formula, resulting in varying definitions of "eligible Medicaid days" across the country. By freezing the current DSH levels for the next two years, the level of support for DSH hospitals will be sustained while the Secretary develops a proposal to refine the DSH criteria and adjustment.

Part B Issues

o Replace "Reasonable Charge" Methodology (and "Reasonable Cost" Methodology for Ambulances) with Fee Schedules

Create fee schedules, on a budget neutral basis, for the few Part B services still paid according to "reasonable charge" methodology (the most significant services affected would be ambulances, and enteral and parenteral nutrition). Specify that ambulance services provided by hospitals or "under arrangements" would also be covered by the new ambulance fee schedule, with adjustments allowed for certain "core services" that may have higher costs. This proposal will make the payment methodology consistent for all Part B services and improve administrative efficiency. Including hospital based ambulance services under the fee schedule will remove incentives for independent suppliers to evade fee schedule limits by establishing costlier arrangements with hospitals.

FRAUD AND ABUSE

o Clarify the Definition of "Homebound"

This would redefine the "homebound" definition by adding several calendar month benchmarks to emphasize that home health coverage is only available to those who are truly unable to leave the home. The current definition of "confined to the home" is vague and over broad. It allows for considerable discretion in interpretation and fraud and abuse. Financial reviews show that Medicare routinely reimburses care to beneficiaries who are not truly homebound. Without a more concrete definition, this eligibility requirement is very difficult to enforce. The March 1996 GAO report cites the problematic homebound definition as contributing to excessive spending and fraud and abuse.

o Provide Secretarial Authority to Make Payment Denials Based on Normative Service Standards

This proposal would allow the HHS Secretary to establish normative numbers of visits for specific conditions or situations. For example, HCFA could establish a normative number of aide visits for a particular condition, and deny payment for those visits that exceed this standard. Allowing the Secretary to establish more objective criteria will help HCFA gain more control over excessive utilization. A March 1996 GAO report criticizes current statutory coverage criteria as leaving too much room for interpretation and inviting fraud and abuse.

o Requirement to Provide Diagnostic Information

Extend to non-physician practitioners, the current requirement that physicians provide diagnostic information on all claims for services that they provide. Also require physicians and non-physician practitioners to provide information to document medical necessity for items or services ordered by the physician or practitioner, when such documentation is required by the Medicare contractor as a condition for payment for the item or service. Diagnostic information is needed by Medicare's contractors to determine the medical necessity of physician services and for use in quality/outcome research. Given the need for this data, there is no reason to exclude non-physician practitioners from the current requirement to include diagnostic codes on claims forms. Also, in regard to non-physician services and DMEPOS items, suppliers providing the services and items ordered by physicians or non-physician practitioners have reported having difficulty obtaining diagnostic information required by Medicare's contractors. This proposal will clarify that the ordering physician or non-physician practitioners is required to provide such information.

MEDICAID FY 1998 PROPOSALS

STATE FLEXIBILITY AND NEW INVESTMENTS

PROMOTING STATE FLEXIBILITY

Increase Flexibility in Provider Payment

o **Repeal Boren Amendment**

Repeal the Boren amendment for hospitals and nursing homes, while establishing a clear and simple public notice process for rate setting for both hospitals and nursing homes.

Modify the process for determining payment rates for hospitals, nursing facilities and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) to add a public notification process that provides an opportunity for review and comment, which should result in more mutually agreeable rates.

o **Eliminate cost-based reimbursement for health clinics**

Federal requirements that most Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) be paid based on costs would be removed beginning in 1999; and a capped, temporary funding pool would be established to help these facilities during the transition.

Increase Flexibility in Program Eligibility

o **Allow Budget Neutral eligibility simplification and enrollment expansion**

Enable States to expand or simplify eligibility to cover individuals up to 150 percent of the Federal poverty level through a simplified and expedited procedure. Current rules would be retained to the extent they are needed to ensure coverage for those who do not meet the eligibility criteria of the new option. Federal spending would be restrained by the per capita cap for current eligibles and such expansions would be approved only if they were demonstrated to be cost neutral (i.e. no credit for persons who were not otherwise Medicaid eligible in the determination of cap number).

This proposal enables States to expand to new groups that are not eligible under current law without a Federal waiver. Administration would be streamlined and simplified in that States would be able to use the same eligibility rules for everyone eligible under the new percent-of-poverty option in place of the current plethora of different rules for different groups. Integrity of Federal spending limits would be maintained by the cost neutrality requirement.

o **Guarantee eligibility for 12 months for children**

This proposal would permit States to provide 12-month continuous Medicaid eligibility for children ages 1 and older. (Continuous coverage was enacted for infants by OBRA 90.)

This proposal would provide stable health care coverage for children – particularly children in families with incomes close to the eligibility income limits, who often lose eligibility for a month due to an extra pay period within a month. This proposal would also reduce State administrative burden by requiring fewer eligibility determinations.

Eliminate Unnecessary Administrative Requirements

o **Eliminate OB/Peds physician qualification requirements**

Federal requirements related to payment for obstetrical and pediatric services would be repealed. States would only have to certify providers serving pregnant women and children based on their State licensure requirements

The minimum provider qualification requirements under current law do not effectively address quality of care. In addition, current law fails to recognize all bodies of specialty certification, so certain providers are precluded from participation in Medicaid (e.g., foreign medical graduates). Congress amended the law in 1996 to include providers certified by the American Osteopathic Association and emergency room physicians.

o **Eliminate annual State reporting requirements for certain providers**

States would no longer have to submit reports regarding payment rates and beneficiary access to obstetricians and pediatricians.

Current law assumes that access is linked to payment rates. However, the State-reported data do not reveal much regarding the link between payment rates and access.

o **Eliminate Federal requirements on private health insurance purchasing**

Eliminate requirement that States pay for private health insurance premiums for Medicaid beneficiaries where cost-effective.

The current law provision is not necessary. States have an inherent incentive to move Medicaid beneficiaries into private health insurance where it is cost-effective. The proposed per capita spending limits increase this incentive. The current, detailed, one-size-fits-all Federal rules hinder States from designing programs that most effectively suit local circumstances.

o **Simplify computer systems requirements**

Eliminate detailed Federal standards for computer systems design. State systems would be held to general performance parameters for electronic claims processing and information retrieval systems.

Current detailed requirements for system design were developed for an earlier time in which technology was primitive and detailed Federal rules were necessary to move States closer to what was then state-of-the-art. This is no longer the case. It is now sufficient to require States merely to show that their State-designed system meets performance standards established under an outcome-oriented measurement process.

o **Reduce unnecessary personnel requirements**

We would work with States and State employees to replace the current, excessively detailed, and ineffective Federal rules regarding administrative issues that are properly under the purview of States, such as personnel standards, and training of sub-professional staff.

Increase Flexibility Regarding Managed Care

o **Modify upper payment limit for capitation rates**

Modify upper payment limit and actuarial soundness standards for capitation rates to better reflect historical managed care costs by requiring actuarial review of the rates.

The current Medicaid upper payment limit for managed care contracts (i.e., 100% of fee-for-service) is not an accurate payment measurement for Medicaid managed care plans. It does not reflect historical managed care costs and States claim it is inadequate to attract plans to participate. This proposal would modify the definition of the UPL to more accurately reflect Medicaid spending. It would also modify actuarial soundness standards.

o **Convert managed care waivers [1915(b)(1)] to State Plan Amendments**

Permit mandatory enrollment in managed care without federal waivers. States would be able to require enrollment in managed care without applying for a freedom of choice waiver [1915(b)(1)]. States would be allowed to establish mandate enrollment managed care programs through a State plan amendment. Qualified IHS, tribal, and urban Indian organization providers would be guaranteed the right to participate in State managed care networks.

This proposal would provide States greater flexibility in administering their State Medicaid programs by eliminating the freedom-of-choice waiver application process. States would not have to submit applications for implementation or renewal. The Administration is pursuing strategies to assure quality in Medicaid managed care that are more effective and less burdensome than the assurances added through the waiver process. Guaranteeing urban Indian organization providers the right to participate in State Medicaid managed

care networks integrates ITUs into managed care delivery systems and recognizes their unique health delivery role.

o **Modify Quality Assurance with new data collection authority while eliminating 75/25 enrollment composition rule**

Replace the current enrollment composition rule with a new quality data monitoring system under a beneficiary purchasing strategy with new data collection authority.

As part of the continuous effort to ensure Medicaid managed care beneficiaries receive quality care, HCFA proposes to implement a "beneficiary-centered purchasing" (BCP) strategy. BCP will replace certain current federal managed care contract requirements. The current enrollment composition rule (i.e., 75/25 rule) requires that no more than 75 percent of the enrollment can be Medicare and Medicaid beneficiaries. The current requirement is a process-related, ineffective proxy for quality. This requirement would be replaced with a quality monitoring system based on standardized performance measures.

HCFA, in collaboration with States, would define and prioritize a new standard set of program performance indicators, including a new quality monitoring system. These measures would be used to quantify and compare plans' quality of care, provide purchasers and beneficiaries with the means to hold plans accountable, and provide HCFA with comparable data to compare the performance of State programs to effectively hold States accountable as well.

This proposal would enhance the Secretary's ability to ensure that beneficiaries' interests are being protected as enrollment in managed care increases, and to detect and correct possible abuses by managed care plans. A more outcome oriented quality review process is vital to the Federal and State oversight of managed care plans to ensure that Medicaid beneficiaries are receiving the highest quality care possible. Data would be vital to the success of such an effort.

o **Change threshold for federal review of contracts**

Raise the threshold for the federal review of managed care contracts from the current \$100,000 threshold to \$1 million contract amount (or base threshold for federal review on lives covered by plan).

This proposal would provide greater State flexibility in management and oversight of Medicaid managed care programs. It would also reduce the number of managed care plan contracts requiring HCFA review and approval.

o **Nominal copayments for HMO enrollees**

Permit States to impose nominal copayments on HMO enrollees.

This proposal would bring policy on Medicaid copayments for HMO enrollees more in line with Medicaid copayments that a State may elect to impose in fee-for service settings. It would also allow HMOs to treat Medicaid enrollees in a manner similar to how they treat non-Medicaid enrollees. However, impact on beneficiaries would not be harmful since copayments, if imposed, would still have to be nominal.

Increase Flexibility Regarding Long-Term Care

o **Convert Home and Community Based Waivers (1915(c)) to State Plan Amendments**

Give States the option to create a home and community-based services program without a Federal waiver, through a State plan amendment. This proposal would benefit States and beneficiaries by eliminating the constant and costly necessity of renewing the waivers, while ensuring a high level of care.

o **Increase the Medicaid Federal financial participation rate from 75 percent to 85 for nursing home Survey and Certification activities**

Raise the Medicaid Federal financial participation (FFP) rate to 85 percent.

Federal funding is important to maintain both quality standards established by OBRA 87 and resulting enforcement activities. Increasing the Medicaid federal financial participation percentage to 85 percent would encourage States to increase total spending on nursing home survey and certification activities.

o **Permit waiver of prohibition of nurse aide training and competency evaluation programs in certain facilities. Clarify that the trigger for disapproval of nurse aide or home health aide training and competency evaluation programs is substandard quality of care (Medicare and Medicaid).**

This would allow States to waive the prohibition on nurse aide training and competency evaluation programs offered in (but not by) a SNF or Medicaid NF if the State: (1) determines that there is no other such program offered within a reasonable distance of the facility; (2) assures, through an oversight effort, that an adequate environment exists for operating the program in the facility; and (3) provides notice of such determination and assurances to the State long-term care ombudsman. The proposal would also make clear that a survey finding substandard quality of care, rather than the mere occurrence of an extended or partial extended survey is what triggers the sanction of the training program.

The current prohibition on nurse aide training and competency evaluation programs causes a special problem for rural nursing home where a community college or other training facility may be inaccessible to nurse aides. This proposal would safeguard the availability of nursing homes which might otherwise stop participation in Medicare and Medicaid as a

result of losing a training program's approval. This proposal is also a part of the Vice-President's Reinventing Government initiative. A clarification of the circumstances under which a program must be sanctioned is needed because the fact that an extended or partial extended survey is conducted is not, in itself, an indication that substandard quality of care exists in the SNF, NF, or HHA.

o **Eliminate repayment requirement for alternative remedies for nursing home sanctions**

Eliminate the requirement for repayment of federal funds received if a State chooses to use alternative remedies to correct deficiencies rather than termination of program participation.

This proposal would allow States to promote compliance by employing alternative remedies on nursing facilities. This provision for alternative remedies gives States the flexibility for more creative implementation of the enforcement regulations.

o **Delete Inspection of Care requirements in mental hospitals and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)**

Eliminate the duplicative requirement for Inspection of Care (IOC) reviews in mental hospitals and ICFs/MR. The survey and certification reviews that currently take place in mental hospitals and ICFs/MR would remain in place.

Inspection of Care (IOC) reviews were originally designed to ensure that Medicaid recipients were not being forgotten in long term care facilities. The current survey process has been improved through a new outcome-oriented process that protects recipients in mental hospitals and ICFs/MR from improper treatment. Consequently, IOC reviews are no longer needed and are, in fact, in direct conflict with the revised ICF/MR survey protocol. The current requirement for two reviews (IOC and the ICF/MR survey) has become duplicative. If the IOC were eliminated, the ICF/MR survey and certification process would remain in place.

o **Alternative sanctions in Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)**

Provide for alternative sanctions in ICFs/MR that already are available for nursing homes. Alternative sanctions that currently are available in nursing homes include: directed in-service training, directed plan of correction, denial of payment for new admissions, civil monetary penalties and temporary management.

Sanctions other than immediate termination were established for nursing homes under the OBRA-87 legislation, but not for ICFs/MR. This proposal would extend the alternative sanction option to ICFs/MR.

SPECIAL POPULATIONS

- o **Allow SSI beneficiaries who earn more than the 1619(b) thresholds to buy into Medicaid**

This proposal would give States the option of creating a new eligibility category for disabled persons to encourage them to work beyond the 1619(b) income thresholds. SSI beneficiaries who become eligible for this new category would contribute to the cost of the program by paying a premium. Premium levels would be on a sliding scale, based on the individual's income as determined by the States.

Despite existing work incentives in SSI, fewer than 1/2 of 1 percent of beneficiaries return to substantial gainful employment annually. The fear of losing medical benefits has been identified as one of the most significant barriers to disabled beneficiaries returning to work or working for the first time. Under this proposal, Medicaid would be used to extend access to coverage for the working disabled who no longer qualify for health care benefits under current law.

- o **Grant Programs for All inclusive Care for the Elderly (PACE) permanent provider status**

Grant full permanent provider status for Program of All-inclusive Care for the Elderly (PACE) demonstration sites that currently meet the PACE protocol. PACE has proven to be a successful model for a unique service delivery system for frail-elderly persons who live in the community.

IMPROVEMENTS RELATED TO WELFARE REFORM

Disabled Beneficiaries

- o **Retain Medicaid for current disabled children who lose SSI**

Medicaid would be retained for children currently receiving Medicaid who lose their Supplemental Security Income (SSI) benefits because of changes in the definition of disability.

Most of these children would requalify for Medicaid by meeting another eligibility category either by meeting other SSI disability listings or other Medicaid categories for non-disabled low-income children. Those who do not, and who would be grandfathered under this proposal, continue to have relatively extensive health and developmental needs which would not be met if these children lost their Medicaid coverage.

Immigrants

- o **Exempt certain disabled individuals from the ban on SSI cash assistance**

This proposal exempts immigrants who become disabled after entering this country from the recently enacted ban on SSI cash assistance for "qualified aliens", and ensures that they would retain their Medicaid benefits. The exemption would apply to immigrants who were already here on the date of enactment as well as to new arrivals.

This proposal allows States to continue providing SSI and Medicaid benefits to immigrants who become disabled and who would otherwise be cut off due to welfare reform. It protects those who can no longer be expected to work due to circumstances beyond their control.

o **Exempt immigrant children and certain disabled immigrants from the Medicaid bans and deeming requirements**

This proposal would exempt immigrant children and immigrants who are disabled after entering this country from the bans on Medicaid benefits for current and future immigrants. Immigrant children and immigrants disabled after entry would also be exempt from the new deeming requirements that mandate that the income and resources of an immigrant's sponsor be counted when determining Medicaid eligibility.

These proposals assist the most vulnerable groups of immigrants for whom lack of access to medical care may produce long-term negative consequences and whose medical care may result from an unexpected injury or illness that occurs after their arrival.

o **Extend the Exemption for Refugees/Asylees from 5 to 7 Years**

This proposal would extend the exemption from Medicaid bans and deeming requirements for refugees and asylees by an additional 2 years for a total of 7 years.

Protection of refugees and asylees has been a consistent feature of U.S. immigration policy. Refugees and asylees often face challenges that other immigrants do not because of persecution. Extending the exemption for an additional two years allows for these unique circumstances and possible difficulties these individuals may have in becoming self-sufficient. In addition, more recent populations have included larger numbers of elderly individuals, who may take a longer time to adjust to new circumstances.

STRENGTHENING FINANCIAL ACCOUNTABILITY

o Establish a Federal Payment Commission

Establish a commission to review equity among the States in Medicaid financing formula (FMAP), as well as the base year and growth rates in the per capita spending limits.

The formula for determining the Federal and State contribution to the Medicaid program, which is based on per capita income in a State, has long been criticized as failing to adequately reflect State variations in their ability to raise revenues and in magnitude of State need. An impartial commission could make recommendations for a more refined formula. Similarly, once the per capita cap has an established track record, an impartial commission would make recommendations for further improvements to improve equity across States.

o Strengthen Medicaid Eligibility Quality Control (MEQC)

Modify and strengthen Medicaid Eligibility Quality Control (MEQC) system. Under a per capita cap limit on spending where Federal funding is tied to the number of beneficiaries in a State, it would become more important than ever to ensure Federal matching payments are provided to States only for their spending on people who actually meet the State's eligibility criteria. The current MEQC system is the appropriate tool for this task, but it must be modified to accommodate and measure population components of the per capita cap. States would have a reasonable error tolerance limit of three percent of enrollments, which is similar to the current tolerance limit.

o Increase Federal Payment Cap for Puerto Rico

Increase the Federal Medicaid payment cap for Puerto Rico by \$30 M, \$40 M, \$50 M, \$60 M, and \$70 M over current law for FY 1998-2002 respectively.

Federal matching for the Puerto Rico has always been capped, but at amounts determined by Congress unrelated to impartial measures of need in the Puerto Rico or their ability to contribute a share of program costs. Beginning after 1994, Federal payments are increased every year by the medical component of the CPI, but continue not to take population factors into account. Given underlying eligibility structure in Puerto Rico it would not be appropriate to apply per beneficiary Federal spending limits to Puerto Rico. Nevertheless, some adjustment for population is called for in Puerto Rico, which has had a demonstrated need for Medicaid funding beyond its cap for a number of years.

o Increase Federal payment to District of Columbia

Increase the Federal payment to the District of Columbia by changing the Federal matching rate from 50 percent to 70 percent.

This proposal would change the District's share of the costs of health care services under Medicaid from 50 percent to 30 percent. This equals the maximum amount that the District, as a local government, could be required to contribute if it were located within a State.

Cost Estimates for FY98 President's Budget Medicaid Proposals

	Cost(Savgs) in \$bill					FY98-02
	FY1998	FY1999	FY2000	FY2001	FY2002	Total
Welfare Reform Legislative Changes						
Exempt disabled from SSI ban	0.395	0.455	0.473	0.496	0.484	2.303
Exempt disabled from 5-yr ban/deeming	0.206	0.312	0.466	0.649	0.774	2.407
Exempt children from 5-yr ban/deeming	0.013	0.021	0.031	0.044	0.052	0.161
Extend refugee/asylee exemption	0.005	0.005	0.005	0.005	0.005	0.025
Sub-Total - Welfare	0.619	0.793	0.975	1.194	1.315	4.896
Children's Health Initiatives						
State Partnership Demos- MCD Outreach Impact	0.062	0.130	0.227	0.349	0.368	1.135
12-mo Continuous Eligibility for Children	0.282	0.458	0.708	1.014	1.162	3.623
Sub-Total - Children	0.344	0.587	0.934	1.362	1.530	4.758
Other Proposals						
Increase DC FMAP to 70%	0.156	0.169	0.182	0.197	0.213	0.918
Increase Payments to Puerto Rico	0.030	0.040	0.050	0.060	0.070	0.250
Extension of VA Sunset	0.000	0.300	0.300	0.300	0.300	1.200
Working Disabled	0.000	0.001	0.003	0.007	0.009	0.020
Retain MCD for curr disab children who lose SSI	0.075	0.070	0.065	0.065	0.060	0.335
Impact of Medicare Proposals						
Part B Premium	-0.012	0.050	0.136	0.243	0.385	0.801
Subtotal - Other Initiatives	0.250	0.629	0.737	0.872	1.037	3.524
GRAND TOTAL	1.213	2.009	2.646	3.428	3.882	13.178

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