

Section 10308. Advisory Opinions Regarding Certain Physician Self-Referral Provisions

Current Law. Section 1877 of the Social Security Act establishes a ban on certain financial arrangements between a referring physician and an entity. Specifically, if a physician (or immediate family member) has an ownership or investment interest in or a compensation arrangement with an entity, the physician is prohibited from making certain referrals to the entity for services for which Medicare would otherwise pay.

Explanation of Provision. The provision would require the Secretary of HHS to issue written advisory opinions concerning whether a physician referral relating to designated health services (other than clinical laboratory services) is prohibited under Section 1877 of the Social Security Act. Such opinions would be binding as to the Secretary and the party requesting the opinion. To the extent practicable, the Secretary is to apply the regulations issued under the advisory opinion provisions of Section 1128D of the Social Security Act to the issuance of advisory opinions under this provision.

Section 10309. Other Fraud and Abuse Related Provisions

Current Law. Section 1128D provides for safe harbors, advisory opinions, and fraud alerts as guidance regarding application of health care fraud and abuse sanctions. Section 1128E of the Social Security Act directs the Secretary of HHS to establish a national health care fraud and abuse data collection program for the reporting of final adverse actions against health care providers, suppliers, or practitioners.

Explanation of Provision. The provision would make certain technical changes in provisions added by the Health Insurance Portability and Accountability Act of 1996. The provision would also provide that mandatory and permissive exclusions under Section 1128 apply to any Federal health care program, defined as any program providing health benefits, whether directly or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the Federal Employees Health Benefits Program). A new provision is added to the health care fraud and abuse data collection program to provide a civil money penalty of up to \$25,000 to be imposed against a health plan that fails to report information on an adverse action required to be reported under this program. The Secretary would also publicize those government agencies which fail to report information on adverse actions as required.

The change in the federal programs under which a person may be excluded under Section 1128 of the Social Security Act would be effective on the date of enactment of this Act. The sanction provision for failure to report adverse action information as required under Section 1128E of the Social Security Act would apply to failures occurring on or after the date of the enactment of this Act. The other amendments made by this section would be effective as if included in the enactment of the Health Insurance Portability and Accountability Act of 1996.

SUBTITLE E - PROSPECTIVE PAYMENT SYSTEMS

CHAPTER 1 - PAYMENT UNDER PART A

Section 10401. Prospective Payment for Skilled Nursing Facility (SNF) Services

Current Law. Currently Medicare reimburses the great bulk of SNF care on a retrospective cost-based basis. This means that SNFs are paid after services are delivered for the reasonable costs (as defined by the program) they have incurred for the care they provide. For Medicare reimbursement purposes, the costs SNFs incur for providing services to beneficiaries can be divided into three major categories: (1) routine services costs that include nursing, room and board, administration, and other overhead; (2) ancillary services, such as physical and occupational therapy and speech language pathology, laboratory services, drugs, supplies and other equipment; and (3) capital-related costs.

Routine costs are subject to national average per diem limits. Separate per diem routine cost limits are established for freestanding and hospital-based SNFs by urban or rural area. Freestanding SNF routine limits are set at 112% of the average per diem labor-related and nonlabor-related costs. Hospital-based SNF limits are set at the limit for freestanding SNFs, plus 50% of the difference between the freestanding limits and 112% of the average per diem routine services costs of hospital-based SNFs. Routine cost limits for SNF care are required to be updated every 2 years. In the interim the Secretary applies a SNF market basket developed by HCFA to reflect changes in the price of goods and services purchased by SNFs. OBRA93 eliminated updates in SNF routine cost limits for cost reporting periods beginning in FY1994 and FY1995.

Ancillary service and capital costs are both paid on the basis of reasonable costs and neither are subject to limits.

Congress on a number of occasions has required the Secretary to develop alternative methods for paying for SNF care on a prospective basis. In response, HCFA has conducted research to develop a prospective payment system that uses a patient classification system, known as resource utilization groups, that will account for variations in resource use among Medicare SNF patients.

SNFs providing less than 1,500 days of care per year to Medicare patients in the preceding year have the option of being paid a prospective payment rate set at 105 percent of the regional mean for all SNFs in the region. The rate covers routine and capital-related costs (and not ancillary services) and is calculated separately for urban and rural areas, adjusted to reflect differences in wage levels. Prospective rates can not exceed the routine service costs limits that would be applicable to the facility, adjusted to take into account average capital-related costs with respect to the type and location of the facility.

Explanation of Provision. The provision would phase in a prospective payment

system for SNF care that would pay a Federal per diem rate for covered SNF services. Covered services would include Part A SNF benefits as well as all services for which payment may be made under Part B during the period when the beneficiary is provided covered SNF care (excluding, however, physician services, certain nurse practitioner and physician assistant services, certified nurse-midwife services, qualified psychologist services, services of a certified registered nurse anesthetist, and certain dialysis services and drugs). The per diem payment would cover routine service costs, ancillary and capital-related costs, but would not include costs associated with approved educational activities.

During a transition period lasting through the three cost reporting periods beginning on or after July 1, 1998, a portion of the per diem payment to a SNF would be based on a facility-specific rate, and the remaining portion on the Federal rate. For the first cost reporting period, the facility specific percentage would be 75 percent and Federal per diem percentage would be 25. For the second cost reporting period, the facility-specific percentage would be 50 percent and the Federal 50. For the last period, the facility-specific percentage would be 25 percent and the Federal 75.

In determining for a cost reporting period the facility-specific per diem rate for each SNF, the Secretary would calculate, on a per diem basis, the total of allowable costs for covered SNF benefits for the latest settled cost reporting period for which data are available, and an estimate of amounts that would be payable under Part B for services described above, regardless of whether or not payment had been made for the Part B services to the facility or another entity. This total would be updated to the relevant cost reporting period by the SNF historical trend factor. The SNF historical trend factor for a fiscal year or other annual period would be defined as the percentage change, from the midpoint of a prior fiscal year to the midpoint of the year involved, in the SNF routine cost index used for per diem routine cost limits, reduced (on an annualized basis) by 1 percentage point. Beginning with the first cost reporting period of the transition, the facility-specific per diem rate would be updated by the SNF market basket.

For the Federal per diem rate, the Secretary would first estimate, on a per diem basis for each freestanding SNF that received Medicare payments during a cost reporting period beginning in FY 1995 and that was subject to routine cost limits of current law, the total of allowable costs for covered SNF benefits for the latest settled cost reporting period for which data are available, and an estimate of amounts that would be payable under Part B, regardless of whether or not payment had been made for the Part B services to the facility or another entity. This total would be updated to the relevant cost reporting period by the SNF historical trend factor (again reflecting a 1 percentage point reduction in the routine cost index). The Secretary would standardize the updated amount for each facility by adjusting for variations among facilities in average wage levels and case mix. The Secretary would then compute a weighted average per diem rate. This would equal the average of the standardized amounts, weighted for each facility by the number of covered days of care provided during the cost reporting period. The Secretary could compute and apply an average separately for facilities located in urban and rural areas.

Beginning with FY 1998, the Secretary would be required to compute for each SNF an unadjusted Federal per diem rate equal to the weighted average per diem rate, updated by the SNF market basket. The actual per diem rate paid to a SNF would include adjustments for case mix based on a resident classification system established by the Secretary to account for relative resource utilization of different patient types. The labor-related portion of the rate would also include budget neutral adjustments to reflect the relative level of wages and wage-related costs for the geographic area in which the facility is located. To deal with case-mix "creep" when changes in the coding or classification of residents result in higher aggregate payments that do not reflect real changes in case mix, the Secretary would be authorized to adjust per diem rates to discount the effect of coding changes.

The Secretary would be required to publish in the Federal Register before July 1 preceding each fiscal year (beginning with FY 1999): (1) the unadjusted Federal per diem rates for covered SNF care during the fiscal year; (2) the case mix classification system to be applied to the rates; and (3) the factors to be applied in making area wage adjustments. SNFs would be required to provide the Secretary resident assessment data necessary to develop and implement pre diem rates in the manner and within the timeframes prescribed by the Secretary.

The Secretary would be required to establish an appropriate transition to the new prospective per diem payment system for low-volume SNFs and for rural hospitals using inpatient beds to provide SNF care.

Administrative or judicial review would not be permitted for the determination of facility-specific per diem rates; the determination of Federal per diem rates, including the computation of the standardized per diem rates and adjustments for case mix and relative wage levels; and for the transition for low-volume SNFs and rural hospitals providing SNF care with inpatient beds.

For beneficiaries residing in SNFs but no longer eligible for Part A SNF care, payments for Part B covered services would have to be made to the facility without regard as to whether or not the item or service was furnished by the facility, by others under arrangement, or under any other contracting or consulting arrangement. Payments for Part B services would be based on existing or other fee schedules established by the Secretary. Claims for Part B items and services would be required to include a code identifying the items or services delivered.

The Secretary would be required to establish and implement a thorough medical review process to examine the effects of the new prospective payment system on the quality of covered SNF care. In this medical review process, the Secretary would be required to place a particular emphasis on the quality of non-routine covered services and physician services.

Section 10402. Prospective Payment For Inpatient Rehabilitation Hospital Services Based on Discharges Classified By Patient Case Mix Groups

Current Law. Under Medicare, five types of specialty hospitals (psychiatric, rehabilitation, long-term care, children's and cancer) and two types of distinct-part units in general hospitals (psychiatric and rehabilitation) are exempt from PPS. They are subject to the payment limitations and incentives established in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Each provider is paid on the basis of reasonable cost subject to a rate of increase ceiling on inpatient operating costs. The ceiling is based on a target amount per discharge. The target amount for a cost reporting period is equal to the hospital's allowable inpatient operating costs (excluding capital and medical education costs) per discharge in a base year increased by applicable update factors for subsequent years. This amount is then multiplied by Medicare discharges, to yield the ceiling or upper limit on operating costs.

Explanation of Provision. The provision would require the Secretary to establish a prospective payment system for inpatient rehabilitation hospital services based on patient case mix groups.

For this system, the Secretary would be required to establish (1) classes of discharges of rehabilitation facilities by patient case mix groups based on impairment, age, related prior hospitalization, comorbidities, and functional capability of the discharged individual and other appropriate factors; and (2) a method of classifying specific discharges from rehabilitation facilities within these groups.

The provision would require the Secretary to assign each case mix group an appropriate weighting which would reflect the relative facility resources used with respect to discharges classified within a group compared to discharges classified within other groups. The Secretary would be required to adjust the classifications and weighting factors to correct for forecast errors and to reflect changes in treatment patterns, technology, case mix, number of discharges paid for under Medicare, and other factors which might affect the relative use of resources. The Secretary would be authorized to require rehabilitation facilities providing inpatient hospital services to submit data on discharges classified according to case mix group or other rehabilitation impairment groups, measurement of functional disability, and other patient assessment factors as deemed necessary to establish and administer the prospective payment system.

The Secretary would be required to determine a prospective payment rate for each payment unit for which a rehabilitation facility is entitled to be paid under Medicare. The payment rate would be based on the average payment per discharge under Medicare for operating and capital costs of rehabilitation facilities in FY1995, adjusted by (1) updating such per-unit amounts to the fiscal year involved by the applicable percentage increases

provided by the bill for each fiscal year and up to FY2000, and an increase factor specified by the Secretary for subsequent fiscal years; (2) reducing such rates by a factor equal to the proportion of payments by Medicare for outliers; (3) variations among rehabilitation facilities by areas; (4) weighting factors described in the bill; and (5) other factors the Secretary determines are necessary to reflect variations in necessary costs of treatment among rehabilitation facilities.

Prospective payment rates would be phased in between October 1, 2000 and before October 1, 2003, by blending the prospective rate with the TEFRA percentage of the hospital's target amount that would have been paid under Part A if this provision did not apply, and the prospective payment percentage of the per unit payment rate established by the Secretary. For cost reporting periods beginning on or after October 1, 2000 and before October 1, 2001, the TEFRA percentage would be 75% and the prospective payment percentage would be 25%; for cost reporting periods on or after October 1, 2001, and before October 1, 2002, the TEFRA percentage would be 50% and the prospective payment percentage would be 50%; for cost reporting periods on or after October 1, 2002, and before October 1, 2003, the TEFRA percentage would be 25% and the prospective payment percentage would be 75%. Payment rates on or after October 1, 2003, would be equal to the per unit fully prospective payment rate. Payment per unit would mean a discharge, day of inpatient hospital services, or other unit of payment specified by the Secretary.

For fiscal years 2001 through 2004, the Secretary would be required to establish prospective payment amounts that were budget neutral, so that total payments for rehabilitation hospitals would equal 99% of the amount of payments that would have been made if prospective payments had not been made. The Secretary would be required to develop an increase factor which could be based on an appropriate percentage increase in a market basket of goods and services purchased by rehabilitation hospitals. The Secretary would also be required to provide for an additional payments for outlier cases that involved unusually long length of stay or were very costly, or other factors. The Secretary would be required to adjust prospective payments to rehabilitation facilities by a wage index that reflected area differences for wages and wage-related costs. No later than October 1, 2001, the Secretary would be required to update the area wage adjustment factor based on a survey of wages and wage related costs of providing rehabilitation services. The provision would also prohibit administrative or judicial review of the provisions of the prospective payment system.

CHAPTER 2. - PAYMENT UNDER PART B

Subchapter A - Payment for Hospital Outpatient Department Services

Section 10411. Elimination of Formula-Driven Overpayments (FDO) for Certain Outpatient Hospital Services.

Current Law. Medicare payments for hospital outpatient ambulatory surgery, radiology, and other diagnostic services equals the lesser of: (1) the lower of a hospital's reasonable costs or its customary charges, net of deductible and coinsurance amounts, or (2) a blended amount comprised of a cost portion and a fee schedule portion, net of beneficiary cost-sharing. The cost portion of the blend is based on the lower of the hospital's costs or charges, net of beneficiary cost sharing, and the fee schedule portion is based, in part, on ambulatory surgery center payment rates or the rates for radiology and diagnostic services in other settings, net of beneficiary coinsurance. For cost reporting periods beginning on or after January 1, 1991, the hospital cost portion and the ASC cost portion are 42% and 58%, respectively.

A hospital may bill a beneficiary for the coinsurance amount owed for the outpatient service provided. The beneficiary coinsurance is based on 20 percent of the hospital's submitted charges for the outpatient service, whereas Medicare usually pays based on the blend of the hospital's costs and the amount paid in other settings for the same service. This results in an anomaly whereby the amount a beneficiary pays in coinsurance does not equal 20 percent of the program's payment and does not result in a dollar-for-dollar decrease in Medicare program payments.

Explanation of Provision. The provision would require that beneficiary coinsurance amounts be deducted later in the reimbursement calculation for hospital outpatient services, so that Medicare payments for covered services would be lower. Medicare's payment for hospital outpatient services would equal the blended amount less any amount the hospital may charge the beneficiary as coinsurance for services furnished during portions of cost reporting periods occurring on or after October 1, 1997.

Section 10412. Extension of Reductions in Payments for Costs of Hospital Outpatient Services

Current Law:

a. Reduction in Payments for Capital-Related Costs. Hospitals receive payments for Medicare's share of capital costs associated with outpatient departments. OBRA 93 extended a 10 percent reduction in payments for the capital costs of outpatient departments through FY1998.

b. Reduction in Payments for Non-Capital-Related Costs. Certain hospital outpatient services are paid on the basis of reasonable costs. OBRA 93 extended a 5.8 percent reduction for those services paid on a cost-related basis through FY1998.

Explanation of Provision.

a. Reduction in Payments for Capital-Related Costs. The provision would extend the 10 percent reduction in payments for outpatient capital through FY1999 and during FY2000 before January 1, 2000.

b. *Reduction in Payments for Non-Capital-Related Costs.* The 5.8 percent reduction for outpatient services paid on a cost basis would be extended through FY1999 and during FY2000 before January 1, 2000.

Section 10413. Prospective Payment System for Hospital Outpatient Department Services

Current Law. Medicare payments for hospital outpatient ambulatory surgery, radiology, and other diagnostic services equals the lesser of: (1) the lower of a hospital's reasonable costs or its customary charges, net of deductible and coinsurance amounts, or (2) a blended amount comprised of a cost portion and a fee schedule portion, net of beneficiary cost-sharing. The cost portion of the blend is based on the lower of the hospital's costs or charges, net of beneficiary cost sharing, and the fee schedule portion is based, in part, on ambulatory surgery center payment rates or the rates for radiology and diagnostic services in other settings, net of beneficiary coinsurance. For cost reporting periods beginning on or after January 1, 1991, the hospital cost portion and the ASC cost portion are 42% and 58%, respectively.

Explanation of Provision. The provision would require the Secretary to establish a prospective payment system for covered OPD services furnished beginning in 1999. The Secretary would be required to develop a classification system for covered OPD services, such that services classified within each group would be comparable clinically and with respect to the use of resources. The Secretary would be required to establish relative payment rates for covered OPD services using 1997 hospital claims and cost report data, and determine projections of the frequency of utilization of each such service or group of services in 1999. The Secretary would be required to determine a wage adjustment factor to adjust the portions of payment attributable to labor-related costs for relative geographic differences in labor and labor-related costs that would be applied in a budget neutral manner. The Secretary would be required to establish other adjustments as necessary to ensure equitable payments under the system. The Secretary would also be required to develop a method for controlling unnecessary increases in the volume of covered OPD services.

Hospitals OPD copayments would be limited to 20% of the national median of the charges for the service (or services within the group) furnished in 1997 updated to 1999 using the Secretary's estimate of charge growth during this period. The Secretary would be required to establish rules for the establishment of a copayment amount for a covered OPD service not furnished during 1997, based on its classification within a group of such services.

For 1999, the Secretary would be required to establish a conversion factor for determining the Medicare OPD fee payment amounts for each covered OPD service (or group of services) furnished in 1999 so that the sum of the products of the Medicare OPD fee payment amounts and the frequencies for each service or group would be required to equal the total amounts estimated by the Secretary that would be paid for OPD services

in 1999. In subsequent years, the Secretary would be required to establish a conversion factor for covered OPD services furnished in an amount equal to the conversion factor established for 1999 and applicable to services furnished in the previous year increased by the OPD payment increase factor. The increase factor would be equal to the hospital market basket (MB) percentage increase plus 3.5 percentage points.

The Secretary would be required to establish a procedure under which a hospital, before the beginning of a year (starting with 1999), could elect to reduce the copayment amount for some or all covered OPD services to an amount that is not less than 25% of the Medicare OPD fee schedule amount for the service involved, adjusted for relative differences in labor costs and other factors. A reduced copayment amount could not be further reduced or increased during the year involved, and hospitals could disseminate information on the reduction of copayment amount.

The Secretary would be authorized periodically to review and revise the groups, relative payment weights, and the wage and other adjustments to take into account changes in medical practice, medical technology, the addition of new services new cost data, and other relevant information. Any adjustments made by the Secretary would be made in a budget neutral manner. If the Secretary determined that the volume of services paid for under this subsection increased beyond amounts established through those methodologies, the Secretary would be authorized to adjust the update to the conversion factor otherwise applicable in a subsequent year.

The provision would provide that the copayment for covered OPD services would be determined by the provisions of this bill instead of the standard 20% coinsurance for other Part B services. The provision would prohibit administrative or judicial review of the prospective payment system. The provision would also provide for conforming amendments regarding approved ambulatory surgical center procedures performed in hospital OPDs, for radiology and other diagnostic procedures, and for other hospital outpatient services.

Subchapter B - Rehabilitation Services

Section 10421. Rehabilitation Agencies and Services

Current Law. Medicare provides for special payment rules for certain types of providers of services covered under Part B and paid out of the SMI Trust Fund.

Explanation of Provision. For outpatient physical therapy and occupational therapy services, payments for services provided in 1998 would be, the least of: (1) the actual charges for the services; (2) the adjusted reasonable costs for the services, defined as reasonable costs reduced by 5.8% of the reasonable costs for operating costs and 10% of the reasonable cost for capital; or (3) a blended rate equal to the sum of 50% of the adjusted reasonable cost for the services and 50% of the applicable physician fee schedule amount for the services. After 1998, payment for these services would be 80% of the

lesser of the actual charge for the services, or the applicable physician fee schedule amount. The provision would also exclude from Medicare coverage outpatient occupational therapy and physical therapy services furnished as an incident to a physician's professional services that did not meet the standards provided for outpatient physical therapy services furnished by a provider in a clinic, rehabilitation agency, public health agency, or by others under an arrangement with and under the supervision of such providers.

The provision would also apply the per beneficiary cap of \$900 per year for outpatient physical therapy services.

Section 10422. Comprehensive Outpatient Rehabilitation Facilities (CORFs)

Current Law. Medicare provides for special payment rules for certain types of providers of services covered under Part B and paid out of the SMI Trust Fund.

Explanation of Provision. CORF payments for services provided in 1998, would be the least of: (1) the charges for the services; (2) the adjusted reasonable costs for the services, defined as reasonable costs reduced by 5.8% of the reasonable costs for operating costs and 10% of the reasonable cost for capital; or (3) a blended rate equal to the sum of 50% of the adjusted reasonable cost for the services and 50% of the applicable physician fee schedule amount for the services. After 1998, payment for these services would be 80% of the lesser of the actual charge for the services, or the applicable physician fee schedule amount.

Subchapter C - Ambulance Services

Section 10431. Payments for Ambulance Services.

Current Law. Payment for ambulance services provided by freestanding suppliers is based on reasonable charge screens developed by individual carriers based on local billings. Hospital or other provider-based ambulance services are paid on a reasonable cost basis; payment cannot exceed what would be paid to a freestanding suppliers.

Explanation of Provision. The provision would specify payment rules for ambulance services for FY 1998 through FY 2002. For ambulance services paid on a reasonable cost basis, the annual increase in the costs recognized as reasonable would be limited to the percentage increase in the consumer price index reduced for fiscal years 1998 and 1999 by 1 percent. Similarly, for ambulance services furnished on a reasonable charge basis, the annual increase in the charges recognized as reasonable would be limited to the percentage increase in the consumer price index reduced for fiscal years 1998 and 1999 by 1 percent.

The provision would require the Secretary to establish a fee schedule for ambulance services through a negotiated rule-making process. In establishing the fee

schedule, the Secretary would be required to: (1) establish mechanisms to control Medicare expenditure increases; (2) establish definitions for services; (3) consider appropriate regional and operational differences; (4) consider adjustments to payment rates to account for inflation and other relevant factors; and (5) phase-in the application of the payment rates in an efficient and fair manner. The Secretary would be required to assure that payments in FY 2000 under the fee schedule did not exceed the aggregate amount of payments which would have been made in the absence of the fee schedule. The annual increase in the payment amounts in each subsequent year would be limited to the increase in the consumer price index. Medicare payments would equal 80% of the lesser of the fee schedule amount or the actual charge.

The provision would authorize payment for advanced life support (ALS) services provided by paramedic intercept service providers in rural areas. The ALS services would be provided as part of a two-tiered system in conjunction with one or more volunteer ambulance services. The volunteer ambulance service involved must be certified as qualified to provide the service, have a contractual agreement with the volunteer ambulance service providing the additional ALS intercept service, provide only basic life support services at the time of the intercept, and be prohibited by state law from billing for services. The ALS service provider must be certified to provide the services and bill all recipients (not just Medicare beneficiaries) for ALS intercept services.

Section 10432. Demonstration of Coverage of Ambulance Services Under Medicare Through Contracts With Units of Local Government

Current Law. No provision.

Explanation of Provision. The provision would require the Secretary to establish up to 3 demonstration projects under which, at the request of a county or parish, the Secretary enters into agreement with such entity to furnish or arrange for the furnishing of ambulance services. The county or parish could not enter into a contract unless the contract covered at least 80% of the residents enrolled in Part B. Individuals or entities furnishing services would have to meet the requirements otherwise applicable. The Secretary would make monthly per capita payments to the county or parish. In the first year, the capitated payment would equal 95% of the average annual per capita payment made in the most recent 3 years for which data is available. In subsequent years, it would equal 95% of the amount established for the preceding year increased by the CPI.

The contract could provide for the inclusion of persons residing in additional counties or parishes, permit transportation to non-hospital providers, and implement other innovations proposed by the county or parish.

The Secretary would be required to evaluate the demonstration projects and report by January 1, 2000, on the study including recommendations regarding modifications to the payment methodology and whether to extend or expand such projects.

CHAPTER 3 - PAYMENT UNDER PARTS A AND B

Section 10441. Prospective Payment for Home Health Services

Current Law. Medicare reimburses home health agencies on a retrospective cost-based basis. This means that agencies are paid after services are delivered for the reasonable costs (as defined by the program) they have incurred for the care they provide to program beneficiaries, up to certain limits. In provisions contained in the Orphan Drug Act of 1983, OBRA 87 and OBRA 90, Congress required the Secretary to develop alternative methods for paying for home health care on a prospective basis. In 1994, the Office of Research and Demonstration in the Health Care Financing Administration (HCFA) completed a demonstration project that tested prospective payment on a per visit basis. Preliminary analysis indicates that the per visit prospective payment methodology had no effect on cost per visit or volume of visits. HCFA has begun a second project, referred to as Phase II, to test prospective payment on a per episode basis, and has also undertaken research to develop a home health case-mix adjustor that would translate patients' varying service needs into specific reimbursement rates.

Explanation of Provision. The provision would require the Secretary to establish a prospective payment system for home health and implement the system beginning October 1, 1999. All services covered and paid on a reasonable cost basis at the time of enactment of this section, including medical supplies, would be required to be paid on a prospective basis. In implementing the system, the Secretary could provide for a transition of not longer than 4 years during which a portion of the payment would be based on agency-specific costs, but only if aggregate payments were not greater than they would have been if a transition had not occurred.

In establishing the prospective system, the Secretary would be authorized to consider an appropriate unit of service and the number of visits provided within that unit, potential changes in the mix of services provided within that unit and their cost, and a general system design that provides for continued access to quality services.

Under the new system, the Secretary would compute a standard prospective payment amount (or amounts) that would initially be based on the most current audited cost report data available to the Secretary. For fiscal year 2000, payment amounts under the prospective system would be computed in such a way that total payments would equal amounts that would have been paid had the system not been in effect, but would also reflect a 15% reduction in cost limits and per beneficiary limits in effect September 30, 1999. Payment amounts would be standardized in a manner that eliminates the effect of variations in relative case mix and wage levels among different home health agencies in a budget neutral manner. The Secretary could recognize regional differences or differences based on whether or not services are provided in an urbanized area. Beginning with FY 2001, standard prospective payment amounts would be adjusted by the home health market basket.

The payment amount for a unit of home health service would be adjusted by a case mix adjustor factor established by the Secretary to explain a significant amount of the variation in the cost of different units of service. The labor-related portion of the payment amount would be adjusted by an area wage adjustment factor that would reflect the relative level of wages and wage-related costs in a particular geographic area as compared to the national average. The Secretary could provide for additions or adjustments to payment amounts for outliers because of unusual variations in the type or amount of medically necessary care. The total amount of outlier payments could not exceed 5 percent of total payments projected or estimated to be made in a year. The Secretary would be required to reduce the standard prospective payments by amounts that in the aggregate would equal outlier adjustments. If a beneficiary were to transfer to or receive services from another home health agency within the period covered by a prospective payment amount, then the payment would be prorated between the agencies involved.

Payments for exceptions and adjustments to the prospective amounts would be limited to aggregate payments made in FY 1994 for exemptions and exceptions to cost limits, adjusted for increases in the home health market basket. The Secretary would be required to publish annually in the Federal Register a report describing the total amounts of payments made to home health agencies for exceptions for cost reporting periods ending during the previous fiscal year.

Claims for home health services furnished on or after October 1, 1998, would be required to contain an appropriate identifier for the physician prescribing home health services or certifying the need for care. Claims would also be required to include for four home health service categories information (coded in an appropriate manner) on the length of time of a service, as measured in 15 minute increments. The four categories of services for which time information would have to be included on a claim would be skilled nursing care; therapies--physical and occupational therapy and speech language pathology; medical social services; and home health aide services.

Administrative or judicial review would not be permitted for the transition period (if any) for the prospective system; the definition and application of payment units; the computation of initial standard payment amounts; adjustments for outliers, case-mix and area wage adjustments; and the amounts or types of exceptions or adjustments to the prospective payment amounts.

Periodic interim payments for home health services would be eliminated. All home health care agencies would be paid according to the prospective payment system.

In order for home health services to be considered covered care, home health care agencies would be required to submit claims for all services, and all payments would be made to a home health agency without regard to whether or not the item or service was furnished by the agency, by others under arrangement, or under any other contacting or consulting arrangement.

SUBTITLE F - PROVISIONS RELATING TO PART A

CHAPTER 1. - PAYMENT OF PPS HOSPITALS

Section 10501. PPS Hospital Payment Update

Current Law. Hospitals are paid on the basis of a prospectively fixed payment rate for costs associated with each discharge. Each hospital's basic payment rate is based on a national standardized payment amount, which is higher for hospitals in large urban areas than for other hospitals. Each standardized payment amount is adjusted by a wage index. Payment also depends on the relative costliness of the case, based on the diagnosis related group (DRG) to which the discharge is assigned. Additional payments are made for: extraordinary costs (outliers); indirect costs of medical education; and for hospitals serving a disproportionate share of low-income patients. Other exceptions and adjustments are made.

PPS payment rates are annually updated using an "update factor." The annual update factor applied to increase the Federal base payment amounts is determined, in part, by the projected increase in the hospital market basket index (MBI), which measures the costs of goods and services purchased by hospitals. Under the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), the PPS update factor for all PPS hospitals is equal to the percentage increase in the market basket minus 2 percentage points.

Explanation of Provision. The proposal sets the update factor for FY1998 at 0% for all hospitals in all areas; for FY1999-2002, at MBI minus 1.0 percentage points for all hospitals in all areas, and for FY2003 and each subsequent fiscal year equal to the MBI for all hospitals in all areas.

Section 10502. Capital Payments for PPS Hospitals

Current Law. In FY1992, Medicare began phasing in prospectively-determined per case rates for capital-related costs. During the 10-year transition to a single capital rate, payments will reflect both hospital-specific costs and a single Federal capital payment rate. During the transition, hospitals are paid according to either a fully prospective method or a "hold harmless" method of payment.

Capital payment rates are updated annually. For the first 5 years of the transition to prospectively determined per-case rates, historical cost increases were used to increase the Federal and hospital-specific rates. Under a budget neutrality requirement, per case capital rates were adjusted in the first 5 years of the transition so that total payments equaled 90 percent of estimated Medicare-allowed capital costs. In FY1996, the budget neutrality requirement was lifted. In addition, the cost-based updates are replaced by an "update framework" (developed by HCFA and proposed in the June 2, 1995 Federal

Register), which determines payment rate growth. This analytical framework is to take into account changes in the price of capital and appropriate changes in capital requirements resulting from development of new technologies and other factors.

Medicare's capital-related costs include local property taxes and property "fees" paid by nonprofit hospitals. The hospital-specific component of capital payments is based on a hospital's spending in a base year (generally 1990). Hospitals that have changed from nonprofit or public to proprietary may become subject to property taxes not included in their base; this may also occur as a result of changes in State or local law.

Explanation of Provision. The provision would require the Secretary to rebase the capital payment rates for FY1998 by the actual rates in effect in FY1995, by applying the budget neutrality adjustment factor used to determine the federal capital payment rate on September 30, 1995 to the unadjusted standard federal capital payment rate in effect on September 30, 1997, and to the unadjusted hospital-specific rate in effect on September 30, 1997.

The provision would make an adjustment to hospital capital payment rates for hospitals that incur capital-related tax costs for a fiscal year, generally state or local property taxes. The provision would be budget neutral. The provision would not apply to hospitals that first incur capital-related tax costs in a fiscal year after FY1996 because of a change from nonproprietary to proprietary status or because the hospital began operation after FY1996 until the second full fiscal year after the first year the hospital incurred the capital-related tax cost. Hospitals that incurred capital-related tax costs after FY1994 because of a change in State and local tax laws would not be eligible to receive an additional payment for discharges occurring before the fourth full fiscal year following the fiscal year in which the hospital first incurred such costs. The payment adjustment would be equal to the lower of the capital-related tax costs per discharge of the hospital for a base year, or as appropriate, updated by a factor equal to the percentage increase of the federal capital rate from the base year to the fiscal year when the actual costs are incurred.

The provision would also revise the exceptions process for certain capital projects provided under PPS.

Section 10503. Freeze in Disproportionate Share

Current Law. Under PPS, an adjustment is made to the payment to hospitals that serve a disproportionate share of low-income patients. The disproportionate share hospital (DSH) adjustment is intended to compensate hospitals that treat large proportions of low-income patients. The factors considered in determining whether a hospital qualifies for a DSH payment adjustment include the number of beds, the number of patient days, and the hospital's location. A hospital's disproportionate patient percentage is the sum of (1) the total number of inpatient days attributable to Federal SSI beneficiaries divided by the total number of Medicare patient days, and (2) the number

of Medicaid patient days divided by total patient days, expressed as a percentage. A hospital is classified as a DSH under any of the following circumstances:

- (1) If its disproportionate patient percentage equals or exceeds:
 - (a) 15 percent for an urban hospital with 100 or more beds, or a rural hospital with 500 or more beds (the latter is set by regulation);
 - (b) 30 percent for a rural hospital with more than 100 beds and fewer than 500 beds or is classified as a sole community hospital (SCH);
 - (c) 40 percent for an urban hospital with fewer than 100 beds; or
 - (d) 45 percent for a rural hospital with 100 or fewer beds, or
- (2) if it is located in an urban area, has 100 or more beds, and can demonstrate that, during its cost reporting period, more than 30 percent of its net inpatient care revenues are derived from State and local government payments for care furnished to indigent patients. (This provision is intended to help hospitals in States that fund care for low-income patients through direct grants rather than expanded Medicaid programs.)

For a hospital qualifying on the basis of (1)(a) above, if its disproportionate patient percentage is greater than 20.2 percent, the applicable PPS payment adjustment factor is 5.88 percent plus .825 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage. If the hospital's disproportionate patient percentage is less than 20.2 percent, the applicable payment adjustment factor is equal to: 2.5 percent plus 65 percent of the difference between 15 percent and the hospital's disproportionate patient percentage. If the hospital qualifies as a DSH on the basis of (1)(b), the payment adjustment factor is determined as follows:

- (a) if the hospital is classified as a rural referral center, the payment adjustment factor is 4 percent plus 60 percent of the difference between the hospital's disproportionate patient percentage and 30 percent;
- (b) if the hospital is a SCH, the adjustment factor is 10 percent;
- (c) if the hospital is classified as both a rural referral center and a SCH, the adjustment factor is the greater of 10 percent or 4 percent plus 60 percent of the difference between the hospital's disproportionate patient percentage and 30 percent; and
- (d) if the hospital is not classified as either a SCH or a rural referral center, the payment adjustment factor is 4 percent.

If the hospital qualifies on the basis of (1)(c), the adjustment factor is equal to 5 percent. If the hospital qualifies on the basis of (1)(d), the adjustment factor is 4 percent. If the hospital qualifies on the basis of (2) above, the payment adjustment factor is 35 percent.

Explanation of Provision. The provision would freeze DSH payments for discharges occurring on or after October 1, 1997, and provide a 0% update for FY1998

and FY1999. The Secretary would be required to develop a proposal to modify the current definitions for DSH payments and transmit the proposal developed to the Committees on Ways and Means of the House and Finance of the Senate by April 1, 1999.

Section 10504. Medicare Capital Asset Sales Price Equal to Book Value

Current Law. Medicare provides for establishing an appropriate allowance for depreciation and for interest on capital indebtedness and a return on equity capital when a hospital has undergone a change of ownership. The valuation of the asset is the lesser of the allowable acquisition costs of the asset to the owner of record, or the acquisition cost of such asset to the new owner.

Explanation of Provision. The provision would eliminate the allowance for return on equity capital, and would provide for a depreciation adjustment of the historical cost of the asset recognized by Medicare, less depreciation allowed, to the owner of record as of the date of enactment of this bill, or to the first owner of record of the asset in the case of an asset not in existence as of the date of enactment. The provision would apply to changes of ownership that occur three months after the date of enactment.

Section 10505. Elimination of Indirect Medical Education (IME) Adjustment and DSH Payments Attributable to Outlier Payments

Current Law. Medicare provides outlier payments to hospitals intended to protect hospitals from the risk of financial losses associated with cases having exceptionally high costs or unusually long hospital stays. Outlier payments are adjusted to include an IME adjustment for teaching hospitals and a DSH payment adjustment for hospitals disproportionately providing services to low-income patients.

Explanation of Provision. The provision would eliminate the IME and DSH payment adjustments from outlier payments to hospitals. The provision would apply to discharges occurring after September 30, 1997.

Section 10506. Reduction in Adjustment for Indirect Medical Education

Current Law. Medicare recognizes the costs of graduate medical education in teaching hospitals and the higher costs of providing services in those institutions. Medicare recognizes the costs of graduate medical education under two mechanisms: direct graduate medical education (GME) payments and an indirect medical education (IME) adjustment. The IME is designed to compensate hospitals for indirect costs attributable to the involvement of residents in patient care and the severity of illness of patients requiring specialized services available only in teaching hospitals. The additional payment to a hospital is based on a formula that provides an increase of approximately 7.7 percent in the DRG payment, for each 0.1 percent increase in the hospital's intern and resident-to-bed ratio on a curvilinear basis (i.e., the increase in the payment is less than

proportional to the increase in the ratio of interns and residents to beds).

Explanation of Provision. The IME adjustment would be reduced from the aggregate 7.7% to 6.8% in FY1998, and to 5.5% during and after FY1999. For discharges occurring on or after October 1, 1997, the total number of residents and interns in either a hospital or non-hospital setting could not exceed the number of interns and residents reported on the hospital's cost report for the period ending December 31, 1996. For hospital's first cost reporting period beginning on or after October 1, 1997, the total number of FTE residents and interns for payment purposes would equal the average of the actual FTE resident and intern count for the cost reporting period and the preceding year's cost reporting period. For the cost reporting period beginning October 1, 1998, and each subsequent cost reporting period, subject to certain limits, the total number of FTE residents and interns for payment purposes would equal the average of the actual FTE resident count for the cost reporting period and the preceding two year's cost reporting periods.

Section 10507. Treatment of Transfer Cases

Current Law. No provision. PPS hospitals that move patients to PPS-exempt hospitals and distinct-part hospital units, or skilled nursing facilities are currently considered to have "discharged" the patient and receive a full DRG payment.

Explanation of Provision. The provision would define a "transfer case" to include an individual discharged from a PPS hospital who is: (1) admitted as an inpatient to a hospital or distinct-part hospital unit that is not a PPS hospital for further inpatient hospital services; (2) is admitted to a skilled nursing facility or other extended care facility for extended care services; or (3) receives home health services from a home health agency if such services directly relate to the condition or diagnosis for which the individual received inpatient hospital services, and if such services were provided within an appropriate period, as determined by the Secretary in regulations promulgated no later than April 1, 1998. Under the provision, a PPS hospital that "transferred" a patient would be paid on a per diem basis instead of the full DRG payment.

The provision, with respect to transfers from PPS-exempt hospitals and SNFs, would apply to discharges occurring on or after October 1, 1997. For home health care, the provision would apply to discharges occurring on or after April 1, 1998.

Chapter 2 - Payment of PPS Exempt Hospitals

Section 10511. Payment Update

Current Law. Under Medicare, five types of specialty hospitals (psychiatric, rehabilitation, long-term care, children's and cancer) and two types of distinct-part units in general hospitals (psychiatric and rehabilitation) are exempt from PPS. They are

subject to the payment limitations and incentives established in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Each provider is paid on the basis of reasonable cost subject to a rate of increase ceiling on inpatient operating costs. The ceiling is based on a target amount per discharge. The target amount for a cost reporting period is equal to the hospital's allowable inpatient operating costs (excluding capital and medical education costs) per discharge in a base year increased by applicable update factors for subsequent years. This amount is then multiplied by Medicare discharges, to yield the ceiling or upper limit on operating costs.

OBRA 93 provided that the applicable rate of increase percentage, or update, would be equal to the MBI minus 1.0 percent for FY1994-1997.

Explanation of Provision. The provision would set the FY1998 update to 0%, and for FY1999 through FY2002, the update factor would be based on the hospital's target amount. If a hospital's allowable operating costs of inpatient hospital services recognized under Medicare for the most recent cost reporting period (1) is equal to, or exceeds, 110% of the hospital's target amount, the applicable update factor specified under this clause is the market basket percentage; (2) exceeds 100%, but is less than 110% of the hospital target amount, the applicable update factor is the market basket percentage minus 0.25 percentage points for each percentage point by which the allowable operating costs (expressed as a percentage of the target amount) is less than 110% of such target amount; (3) is equal to, or less than 100% of the hospital target amount, but exceeds 2/3 of the target amount for the hospital, the update factor would be the market basket percentage minus 2.5 percentage points; or (4) does not exceed 2/3 of the hospital's target amount, the update factor would be 0%.

Section 10512. Reductions to Capital Payments For Certain PPS-Exempt Hospitals and Units

Current Law. Medicare pays for capital costs for PPS exempt hospitals on a reasonable cost basis.

Explanation of Provision. The provision would require the Secretary to reduce capital payment amounts for PPS-exempt hospitals and distinct part units by 10% for fiscal years 1998 through 2002.

Section 10513. Cap on TEFRA Limits

Current Law. Medicare places limits, referred to as "TEFRA limits," on the annual increases allowed for the operating costs of certain categories of hospitals.

Explanation of Provision. The provision would set the target amounts for PPS-exempt hospitals or units for cost reporting periods beginning on or after October 1, 1997 and before October 1, 2002. The target amounts could not be greater than the 90th percentile of the target amounts for cost reporting periods beginning during that fiscal

year. The cap on the target amounts would apply to psychiatric, rehabilitation, and long-term care hospitals and distinct-part units of such hospitals.

Section 10514. Change In Bonus Payments

Current Law. Medicare provides for bonus payments for hospitals whose operating costs are less than or equal to the target amount, as well as making relief payments to hospitals whose costs exceed their target amount. If the hospital's costs are less than or equal to the target amount for that period, the hospital receives a bonus payment equal to 50% of the amount by which the target amount exceeds the amount of the operating costs, or 5% of the target amount, whichever is less. If a hospital's operating costs are greater than the target amount, the amount of the payment is equal to (1) the target amount, plus (2) an additional amount equal to 50% of the amount by which the operating costs exceed the target amount, but not more than 10% of the target amount.

Explanation of Provision. The provision would allow bonuses of (1) 10% of the amount by which the target amount exceeds the amount of operating costs, or (2) 1% of operating costs, whichever is less. The provision would change the relief payments to provide that costs would be required to exceed 110% in order to receive relief payments, except that the relief payment could not be more than 20% of the target amount.

Section 10515. Change in Payment and Target Amount for New Providers

Current Law. No provision.

Explanation of Provision. The provision would establish different payment and target amount rules for hospitals or distinct-part units within hospitals that first receive Medicare payments on or after October 1, 1997. The provision would apply to psychiatric, rehabilitation, and long-term care hospitals and distinct-part units of hospitals. For the first 2 full or partial cost reporting periods, the amount of payment for operating costs under Part A on a per discharge or per admission basis would be equal to the lesser of the amount of operating costs for the respective period, or 150% of the national median operating costs for hospitals in the same class of hospital for cost reporting periods beginning during the same fiscal year, adjusted for labor-related costs and case mix. For computing the target amount for subsequent cost reporting periods, the target amount for the preceding cost reporting period would be equal to the amount determined for such preceding period.

For determining national median operating costs for hospitals in the same class, the Secretary would be required to provide for an appropriate adjustment to the labor-related portion of the amount determined to take into account differences between average wage-related costs in the area the hospital is located in and the national average of such costs within the same class of hospital. The Secretary would also be required to provide, to the extent feasible, an adjustment to account for differences in the case mix across

long-term care hospitals in calculating the 150% of the national median cost limits.

Section 10516. Rebasing

Current Law. No provision.

Explanation of Provision. The provision would give psychiatric, rehabilitation, and long-term care hospitals and psychiatric and rehabilitation distinct units of hospitals that received Medicare payments for services furnished before January 1, 1990, the option of electing that the hospital's target amount for the 12-month cost reporting period beginning during FY1998 would be rebased. The rebased target amount would be equal to an average determined by the Secretary as follows: (1) the Secretary would be required to determine the allowable operating cost for inpatient hospital services for the hospital or hospital unit for each of the 5 cost reporting periods for which the Secretary had settled cost reports as of the date of enactment; (2) the Secretary would be required to increase the amount determined for the 5 cost reporting periods by the applicable percentage increase used to update costs for each of the cost reporting periods; (3) the Secretary would be required to identify among the 5 cost reporting periods the periods for which the updated cost amount was the highest and the lowest; (4) the Secretary would be required to compute the average cost per discharge of the updated cost report amounts for the 3 cost reporting periods that were not the highest or the lowest amounts.

The provision would also allow certain qualified long-term care hospitals that elect to do so, to apply for rebasing of their target amount beginning during FY1998. The target amount for the hospital's 12-month cost reporting period would be equal to the allowable operating costs of inpatient hospital services recognized by Medicare for the 12-month cost reporting periods beginning during FY1996, increased by the applicable percentage increase for the cost reporting period beginning during FY1997. The provision defines a qualified long-term care hospital as a PPS-exempt hospital that received Medicare payments during each of the 2 cost reporting periods for which the Secretary has the most recent settled cost reports as of the date of enactment. In addition, for each of the 2 cost reports the hospital's allowable operating costs of inpatient hospital services under Medicare exceeded 115% of the hospital's target amount, and the hospital had a disproportionate patient percentage of at least 70%.

Section 10517. Treatment of Certain Long-Term Care Hospitals Located Within Other Hospitals

Current Law. No provision.

Explanation of Provision. The provision would extend the classification of a hospital that was classified by the Secretary on or before September 30, 1995, as a long-term care hospital, notwithstanding that it was located in the same building as, or on the same campus as, another hospital. The provision would apply to discharges occurring on or after October 1, 1995.

Section 10518. Elimination of Exemptions; Report on Exceptions and Adjustments

Current Law. The Secretary is required to provide an exemption from various provisions of the law regarding Medicare payments to PPS-excluded hospitals.

Explanation of Provision. The provision would amend the law, replacing the term "exemption from, or an exception and adjustment to," with "an exception and adjustment to" each place it appears, eliminating exemption from the target amounts. The provision would apply to hospitals that qualify as PPS-excluded facilities on or after October 1, 1997.

The provision would also require the Secretary to publish annually in the *Federal Register* a report describing the total amount of payments made to PPS-excluded hospitals, as amended, for cost reporting periods ending during the previous fiscal year.

CHAPTER 3 - PROVISIONS RELATED TO HOSPICE SERVICES**Section 10521. Payments for Hospice Services**

Current Law. Medicare covers hospice care, in lieu of most other Medicare benefits, for terminally ill beneficiaries. Payment for hospice care is based on one of four prospectively determined rates, which correspond to four different levels of care, each day a beneficiary is under the care of the hospice. The four rate categories are routine home care, continuous home care, inpatient respite care, and general inpatient care. The prospective payment rates are updated annually by the hospital market basket (MB).

Explanation of Provision. For each of the fiscal years 1998 through 2002, the hospice prospective payment rates would be updated by the market basket minus 1.0 percentage point. The Secretary would be required to collect data from participating hospices on the costs of care they provide for each fiscal year beginning with FY 1999.

Section 10522. Payment for Home Hospice Care Based on Location Where Care is Furnished

Current Law. Hospices generally bill Medicare on the basis of the location of the home office, rather than where service is actually delivered.

Explanation of Provision. Effective for cost reporting periods beginning on or after October 1, 1997, hospices would be required to submit claims on the basis of the location where a service is actually furnished.

Section 10523. Hospice Care Benefits Periods

Current Law. Persons electing Medicare's hospice benefit are covered for four benefit periods: two 90-day periods, a subsequent 30-day period, and a final period of unlimited duration.

Explanation of Provision. Hospice benefit periods would be restructured to include two 90-day periods, followed by an unlimited number of 60-day periods. The medical director or physician member of the hospice interdisciplinary team would have to recertify at the beginning of the 60-day periods that the beneficiary is terminally ill.

Section 10524. Other Items and Services Included in Hospice Care

Current Law. Hospice services are defined in Medicare statute to include nursing care; physical and occupational therapy and speech language pathology services; medical social services; home health aide services; medical supplies (including drugs and biologicals) and medical appliances; physician services; short-term inpatient care (including both respite care and procedures necessary for pain control and acute and chronic symptom management); and counseling. Beneficiaries electing hospice waive coverage to most Medicare services when the services they need are related to the terminal illness.

Explanation of Provision. The definition for hospice care would be amended to include the above-enumerated services as well as any other item or service which is specified in a patient's plan of care and which Medicare may pay for.

Section 10525. Contracting with Independent Physicians or Physician Groups for Hospice Care Services Permitted

Current Law. Medicare law requires that hospices routinely provide directly substantially all of certain specified services, often referred to as core services. Physician services are among these core services. HCFA has defined "directly" to require that services be provided by hospice employees.

Explanation of Provision. The provision would delete physician services from a hospice's core services and allow hospices to employ or contract with physicians for their services.

Section 10526. Waiver of Certain Staffing Requirements for Hospice Care Programs in Non-Urbanized Areas

Current Law. Hospices must provide certain services in order to participate in Medicare.

Explanation of Provision. The provision would allow the Secretary to waive requirements with regard to hospices having to provide certain services so long as they are *not* located in urbanized areas and can demonstrate to the satisfaction of the Secretary that they have been unable, despite diligent efforts, to recruit appropriate personnel. For these hospices, the Secretary could waive specifically the provision of physical or occupational therapy or speech-language pathology services and dietary counseling.

Section 10527. Limitation on Liability of Beneficiaries and Providers for Certain Hospice Coverage Denials

Current Law. Medicare law provides financial relief to beneficiaries and providers for certain services for which Medicare payment would otherwise be denied. Medicare payment under this "limitation of liability" provision is dependent on a finding that the beneficiary or provider did not know and could not reasonably have been expected to know that services would not be covered on one of several bases.

Explanation of Provision. The provision would extend limitation of liability protection to determinations that an individual is not terminally ill.

Section 10528. Extending the Period for Physician Certification of an Individual's Terminal Illness

Current Law. At the beginning of the first 90-day period when a Medicare beneficiary elects hospice, both the individual's attending physician and the hospice physician must certify in writing that the beneficiary is terminally ill not later than 2 days after hospice is initiated (or, verbally not later than 2 days after care is initiated and in writing not later than 8 days after care has begun).

Explanation of Provision. The provision would eliminate the specific time frame specified in statute for completion of physicians' certifications for admission to hospice to require only that physicians certify that a beneficiary is terminally ill at the beginning of the initial 90-day period.

Sec. 10531. Modification of Part A Home Health Benefit for Individuals Enrolled under Part B

Current Law. Both Parts A and B of Medicare cover home health. Neither part of the program applies deductibles or coinsurance to covered visits, and beneficiaries are entitled to an unlimited number of visits as long as they meet eligibility criteria. Section 1833(d) of Medicare law prohibits payments to be made under part B for covered services to the extent that individuals are also covered under Part A for the same services. As a result, the comparatively few persons who have no Part A coverage are the only beneficiaries for whom payments are made under Part B.

Explanation of Provision. The provision would gradually transfer from Part A to Part B home health visits that are not part of the first 100 visits following a beneficiary's stay in a hospital or skilled nursing facility and during a home health spell of illness. The transfer would be phased in between 1998 and 2003. In order to determine what portion of visits to transfer in a given year, the Secretary would first estimate the amount of payments that would have been made if (1) Part A home health services had the definition they did before enactment of this section and (2) Part A home health services were limited to the 100 visits following an institutional stay. The Secretary would next determine the difference between the two amounts for each year 1998 through 2002 and then multiply that amount by a proportion specified for the given year. For 1998, the proportion is 1/6; for 1999, 2/6; for 2000, 3/6; for 2001, 4/6; and for 2002, 5/6. The Secretary would be required to specify a visit limit or a post-institutional limitation that would result in a reduction in the amount of Part A home health payments equal to the transfer amount specified above. On or after January 1, 2003, Part A would cover only post-institutional home health services for up to 100 visits during a home health spell of illness, except for those persons with Part A coverage only who would be covered for services without regard to the post-institutional limitation.

Post-institutional home health services would be defined as services furnished to a Medicare beneficiary: (1) after an inpatient hospital or rural primary care hospital stay of at least 3 days, initiated within 14 days after discharge; or (2) after a stay in a skilled nursing facility, initiated within 14 days after discharge. Home health spell of illness would be defined as the period beginning when a patient first receives post-institutional home health services and ending when the beneficiary has not received inpatient hospital, skilled nursing facility, or home health services for 60 days.

CHAPTER 4. - OTHER PAYMENT PROVISIONS

Section 10541. Reductions in Payments For Enrollee's Bad Debt

Current Law. Certain hospital and other provider bad debts are reimbursed by Medicare on an allowable cost basis. To be qualified for reimbursement, the debt must be related to covered services and derived from deductible and coinsurance amounts left unpaid by Medicare beneficiaries. The provider must be able to establish that reasonable collection efforts were made and that sound business judgement established that there was no likelihood of recovery at any time in the future.

Explanation of Provision. The provision would reduce the allowable costs of bad debt payments to providers to 75% for cost reporting periods beginning during FY1998; 60% for cost reporting periods beginning during FY1999; and 50% for cost reporting periods beginning during FY2000 and each subsequent fiscal year.

Section 10542. Permanent Extension of Hemophilia Pass-Through

Current Law. Medicare makes additional payments for the costs of administering blood clotting factor to Medicare beneficiaries with hemophilia admitted for hospital stays where the clotting factor was furnished between June 19, 1990 and September 30, 1994.

Explanation of Provision. The provision would make the pass-through payment permanent, effective October 1, 1997.

Section 10543. Reduction in Part A Medicare Premium for Certain Public Retirees

Current Law. Almost all persons age 65 or over are automatically entitled to Part A. These individuals (or their spouses) established entitlement during their working careers by paying the hospital insurance (HI) payroll tax on earnings covered by either the social security or railroad retirement systems.

Persons not automatically entitled to Part A include some state and local government employees. State and local governments can choose whether or not to participate in Medicare for employees hired before April 1, 1986. They are required to participate (and pay the employer share of the payroll taxes) for all employees hired after that date.

Persons not automatically entitled to Part A may obtain coverage by paying the Part A premium. The 1997 premium is \$311. Beginning in 1994, certain persons are entitled to a reduction in the voluntary premium amount. Persons entitled to a reduction are those who (1) had at least 30 quarters of coverage under social security; (2) had been married for at least the previous year to a worker who had at least 30 quarters of coverage; (3) had been married for at least one year to a worker who had at least 30 quarters of coverage before the worker died; or (4) are divorced from (after at least 10 years of marriage to) a worker with at least 30 quarters of coverage. The otherwise applicable premium amount was reduced 25% in 1994, 30% in 1995, 35% in 1996, 40% in 1997, and 45% in 1998 and subsequent years.

Explanation of Provision. The provision would specify that the premium amount is zero for certain public retirees. An individual covered under this provision is one who has established to the satisfaction of the Secretary that the individual is receiving cash benefits under a qualified State or local government retirement system on the basis of the individual's employment over at least 40 calendar quarters (or on the basis of some combination of such covered employment and quarters of coverage under social security totaling at least 40 quarters). Also included would be an individual: (1) married for at least a year to an individual who had at least 40 quarters of such coverage; (2) had been married for at least a year to a worker who had at least 40 quarters of coverage before the worker died; or (3) are divorced from (after at least 10 years of marriage to) a worker with

at least 40 quarters of coverage. Individuals covered under this provision are those whose premium will not be paid in whole or part by a state (including under its Medicaid program), a political subdivision of a state, or agency or instrumentality of one or more states or political subdivisions. Further, for each of the preceding 60 months, the individual's premium was not paid in whole or in part by such governmental entity.

The provision would specify that a qualified state or local government retirement system is one which: (1) is established or maintained by a state or political subdivision, or an agency or instrumentality of one or more states or political subdivisions thereof; (2) covers positions of some or all employees of such entity; and (3) does not adjust cash retirement benefits based on eligibility for a premium reduction.

The provision would be effective January 1, 1998, except that months before that date could be counted in determining whether an individual met the 60 month requirement specified above.

SUBTITLE G - PROVISIONS RELATING TO PART B ONLY

CHAPTER 1. - PHYSICIANS' SERVICES

Section 10601. Establishment of Single Conversion Factor for 1998

Current Law. Medicare pays for physicians services on the basis of a fee schedule. The fee schedule assigns relative values to services. Relative values reflect three factors: physician work (time, skill, and intensity involved in the service), practice expenses, and malpractice costs. These relative values are adjusted for geographic variations in the costs of practicing medicine. Geographically-adjusted relative values are converted into a dollar payment amount by a dollar figure known as the conversion factor. There are three conversion factors -- one for surgical services, one for primary care services, and one for other services. The conversion factors in 1997 are \$40.96 for surgical services, \$35.77 for primary care services, and \$33.85 for other services.

Explanation of Provision. The provision would set a single conversion factor for 1998, based on the 1997 primary care conversion factor, updated to 1998 by the Secretary's estimate of the weighted average of the three separate updates that would occur in the absence of the legislation.

Section 10602. Establishing Update to Conversion Factor to Match Spending Under Sustainable Growth Rate.

Current Law. The conversion factors are updated each year by a formula specified in the law. The update equals inflation plus or minus actual rate of spending growth in a prior period compared to a target known as the Medicare volume performance standard (MVPS). (For example, fiscal year 1995 data were used in calculating the calendar 1997 update.) However, regardless of actual performance during a base period, there is a 5 percentage point limit on the amount of the reduction. There is no limit on the amount of the increase.

Explanation of Provision. The provision would specify the update to the conversion factor that would apply beginning in 1999 (unless otherwise provided for by law.) The provision would specify that the update to the single conversion factor for a year would equal the MEI subject to an adjustment to match spending under a sustainable growth rate. Specifically, the update for a year would be calculated by multiplying: (1) 1 plus the percentage change in the MEI, times (2) 1 plus the update adjustment factor (expressed as a percentage) for the year. The result would be reduced by 1 and multiplied by 100.

The provision would specify that the update adjustment factor for a year would equal the difference between the cumulative sum of allowed expenditures for July 1, 1997 through June 30 of the year involved and the cumulative sum of actual expenditures for such period divided by the allowed expenditures for the 12-month period (ending June 30) involved. For the 12-month period ending June 30, 1997, allowed expenditures would be defined as actual expenditures for the period, as estimated by the Secretary. For a subsequent 12-month period, allowed expenditures would be defined as allowed expenditures established for the previous period, increased by the sustainable growth rate established for the fiscal year which begins during that 12-month period..

The provision would establish limits on the amount of variation from the MEI; the update could not be more than four percentage points above or six percentage points below the MEI.

Section 10603. Replacement of Volume Performance Standard with Sustainable Growth Rate

Current Law. The Medicare Volume Performance Standard (MVPS), used to calculate the update in the conversion factor, is a goal for the rate of expenditure growth from one fiscal year to the next. The MVPS for a year is based on estimates of several factors (changes in fees, enrollment, volume and intensity, and laws and regulations). The calculation is subject to a reduction known as the performance standard factor.

Explanation of Provision. The provision would replace the MVPS with the sustainable growth rate. The rate for FY 1998 and subsequent years would be equal to the product of: (1) 1 plus the weighted average percentage change in fees for all physicians services in the fiscal year; (2) 1 plus the percentage change in the average number of individuals enrolled under Part B (other than private plan enrollees) from the previous fiscal year; (3) 1 plus the Secretary's estimate of the percentage growth in real gross domestic product per capita from the previous fiscal year; and (4) 1 plus the Secretary's estimate of the percentage change in expenditures for all physicians services in the fiscal year which will result from changes in law (excluding changes in volume and intensity resulting from changes in the conversion factor update). The result would be reduced by one and multiplied by 100. The term "physicians services" would exclude services furnished to a MedicarePlus plan enrollee.

Section 10604. Payment Rules for Anesthesia Services

Current Law. Anesthesia services are paid under a separate fee schedule (based on base and time units) with a separate conversion factor. The 1997 conversion factor is \$16.68.

Explanation of Provision. The provision would specify that the conversion factor would equal 46% of the conversion factor established for other services for the year.

Section 10605. Implementation of Resource-Based Physician Practice Expense

Current Law. P. L. 103-432 required that the Secretary develop and provide for the implementation, beginning in 1988, of a resource-based methodology for payment of practice expenses under the physician fee schedule. Such expenses are currently paid on the basis of historical charges.

Explanation of Provision. The provision would delay implementation of the practice expense methodology for one year until 1999. It would provide for a phase-in of the new methodology. In 1999, 25 percent of the practice payment would be based on the new methodology. This percentage would increase to 50 percent in 2000 and 75 percent in 2001. Beginning in 2002, the payment would be based solely on the new methodology.

Section 10606 Dissemination of Hospital-Specific Per Admission Relative Value

Current Law. In general, the law does not include a specific limit on the number or mix of physicians services provided in connection with an inpatient hospital stay. (However, the law does require that certain services provided in connection with a surgery be included in a global surgical package and not billed for separately.)

Explanation of Provision. During 1999 and 2001, the Secretary would determine for each hospital the hospital-specific per admission relative value for the following year and whether this amount is projected to be excessive (based on the 1998 national median of such values). The Secretary would be required to notify the medical executive committee of each hospital having been identified as having an excessive hospital-specific relative value.

The hospital-specific relative value projected for a non-teaching hospital would be the average per admission relative value for inpatient physicians services furnished by the medical staff for the second preceding calendar year, adjusted for variations in case mix and disproportionate share status. For teaching hospitals, the projected hospital-specific relative value would be: (1) the average per admission relative value for inpatient physicians services furnished by the medical staff for the second preceding calendar year; plus (2) the equivalent per admission relative value for physicians services furnished by interns and residents during the second preceding year, adjusted for case-mix, disproportionate share status, and teaching status among hospitals. The Secretary would be required to determine the equivalent relative value unit per intern and resident based on the best available data and could make such adjustment in the aggregate. The Secretary would be required to adjust the allowable per admission relative value otherwise determined to take into account the needs of teaching hospitals and hospitals receiving additional payments under PPS as disproportionate share hospitals or on the basis of their

classification as medicare-dependent small rural hospitals. The adjustment for teaching or disproportionate share status could not be less than zero.

Section 10607. No X-Ray Required for Chiropractic Services.

Current Law. Medicare covers chiropractic services involving manual manipulation of the spine to correct a subluxation demonstrated to exist by X-ray. Medicare regulations prohibit payment for the X-ray either if performed by a chiropractor or ordered by a chiropractor.

Explanation of Provision. The provision would eliminate the X-ray requirement effective January 1, 1998.

CHAPTER 2 - OTHER PAYMENT PROVISIONS

Section 10611. Payments for Durable Medical Equipment

Current Law

(a) Freeze in Durable Medical Equipment (DME) Updates. DME is reimbursed on the basis of a fee schedule. Items are classified into five groups for purposes of determining the fee schedules and making payments: (1) inexpensive or other routinely purchased equipment (defined as items costing less than \$150 or which is purchased at least 75 percent of the time); (2) items requiring frequent and substantial servicing; (3) customized items; (4) oxygen and oxygen equipment; and (5) other items referred to as capped rental items. In general, the fee schedules establish national payment limits for DME. The limits have floors and ceilings. The floor is equal to 85 percent of the weighted median of local payment amounts and the ceiling is equal to 100 percent of the weighted median of local payment amounts. Fee schedule amounts are updated annually by the consumer price index for all urban consumers, CPI-U.

(b) Update for Orthotics and Prosthetics. Prosthetics and orthotics are paid according to a fee schedule with principles similar to the DME fee schedule. The fee schedule establishes regional payment limits for covered items. The payment limits have floors and ceilings. The floor is equal to 90 percent of the weighted average of regional payment amounts and the ceiling is 120 percent. Fee schedule amounts are updated annually by CPI-U.

© *Payment Freeze for Parenteral and Enteral Nutrients, Supplies, and Equipment.* Parenteral and enteral nutrients, supplies, and equipment are paid on the basis of the lowest reasonable charge levels at which items are widely and consistently available in the community.

Explanation of Provision

(a) *Freeze in Durable Medical Equipment (DME) Updates.* The provision would eliminate updates to the DME fee schedules for the period 1998 through 2002.

(b) *Update for Orthotics and Prosthetics.* The update for the prosthetics and orthotics fee schedule would be limited to 1 percent for each of the years 1998 through 2002.

© *Payment Freeze for Parenteral and Enteral Nutrients, Supplies, and Equipment.* Payments for PEN would be frozen at 1995 levels for the period 1998 through 2002.

Section 10612. Oxygen and Oxygen Equipment

Current Law. Under Medicare oxygen and oxygen equipment are considered durable medical equipment and are paid according to a DME fee schedule. The fee schedule establishes a national payment limit for oxygen and oxygen equipment.

Explanation of Provision. The provision would reduce the national payment limit for oxygen and oxygen equipment by 20 percent for each of the years 1998 through 2002.

Section 10613. Reduction in Updates to Payment Amounts for Clinical Diagnostic Laboratory Tests

Current Law. Clinical diagnostic laboratory tests are paid on the basis of areawide fee schedules. The law sets a cap on payment amounts equal to 76% of the median of all fee schedules for the test. The fee schedule amounts are updated by the percentage change in the CPI. Variations exist among carriers in rules governing requirements labs must meet in filing claims for payments.

Explanation of Provision. The provision would freeze fee schedule payments for the 1998-2002 period. It would also lower the cap from 76% of the median to 72% of the median beginning in 1998.

Section 10614. Simplification in Administration of Laboratory Services Benefit

Current Law. Significant variations exist among carriers in rules governing requirements labs must meet in filing claims for payments.

Explanation of Provision. The provision would require the Secretary to divide the country into no more than 5 regions and designate a single carrier for each region to process laboratory claims no later than January 1, 1999. One of the carriers would be selected as a central statistical resource. The assignment of claims to a particular carrier

would be based on whether the carrier serves the geographic area where the specimen was collected or other method selected by the Secretary.

The provision would require the Secretary, by July 1, 1998, to adopt uniform coverage, administration, and payment policies for lab tests using a negotiated rule-making process. The policies would be designed to promote uniformity and program integrity and reduce administrative burdens with respect to clinical diagnostic laboratory tests in connection with beneficiary information submitted with a claim, physicians' obligations for documentation and recordkeeping, claims filing procedures, documentation, and frequency limitations.

The provision would provide that during the period prior to the implementation of uniform policies, carriers could implement new requirements under certain circumstances.

The provision would permit the use of interim regional policies where a uniform national policy had not been established. The Secretary would establish a process under which designated carriers could collectively develop and implement interim national standards for up to 2 years.

The Secretary would be required to conduct a review, at least every 2 years, of uniform national standards. The review would consider whether to incorporate or supersede interim regional or national policies.

With regard to the implementation of new requirements in the period prior to the adoption of uniform policies, and the development of interim regional and interim national standards, carriers must provide advance notice to interested parties and allow a 45 day period for parties to submit comments on proposed modifications.

The provision would require the inclusion of a laboratory representative on carrier advisory committees. The representative would be selected by the committee from nominations submitted by national and local organizations representing independent clinical labs.

Section 10615. Updates for Ambulatory Surgical Services

Current Law. Medicare pays for ambulatory surgical center (ASC) services on the basis of prospectively determined rates. These rates are updated annually by the CPI-U. OBRA 93 eliminated updates for ASCs for FY1994 and FY1995.

Explanation of Provision. The provision would set the updates for FY1996 and FY1997 at the percentage increase in the CPI-U. For FY1998 and succeeding fiscal years, the update percentage increase would be the increase in the CPI-U minus 2.0 percentage points.

Section 10616. Reimbursement for Drugs and Biologicals

Current Law. Payment for drugs is based on the lower of the estimated acquisition cost or the national average wholesale price. Payment may also be made as part of a reasonable cost or prospective payment.

Explanation of Provision. The provision would specify that in any case where payment is not made on a cost or prospective payment basis, the payment could not exceed 95 percent of the average wholesale price, as specified by the Secretary.

Section 10617. Coverage of Oral Anti-Nausea Drugs Under Chemotherapeutic Regimen

Current Law. Medicare provides coverage for certain oral cancer drugs. The Administration has specified that Medicare will pay for self-administrable oral or rectal versions of self-administered anti-emetic drugs when they are needed for the administration and absorption of primary Medicare covered oral anticancer chemotherapeutic agents when a high likelihood of vomiting exists.

Explanation of Provision. The provision would provide coverage, under specified conditions, for an oral drug used as an acute anti-emetic used as part of an anticancer chemotherapeutic regimen. It would have to be administered by or under the supervision of a physician for use immediately before, during or after the administration of the chemotherapeutic agent and used as a full replacement for the anti-emetic therapy which would otherwise be administered intravenously.

The provision would establish a per dose payment limit equal to 90 percent of the average per dose payment basis for the equivalent intravenous anti-emetics administered during the year, as computed based on the payment basis applied in 1996. The Secretary would be required to make adjustments in the coverage of or payment for the anti-nausea drugs so that an increase in aggregate payments per capita does not result.

Section 10618. Rural Health Clinics (RHCs)

Current Law. Medicare establishes payment limits for RHC services provided by independent (RHCs). RHCs, among other requirements, must have appropriate procedures for utilization review of clinic services. The Secretary is required to waive the RHC requirement for certain staffing of health professionals if the clinic has been unable to hire a physician assistant, nurse practitioner, or certified nurse-midwife in the previous nine years. The Secretary is prohibited from granting a waiver to a facility if the request for the waiver is made less than 6 months after the date of the expiration of previous waiver of the facility. RHCs are required to be located in a health professionals shortage area. For RHCs that are in operation and subsequently fail to meet the requirement of being located in a health professions shortage area, the Secretary would be required to

continue to consider the facility to meet the health professions shortage area requirement.

Explanation of Provision. The provision would apply per-visit payment limits to all RHCs, other than such clinics in rural hospitals with less than 50 beds. The provision would require that RHCs have a quality assessment and performance improvement program, in addition to appropriate procedures for utilization review.

The provision would amend the waiver on the staffing requirement, to provide a waiver if the facility has not yet been determined to meet the requirement of having a nurse practitioner, physician assistant, or a certified nurse-midwife available 50% of the time the clinic operates. The provision would require that shortage designations for RHCs be reviewed every three years. The provision would further amend the shortage area requirement by adding that RHCs must be located in area in which there are insufficient numbers of needed health care practitioners as determined by the Secretary. The provision would require that RHCs that are in operation and subsequently fail to meet the requirement of being located in a health professions shortage area, continue to be considered to meet the health professions shortage requirement, but only when, under criteria established by the Secretary in regulations, to be essential to the delivery of primary care services that would otherwise be unavailable in the geographic area served by the clinic. The Secretary would be required to issue final regulations implementing the grandfathered clinics that would be required to take effect no later than January 1 of the third calendar year beginning at least one month after enactment. The provision would take effect on the effective date of the regulations.

Section 10619. Increased Medicare Reimbursement for Nurse Practitioners and Clinical Nurse Specialists

Current Law. Separate payments are made for nurse practitioner (NP) services provided in collaboration with a physician, which are furnished in a nursing facility. Recognized payments equal 85% of the physician fee schedule amount. Nurse practitioners and clinical nurse specialists (CNSs) are paid directly for services provided in collaboration with a physician in a rural area. Payment equals 75% of the physician fee schedule amount for services furnished in a hospital and 85% of the fee schedule amount for other services.

Explanation of Provision. The provision would remove the restriction on settings. It would also provide that payment for NP and CNS services could only be made if no facility or other provider charges are paid in connection with the service. Payment would equal 80% of the lesser of either the actual charge or 85% of the fee schedule amount for the same service if provided by a physician. For assistant-at-surgery services, payment would equal 80% of the lesser of either the actual charge or 85% of the amount that would be recognized for a physician serving as an assistant at surgery. The provision would authorize direct payment for NP and CNS services.

The provision would clarify that a clinical nurse specialist is a registered nurse licensed to practice in the state and who holds a master's degree in a defined clinical area of nursing from an accredited educational institution.

Section 10620. Increased Medicare Reimbursement for Physician Assistants

Current Law. Separate payments are made for physician assistant (PA) services when provided under the supervision of a physician : (1) in a hospital, skilled nursing or nursing facility, (2) as an assistant at surgery, or (3) in a rural area designated as a health professional shortage area.

Explanation of Provision. The provision would remove the restriction on settings. It would also provide that payment for PA services could only be made if no facility or other provider charges are paid in connection with the service. Payment would equal 80% of the lesser of either the actual charge or 85% of the fee schedule amount for the same service if provided by a physician. For assistant-at-surgery services, payment would equal 80% of the lesser of either the actual charge or 85% of the amount that would be recognized for a physician serving as an assistant at surgery. The provision would further provide that the PA could be in an independent contractor relationship with the physician. Employer status would be determined in accordance with state law.

Section 10621. Renal Dialysis-Related Services

Current Law. Medicare covers persons who suffer from end-stage renal disease. Facilities providing dialysis services must meet certain requirements.

Explanation of Provision. The provision would require the Secretary to audit a sample of cost reports of renal dialysis providers for 1995 and for each third year thereafter. The Secretary would also be required to develop and implement by January 1, 1999, a method to measure and report on the quality of renal dialysis services provided under Medicare in order to reduce payments for inappropriate or low quality care.

CHAPTER 3 - PART B PREMIUM

Section 10631. Part B Premium

Current Law. When Medicare was established in 1965, the Part B monthly premium was intended to equal 50% of program costs. The remainder was to be financed by federal general revenues, i.e., tax dollars. Legislation enacted in 1972 limited the annual percentage increase in the premium to the same percentage by which social security benefits were adjusted for cost-of-living increases (i.e., cost-of-living or COLA adjustments). As a result, revenues dropped to below 25% of program costs in the early 1980s. Since the early 1980s, Congress has regularly voted to set the premium equal to 25% of costs. Under current law, the 25% provision is extended through 1998; the COLA limitation would again apply in 1999.

Explanation of Provision. In conjunction with the transfer of a portion of home health care spending from Part A to Part B, this provision would transition to the calculation of a Part B premium equal to 25% of program costs.

CHAPTER 1- PROVISIONS RELATING TO MEDICARE SECONDARY PAYER

Section 10701. Permanent Extension of Certain Secondary Payer Provisions

Current Law. Generally, Medicare is the primary payer, that is, it pays health claims first, with an individual's private or other public plan filling in some or all of the coverage gaps. In certain cases, the individual's other coverage pays first, while Medicare is the secondary payer. This is known as the Medicare secondary payer (MSP) program. The MSP provisions apply to group health plans for the working aged, large group health plans for the disabled, and employer health plans (regardless of size) for the end-stage renal disease (ESRD) population for 18 months. The MSP provisions for the disabled expire October 1, 1998. The MSP provisions for the ESRD population apply for 12 months, except the period is extended to 18 months for the February 1, 1991 - October 1, 1998 period.

The law authorizes a data match program which is intended to identify potential secondary payer situations. Medicare beneficiaries are matched against data contained in the Social Security Administration and Internal Revenue Service files to identify cases where a working beneficiary (or working spouse) may have employer-based health insurance coverage.

Explanation of Provision. The provision would make permanent the provisions relating to the disabled and the data match program.

The provision would extend application of the MSP provisions for the ESRD population for 30-months. This would apply to items and services furnished on or after enactment with respect to periods beginning on or after the date that is 18 months prior to enactment.

Section 10702. Clarification of Time and Filing Limitations

Current Law. In many cases where MSP recoveries are sought, claims have never been filed with the primary payer. Identification of potential recoveries under the data match process typically takes several years - considerably in excess of the period many health plans allow for claims filing. A 1994 appeals court decision held that HCFA could not recover overpayments without regard to an insurance plan's filing requirements.

Explanation of Provision. The provision would specify that the U.S. could seek to recover payments if the request for payments was submitted to the entity required or responsible to pay within three years from the date the item or service was furnished. This provision would apply notwithstanding any other claims filing time limits that may apply under an employer group health plan. The provision would apply to items and services furnished after 1990. The provision should not be construed as permitting any waiver of the 3-year requirement in the case of items and services furnished more than 3 years before enactment.

Section 10703. Clarification of Liability of Third Party Administrators

Current Law. A 1994 appeals court decision held that HCFA could not recover from third party administrators of self-insured plans.

Explanation of Provision. The provision would permit recovery from third party administrators of primary plans. However, recovery would not be permitted where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.

The provision would clarify that the beneficiary is not liable in MSP recovery cases unless the benefits were paid directly to the beneficiary.

The provision would apply to services furnished on or after enactment.

CHAPTER 2 - HOME HEALTH SERVICES

Section 10711. Recapturing Savings Resulting from Temporary Freeze on Payment Increases from Home Health Services

Current Law. Home health care agencies are currently reimbursed on the basis of reasonable costs, up to specified limits. Cost limits are determined separately for each type of covered home health service (skilled nursing care, physical therapy, speech pathology, occupational therapy, medical social services, and home health aide), and according to whether an agency is located in an urban or rural area. Cost limits, however, are applied to aggregate agency expenditures; that is, an aggregate cost limit is set for each agency that equals the limit for each type of service multiplied by the number of visits of each type provided by the agency. Limits for the individual services are set at 112 percent of the mean labor-related and nonlabor per visit costs for freestanding agencies. Cost limits are updated annually by applying a market basket index to base year data derived from home health agency cost reports. The labor-related portion of a service limit is adjusted by the current hospital wage index.

The Omnibus Budget Reconciliation Act of 1993 (OBRA 93) required that there be no changes in home health cost limits (including no adjustments for changes in the wage index or other updates of data) for cost reporting periods beginning on or after July 1, 1994, and before July 1, 1996. The Secretary was also required, when granting or extending exceptions to cost limits, to limit any exception to the amount that would have been granted if there were no restriction on changes in the cost limits. OBRA 93 also repealed the requirement that additional payments be made to hospital-based home health agencies for costs attributable to excess overhead allocations, effective for cost reporting periods beginning on or after October 1, 1993.

Explanation of Provision. In establishing home health limits for cost reporting periods beginning after September 30, 1997, the Secretary would be required to capture the savings stream resulting from the OBRA 93 freeze of home health limits by not allowing for the market basket updates to the limits that occurred during the cost reporting periods July 1, 1994 through June 30, 1996. In granting exemptions or exceptions to the cost limits, the Secretary would not consider the preceding provision for recapturing savings from the OBRA 93 freeze.

Section 10712. Interim Payments for Home Health Services.

Current Law. Limits for individual home health services are set at 112 percent of the mean labor-related and nonlabor per visit costs for freestanding agencies (i.e., agencies not affiliated with hospitals). The limits are effective for cost reporting periods beginning on or after July 1 of a given year and ending June 30 of the following year.

Explanation of Provision. The provision would reduce per visit cost limits to 105 percent of the national *median* of labor-related and nonlabor costs for freestanding home

health agencies, effective for cost-reporting periods beginning October 1, 1997 (in effect, delaying the cycle for updating the limits).

For cost reporting periods beginning on or after October 1, 1997, home health agencies would be paid the lesser of: (1) their actual costs (i.e., allowable reasonable costs); (2) the per visit limits, reduced to 105% of the national median; or (3) a new agency-specific per beneficiary annual limit calculated from 1994 reasonable costs (including non-routine medical supplies), updated by the home health market basket. For new providers and those providers without a 12-month cost reporting period ending in calendar year 1994, the per beneficiary limit would be equal to the median of these limits (or the Secretary's best estimates) applied to home health agencies. Home health agencies that have altered their corporate structure or name would not be considered new providers for these purposes. For beneficiaries using more than one home health agency, the per beneficiary limitation would be prorated among the agencies.

The Secretary would be required to expand research on a prospective payment system for home health that ties prospective payments to a unit of service, including an intensive effort to develop a reliable case mix adjuster that explains a significant amount of variance in cost. The Secretary would be authorized to require all home health agencies to submit additional information that is necessary for the development of a reliable case-mix system, effective for cost reporting periods beginning on or after October 1, 1997.

Section 10713. Clarification of Part-Time or Intermittent Nursing Care

Current Law. Both Parts A and B of Medicare cover home health visits for persons who need skilled nursing care on an intermittent basis or physical therapy or speech therapy. Once beneficiaries qualify for the benefit, the program covers part-time or intermittent nursing care provided by or under the supervision of a registered nurse and part-time or intermittent home health aide services, among other services. Coverage guidelines issued by HCFA have defined part-time and intermittent.

Explanation of Provision. Effective for services furnished on or after October 1, 1997, the provision would include in Medicare statute definitions for part-time and intermittent skilled nursing and home health aide. For purposes of receiving skilled nursing and home health aide services, "part-time or intermittent" would mean skilled nursing and home health aide services furnished any number of day per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week). For purposes of qualifying for Medicare's home health benefit because of a need for intermittent skilled nursing care, "intermittent" would mean skilled nursing care that is either provided or needed on fewer than 7 days each week, or less than 8 hours of each day of skilled nursing and home health aide services combined for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).

Section 10714. Definition of Homebound

Current Law. In order to be eligible for home health care, a Medicare beneficiary must be confined to his or her home. The law specifies that this "homebound" requirement is met when the beneficiary has a condition that restricts the ability of the individual to leave home, except with the assistance of another individual or with the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. The law further specifies that while an individual does not have to be bedridden to be considered confined to home, the condition of the individual should be such that there exists a normal inability to leave home, that leaving home requires a considerable and taxing effort by the individual, and that absences from home are infrequent or of relatively short duration, or are attributable to the need to receive medical treatment.

Explanation of Provision. The provision would add to the definition of "homebound" a specification that the beneficiary's condition restrict his or her ability to leave the home for more than an average of 16 hours per calendar month for purposes other than to receive medical treatment that cannot be provided in the home. "Infrequent" would be defined to mean an average of 5 or fewer absences per calendar month, excluding absences to receive medical treatment that cannot be furnished in the home. "Short duration" would mean an absence from the home of 3 or fewer hours, on average per absence, within a calendar month, excluding absences to receive medical treatment that cannot be furnished in the home. "Medical treatment" would mean any services that are furnished by the physician or furnished based on and in conformance with the physician's order, by or under the supervision of a licensed health professional, and for the purpose of diagnosis or treatment of an illness or injury. These changes would be effective for services furnished on or after October 1, 1997.

Section 10715. Payment Based on Location Where Home Health Service is Furnished

Current Law. Some home health agencies are established with the home office in an urban area and branch offices in rural areas. Payment is based on the where the service is billed, in this case the urban area with its higher wage rate, even if the service had been delivered in a rural area.

Explanation of Provision. Effective for cost reporting periods beginning on or after October 1, 1997, home health agencies would be required to submit claims on the basis of the location where a service is actually furnished.

Section 10716. Normative Standards for Home Health Claims Denials

Current Law. As long as they remain eligible, home health users are entitled to unlimited number of visits.

Explanation of Provision. The provision would authorize the Secretary to establish normative guidelines for the frequency and duration of home health services. Payments would be denied for visits that exceed the normative standard. The provision would also authorize the Secretary to establish a process for notifying a physician in which the number of home health visits furnished according to a prescription or certification of the physician significantly exceeds the threshold normative number of visits that would be covered for specific conditions or situations.

Section 10717. No Home Health Benefits Based Solely on Drawing Blood

Current Law. In order to qualify for Medicare's home health benefit, a person must be homebound and be in need a intermittent skilled nursing care or physical or speech therapy.

Explanation of Provision. The provision would clarify that a person could not qualify for Medicare's home health benefit on the basis of needing skilled nursing care for venipuncture for the purpose of obtaining a blood sample.

CHAPTER 3 - BABY BOOM GENERATION MEDICARE COMMISSION

Section 10721. Bipartisan Commission on the Effect of the Baby Boom Generation on the Medicare Program

Current Law. No provision.

Explanation of Provision. The provision would establish a commission to be known as the Bipartisan Commission on the Effect of the Baby Boom Generation on the Medicare Program, hereafter referred to as "the Commission." It would be required to: (1) examine the financial impact on the Medicare program of the significant increase in the number of Medicare eligible individuals which will occur approximately during 2010 and lasting for approximately 25 years, and (2) make specific recommendations to Congress with respect to a comprehensive approach to preserve the Medicare program for the period during which such individuals are eligible for Medicare. In making its recommendations, the Commission would be required to consider: (1) the amount and sources of Federal funds to finance Medicare, including innovative financing methods; (2) methods used by other nations to respond to comparable demographics; (3) modifying age-based eligibility to correspond to that under the OASDI program; and (4) trends in employment-related health care for retirees, including the use of medical savings accounts and similar financing devices.

The Commission would be composed of 15 voting members, 6 appointed by the Majority Leader of the Senate in consultation with the Minority Leader, of whom no more than 4 are of the same party; 6 by the Speaker of the House, after consultation with the Minority Leader, of whom no more than 4 are in the same party; and 3 ex officio members

of the Board of Trustees of the Federal Hospital Insurance Trust Fund and of the Federal Supplementary Medical Insurance Trust Fund who are Cabinet level officials. The provision spells out the appointment of a chair and vice chair, appointment of staff and consultants, compensation, the procedure for filling vacancies, and requirements relating to meetings and quorums. The Chairman, in consultation with the vice chairman, could appoint an advisory panel. Upon request of the Commission, the Comptroller General would be required to conduct such studies or investigations as the Commission determined were needed to carry out its duties. The Director of CBO would be required to provide the commission with cost estimates, for which CBO would be compensated. The Commission would be authorized to detail to it employees of Federal agencies, and to obtain technical assistance and information from Federal agencies.

The Commission would be required to submit to Congress a report, no later than May 1, 1999, containing its findings and recommendations regarding how to protect and preserve the Medicare program in a financially solvent manner until 2030 (or, if later, throughout a period of projected solvency of the Federal Old-Age and Survivors Insurance Trust Fund). The report would be required to include detailed recommendations for appropriate legislative initiatives respecting how to accomplish this objective. The Commission would terminate 30 days after the date of submission of the mandated report. An amount of \$1.5 million would be authorized to be appropriated; 60% would be payable from the Federal Hospital Insurance Trust Fund and 40% from the Federal Supplementary Medical Insurance Trust Fund.

CHAPTER 4 - PROVISIONS RELATING TO DIRECT GRADUATE MEDICAL EDUCATION

Section 10731. Limitation on Payment Based on Number of Residents and Implementation of Rolling Average FTE Count

Current Law. The direct costs of approved graduate medical education (GME) programs (such as the salaries of residents and faculty, and other costs related to medical education programs) are excluded from PPS and are paid on the basis of a formula that reflects Medicare's share of each hospital's per resident costs. Medicare's payment to each hospital equals the hospital's costs per full-time-equivalent (FTE) resident, times the weighted average number of FTE residents, times the percentage of inpatient days attributable to Medicare Part A beneficiaries. Each hospital's per FTE resident amount is calculated using data from the hospital's cost reporting period that began in FY1984, increased by 1 percent for hospital cost reporting periods beginning July 1, 1985, and updated in subsequent cost reporting periods by the change in the CPI. OBRA-93 provided that the per resident amount would not be updated by the CPI for costs reporting periods during FY1994 and FY1995, except for primary care residents in obstetrics and gynecology. The number of FTE residents is weighted at 100 percent for residents in their initial residency period (i.e., the number of years of formal training necessary to satisfy specialty requirements for board eligibility). Residents in preventive care or geriatrics are allowed a period of up to 2 additional years in the initial residency training period. For residents not in their initial residency period, the weighing factor is 50 percent. On or after

July 1, 1986, residents who are foreign medical graduates can only be counted as FTE residents if they have passed designated examinations.

Explanation of Provision. For cost reporting periods beginning on or after October 1, 1997, the provision would limit the total number of full-time equivalent (FTE) residents for which Medicare would make payments to the number of FTE residents in training during the hospital's cost reporting period ending December 31, 1996. For the cost reporting period beginning on or after October 1, 1997, the total number of FTE equivalent residents counted for determining the hospital's direct GME payment would equal the average FTE counts for the cost reporting period and the preceding cost reporting period. For each subsequent cost reporting period, the total number of FTEs residents counted for determining the hospital's direct GME payment, would be equal to the average of the actual FTE counts for the cost reporting period and preceding two cost reporting periods. The provision would allow that, if a hospital's cost reporting period beginning on or after October 1, 1997, was not equal to 12 months, the Secretary would make appropriate modifications to ensure that the average FTE resident counts are based on the equivalent of full 12-month cost reporting periods.

Section 10732. Phased-In Limitation on Hospital Overhead and Supervisory Physician Component of Direct Medical Education Costs

Current Law. Medicare's direct medical education costs for a cost reporting period includes an aggregate amount that is the product of the hospital's approved FTE resident amount and the weighted average number of FTE residents in the hospitals approved medical residency training programs in that period.

Explanation of Provision. The provision would phase-in a limitation on hospital overhead and supervisory physician costs. For hospitals with overhead GME amounts in a base period that exceed the 75th percentile of the weighted overhead GME amount in such period for all hospitals, the GME amount made for periods beginning on or after October 1, 1997, would be reduced by the lesser of: (1) 20% of the amount by which the overhead GME amount exceeds the 75th percentile amount, or (2) 15% of the hospital's overhead GME amount otherwise determined without regard to this provision. The overhead GME amount for a period would be the product of the percentage of the hospital's per resident payment amount for the base period that was not attributable to salaries and fringe benefits, and the hospital specific per resident payment amount for the period involved. The base period would be defined as the cost reporting period beginning in FY1984 or the period used to establish the hospital's per resident payment amount for hospitals that did not have approved residency training programs in FY1984. The Secretary would be required to establish rules for the application of this provision in the case of a hospital that initiated medical residency training programs during or after the base cost reporting period.

Section 10733. Permitting Payment to Non-Hospital Providers

Current Law. No provision.

Explanation of Provision. The provision would require the Secretary to submit to Congress, no later than 18 months after enactment, a proposal for payment to qualified non-hospital providers for their direct costs of medical education, if those costs are incurred in the operation of a Medicare approved medical residency training program. The proposal would be required to specify the amounts, form, and manner in which such payments would be made, and the portion of the payments that would be made from each of the Medicare trust funds. The Secretary would be authorized to implement the proposal for residency years beginning no earlier than 6 months after the date the report is submitted. Qualified non-hospital providers would include federally qualified health centers, rural health clinics, MedicarePlus organizations, and other providers the Secretary determined to be appropriate.

The provision would also require the Secretary to reduce the aggregate approved amount to the extent payment would be made to non-hospital providers for residents included in the hospital's count of FTE residents, and in the case of residents not included in the FTE count, the Secretary would be required to provide for such a reduction in aggregate approved amounts under this subsection to assure that the application of non-hospital providers does not result in any increase in expenditures than would have occurred if payments were not made to non-hospital providers.

Section 10734. Incentive Payments Under Plans For Voluntary Reduction in Number Of Residents

Current Law. No provision.

Explanation of Provision. The provision would establish a program to provide incentive payments to hospitals that developed plans for the voluntary reduction in the number of residents in a training program. For voluntary residency reduction plans for which an application was approved, the qualifying entity submitting the plan would be required to be paid an applicable hold harmless percentage equal to the sum of the amount by which (1) the amount of payment which would have been made under this subsection if there had been a 5% reduction in the number of FTE residents in the approved medical education training programs as of June 30, 1997, exceeded the amount of the payment which would be made taking into account the reduction in the number effected FTEs under the plan; and (2) the amount of the reduction in payment under Medicare's indirect medical education adjustment that was attributable to the reduction in the number of residents effected under the plan.

The provision would prohibit the Secretary from approving the application of an qualifying entity unless: (1) the application was submitted in a form and manner specified by not later than March 1, 2000; (2) the application provided for the operation of a plan for the reduction in the number of FTE residents in the approved medical residency training programs of the entity were consistent with those specified in the provision; (3) the entity elected whether such reduction occurs over a period of not longer than 5 residency training years, or 6 residency training years; (4) the Secretary determined that

the application and the entity and the plan meet other requirements as the Secretary specifies in regulations.

The provision specifies that qualifying entities would include individual hospitals operating one or more approved medical residency training programs; two or more hospitals operating residency programs that apply as a single qualifying entity; or a qualifying consortium. In the case of an application by a qualifying entity consisting of two hospitals, the Secretary would be prohibited from approving the application unless the application represented that the qualifying entity either (1) would not reduce the number of FTE residents in primary care during the period of the plan, or (2) would not reduce the proportion of its residents in primary care (to the total number of residents) below such proportion as in effect during the period the residency reduction plan was in effect. In the case of an application from a consortia, the Secretary would be prohibited from approving the application unless the application represented that the qualifying entity would not reduce the proportion of residents in primary care (to total residents) below such proportion in effect during the period the residency reduction plan was in effect.

For individual hospital applicants, the number of FTE residents in all the approved medical residency training programs operated by or through the facility would be required to be reduced as follows: (1) if the base number of residents exceeded 750 residents, by a number equal to at least 20% of the base number; (2) if the base number of residents exceeded 500, but was less than 750 residents, by 150 residents; (3) if the base number of residents did not exceed 500 residents, by a number equal to at least 25% of the base number; (4) in the case of a qualifying entity that was a consortia, by a number equal to at least 20% of the base number. The reductions in the number of FTE residents in the approved medical residency programs operated through or by an entity would be below the base number of residents for the entity and would be fully effective no later than the 5th residency training year for entities electing a 5-year plan, or the 6th residency training year for entities making the election of a 6-year reduction plan.

The provision would require that entities provide assurance that in reducing the number of residents, entities maintained their primary care residents. Entities would be required to provide assurance that they would maintain the number of primary care residents if: (1) the base number of residents is less than 750; (2) the number of FTE residents in primary care included in the base year was at least 10% of the total number of residents; and (3) the entity represented in its application that there would be no reduction under the plan in the number of FTE residents in primary care. If the entity failed to comply with the requirement that the number of FTE residents in primary care were maintained, the entity would be subject to repayment of all amounts received under this program.

The base number of residents would be defined as the number of FTE residents in residency training program of the entity as of June 30, 1997. The "applicable hold harmless percentage" for entities electing a 5-year reduction plan would be 95% for the first and second residency training years in which the reduction plan; 75% in the third

the fourth year; and 25% in the fifth year. The "applicable hold harmless" entities electing a 6-year reduction plan would be 100% in the first year of the plan; 95% in the second year of the plan; 85% in the third year of the plan; 50% in the fourth year; 25% in the fifth year. In addition, if made under this program to an entity that increased the number of FTE to the number provided in the plan, the entity would then be liable for the Secretary of the total amount paid under the plan. The Secretary would be required to establish rules regarding the counting of residents who are assigned to the program that do not have medical residency training programs participating in a demonstration plan.

The requirements of the residency reduction plan would not apply to any residency demonstration project approved by HCFA as of May 27, 1997. The Secretary is required to take necessary action to assure that in no case the amount of payments under the plan would exceed 95% of what payments would have been prior to the demonstration project. As of May 27, 1997, the Secretary is prohibited from approving any demonstration project that would provide for reduced payments in connection with reductions in the number of residents in the program for any residency training year beginning before July 1, 2006. The Secretary is authorized to promulgate regulations, that take effect on an interim basis and pending opportunity for public comment, by no later than 6 months after the date of enactment.

Demonstration Project on Use of Consortia

Law: No provision.

Text of Provision. The provision would require the Secretary to establish a demonstration project under which, instead of making direct GME payments to teaching hospitals, the Secretary would make payments to each consortium that met the requirements of the demonstration project. A qualifying consortium would be required to meet the following: (1) the consortium would consist of an approved medical residency training program in a teaching hospital and one or more of the following: a school of allopathic or osteopathic medicine, another teaching hospital, an approved medical residency training program, a federally qualified health center, a medical group practice, a managed care entity, an entity providing graduate medical education, or an entity determined to be appropriate by the Secretary; (2) the consortium would have agreed to participate in the programs of graduate medical education that are operated by entities in the consortium; (3) with respect to the distribution of direct GME payments, the members of the consortium would have agreed to allocating the payments among the members; and (4) the consortium would meet the additional requirements established by the Secretary. The total amount of direct GME payments to a consortium for a fiscal year would not be permitted to exceed the amount that would have been paid under the direct GME payment to teaching hospitals. The payments would be required to be made in such manner as to be paid from Medicare trust funds as the Secretary specifies.

Section 10736. Recommendations on Long-Term Payment Policies Regarding Financing Teaching Hospitals and Graduate Medical Education

Current Law. No provision.

Explanation of Provision. The provision would require the Medicare Payment Advisory Commission (established by the bill) to examine and develop recommendations on whether and to what extent Medicare payment policies and other federal policies regarding teaching hospitals and graduate medical education should be reformed. The Commission's recommendations would be required to include each of the following: (1) the financing of graduate medical education, including consideration of alternative broad-based sources of funding for such education and models for the distribution of payments under any all-payer financing mechanism; (2) the financing of teaching hospitals, including consideration of the difficulties encountered by such hospitals as competition among health care entities increases, including consideration of the effects on teaching hospitals of the method of financing used for the MedicarePlus program under part C of Medicare; (3) possible methodologies for making payments for graduated medical education and the selection of entities to receive such payments, including consideration of matters as (A) issues regarding children's hospitals and approved medical residency training programs in pediatrics, and (B) whether and to what extent payments were being made (or should be made) for training in the various nonphysician health professions; (4) federal policies regarding international graduates; (5) the dependence of schools of medicine on service-generated income; (6) whether and to what extent the needs of the U.S. regarding the supply of physicians, in the aggregate and in different specialties, would change during the 10-year period beginning on October 1, 1997, and whether and to what extent any such changes would have significant financial effects on teaching hospitals; (7) methods for promoting an appropriate number, mix, and geographical distribution of health professionals; and (8) the treatment of dual training programs in primary care fields.

The Commission would be required to consult with the Council on Graduate Medical Education and individuals with expertise in the area of graduate medical education, including (1) deans from allopathic and osteopathic schools of medicine; (2) chief executive officers (or their equivalent) from academic health centers, integrated health care systems, approved medical residency training programs, and teaching hospitals that sponsor approved medical residency training programs; (3) chairs of departments or divisions from allopathic and osteopathic schools of medicine, schools of dentistry, and approved medical residency training programs in oral surgery; (4) individuals with leadership experience from each of the fields of advanced practice nursing, physician assistants, and podiatric medicine; (5) individuals with substantial experience in the study of issues regarding the composition of the U.S. health care workforce; and (6) individuals with expertise on the financing of health care.

The Commission would be required to submit a report to the Congress no later than 2 years after enactment providing its recommendations under this section and the reasons and justifications for such recommendations.

Section 10741. Centers of Excellence

Current Law. No provision.

Explanation of Provision. The provision would create a new program, the Centers of Excellence, under which the Secretary would be required to use a competitive process to contract with specific hospitals or other entities for furnishing services related to surgical procedures, and for furnishing services (unrelated to surgical procedures) to hospital inpatients that the Secretary determines to be appropriate. The services could include any services covered by Medicare that the Secretary determined were appropriate, including post-hospital services. The Secretary would be required to contract with entities that meet quality standards established by the Secretary, and contracting entities would be required to implement a quality improvement plan approved by the Secretary.

Payment for services provided under the program would be made on the basis of a negotiated all-inclusive rate. The amount of payment made for services covered under a contract would be required to be less than the aggregate amount of payments that would have been made otherwise for these same services. The contract period would be required to be 3 years, and could be renewed as long as the entity continued to meet quality and other contractual standards. Entities under these contracts would be permitted to furnish additional services (at no cost to a Medicare beneficiary) or waive cost-sharing, subject to approval by the Secretary. The Secretary would be required to limit the number of centers in a geographic area to the number needed to meet project demand for contracted services.

Section 10742. Medicare Part B Special Enrollment Period and Waiver of Part B Late Enrollment Penalty and Medigap Special Open Enrollment Period for Certain Military Retirees and Dependents

Current Law. Persons generally enroll in Part B when they turn 65. Persons who delay enrollment in the program after their initial enrollment period are subject to a premium penalty. This penalty is a surcharge equal to 10% of the premium amount for each 12 months of delayed enrollment. There is no upper limit on the amount of penalty that may apply. Further, the penalty continues to apply for the entire time the individual is enrolled in Part B.

Some persons declined Part B coverage because they thought they would be able to get health care coverage at a nearby military base; many of these bases subsequently closed.

Explanation of Provision. The provision would waive the delayed enrollment penalty for certain persons who enroll during a special six month enrollment period which begins with the first month that begins at least 45 days after enactment. An individual covered under this provision is one: (1) who, on the date of enactment is at least 65 and eligible to enroll in Part B; (2) who, at the time the individual first met the enrollment requirements was a "covered beneficiary" under the military medical and dental care

program. Covered beneficiary as defined in section 1072(5) of title 10 of the U.S. Code excludes an active duty beneficiary. Part B coverage would begin the month after enrollment.

The provision would also guarantee issuance of a Medigap type "A", "B" or "C" policy to an individual who enrolls with a Medigap plan during the same 6-month enrollment period.

SUBTITLE I- MEDICAL LIABILITY REFORM

CHAPTER 1. - GENERAL PROVISIONS

Section 10801. Federal Reform of Health Care Liability Actions

Current Law. There are no uniform Federal standards governing health care liability actions.

Explanation of Provision. The provision would provide for Federal reform of health care liability actions. It would apply to any health care liability action brought in any State or Federal court. The provisions would not apply to any action for damages arising from a vaccine-related injury or death or to the extent that the provisions of the National Vaccine Injury Compensation Program apply. The provisions would also not apply to actions under the Employment Retirement Income Security Act. The provisions would preempt State law to the extent State law provisions were inconsistent with the new requirements. However, it would not preempt State law to the extent State law provisions were more stringent. The provision would not affect or waive the defense of sovereign immunity asserted by any State or the U.S., affect the applicability of the Foreign Sovereign Immunities Act of 1976, preempt State choice-of-law rules with respect to claims brought by a foreign nation or citizen, or affect the right of any court to transfer venue.

Section 10802. Definitions

Current Law. No provision.

Explanation of Provision. The provision would define the following terms for purposes of the Federal reforms: actual damages; alternative dispute resolution system; claimant; clear and convincing evidence; collateral source payments; drug; economic loss; harm; health benefit plan; health care liability action; health care liability claim; health care provider; health care service; medical device; noneconomic damages; person; product seller; punitive damages; and State.

Section 10803. Effective Date

Current Law. No provision.

Explanation of Provision. The provision would specify that Federal reforms apply to any health care liability action brought in any State or Federal court that is initiated on or after the date of enactment. The provision would also apply to any health care liability claim subject to an alternative dispute resolution system, Any health care liability claim or action arising from an injury occurring prior to enactment would be governed by the statute of limitations in effect at the time the injury occurred.

CHAPTER 2 - UNIFORM STANDARDS FOR HEALTH CARE LIABILITY ACTIONS

Section 10811. Statute of Limitations

Current Law. To date reforms of the malpractice system have occurred primarily at the State level and have generally involved changes in the rules governing tort cases. (A tort case is a civil action to recover damages, other than for a breach of contract.)

Explanation of Provision. The provision would establish uniform standards for health care liability claims. It would establish a uniform statute of limitations. Actions could not be brought more than two years after the injury was discovered or reasonably should have been discovered. In no event could the action be brought more than five years after the date of the alleged injury.

Section 10812. Calculation and Payment of Damages

Current Law. No provision.

Explanation of Provision. The provision would limit noneconomic damages to \$250,000 in a particular case. The limit would apply regardless of the number of persons against whom the action was brought or the number of actions brought.

The provision would specify that a defendant would only be liable for the amount of noneconomic damages attributable to that defendant's proportionate share of the fault or responsibility for that claimant's injury.

The provision would permit the award of punitive damages (to the extent allowed under State law) only if the claimant established by clear and convincing evidence either that the harm was the result of conduct that specifically intended to cause harm or the conduct manifested a conscious flagrant indifference to the rights or safety of others. The amount of punitive damages awarded could not exceed \$250,000 or three times the amount of economic damages, whichever was greater. The determination of punitive damages would be determined by the court and not be disclosed to the jury. The provision would not create a cause of action for punitive damages. Further, it would not preempt or supersede any State or Federal law to the extent that such law would further limit punitive damage awards.

The provision would permit either party to request a separate proceeding (bifurcation) on the issue of whether punitive damages should be awarded and in what amount. If a separate proceeding was requested, evidence related only to the claim of punitive damages would be inadmissible in any proceeding to determine whether actual damages should be awarded.

The provision would prohibit the award of punitive damages against a manufacturer or product seller in a case where a drug or medical device was subject to premarket approval by the Food and Drug Administration (or generally recognized as safe according to conditions established by the FDA), unless there was misrepresentation or fraud. A manufacturer or product seller would not be held liable for punitive damages related to adequacy of required tamper resistant packaging unless the packaging or labeling was found by clear and convincing evidence to be substantially out of compliance with the regulations.

The provision would permit the periodic (rather than lump sum) payment of future losses in excess of \$50,000. The judgment of a court awarding periodic payments could not, in the absence of fraud, be reopened at any time to contest, amend, or modify the schedule or amount of payments. The provision would not preclude a lump sum settlement.

The provision would permit a defendant to introduce evidence of collateral source payments. Such payments are those which are any amounts paid or reasonably likely to be paid by health or accident insurance, disability coverage, workers compensation, or other third party sources. If such evidence was introduced, the claimant could introduce evidence of any amount paid or reasonably likely to be paid to secure the right to such collateral source payments. No provider of collateral source payments would be permitted to recover any amount against the claimant or against the claimant's recovery.

Section 10813. Alternative Dispute Resolution

Current Law. No Provision.

Explanation of Provision. The provision would require that any alternative dispute resolution system used to resolve health care liability actions or claims must include provisions identical to those specified in the bill relating to statute of limitations, non-economic damages, joint and several liability, punitive damages, collateral source rule, and periodic payments.

MEDICARE AMENDMENTS -- Full Committee Mark-Up

1. Waxman -- Strike MSAs; use savings for paying premiums for low-income (SLMB)
2. Brown -- Reduce size of MSA demo; use savings to pay copays for preventive benefits
3. Green -- Medigap; allow 1 year in managed care, then guarantee issue back into a Medigap plan, for people who had Medigap before; limit choice of Medigap plans; one-time-only guarantee issue.
4. Stupak -- Fraud (adds additional parts of President's bill)
5. Pallone -- Safe medications for elderly demo (pharmacist cognitive services)
6. Deutsch -- AAPCC; eliminate 70:30 blend
7. Green -- PSO state pre-emption, modification of language agreed to in Subcommittee, as per agreement with Greenwood
8. Brown -- Non-discrimination by health plans against provider, based on license
9. Pallone -- Medicare Commission to look at Medicare role for chronic disease
10. McCarthy -- Baby Boom Commission recommendations must be converted into legislation and voted on, unless Congress develops its own recommendations
11. Engel -- Study of use of adjunctive technology for pap smear screening
12. Pallone -- Medicare counseling program
13. Klink -- Apply balance billing restrictions to MSA plans
14. Engel -- Study of new home health requirements

AMENDMENTS

MEDICAID

1. Waxman - Premium protections for low-income Seniors
2. Strickland - Children with Special Needs
3. Brown/Dingell - Fraud and Abuse
4. Waxman - Patient Choice
5. Stupak - FQHCs
6. DeGette - Presumptive Eligibility

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7. Towns - Nurse Mid-wives
 8. Green - DSH
 9. Green - Texas Privatization
 10. Markey - Strike conscience clause

KID CARE

1. Brown/Waxman/Dingell - CHIPS
2. Waxman - Strike Direct purchase of services
3. Pallone/Eshoo/Furse - Kid care substitute
4. DeGette - Strike Hyde language

File (CJ)
Medicare
FEHBP

THE PRESIDENT'S MEDICARE BUDGET AND FEHBP

Supporters of the Federal Employees Health Benefit Program (FEHBP) as a model for the Medicare program argue that an FEHBP style approach would increase the number of plans from which beneficiaries could choose and provide structural change that would save money. The President's Budget would achieve these goals without changing the fundamental federal guarantees of the Medicare program.

BENEFICIARY CHOICE AND PROTECTION

Annual Open Enrollment With Community Rating

The FEHBP has an annual open enrollment period during which members can move from one plan to another without any penalties based on their age or health status. All FEHBP plans are community rated. Under current Federal law, individuals 65 or over have a once in a lifetime opportunity to select the Medigap plan of their choice when they first become eligible for Part B of Medicare. However, if a beneficiary enrolls in a managed care plan and is later dissatisfied, he or she may not have the opportunity to select the Medigap plan of his or her choice because almost all carriers underwrite. Currently, Medigap plans can use low premiums to entice younger beneficiaries to enroll, but as the enrollee ages, the premiums can increase to unaffordable levels. Because of the difficulties of returning to fee-for-service with the Medigap plan of their choice, some beneficiaries are reluctant to try managed care, and others are locked into managed care options. Under the President's budget, all Medigap and managed care plans will have a one month coordinated open enrollment period each year, similar to FEHBP. Medigap plans would be required to use community rating (the rating methodology used by FEHBP) to establish premiums.

Choice of Plans

FEHBP eligibles often have a choice of several different health plans to select from, including fee-for-service, HMOs, and point-of-service plans. Medicare has already moved in this direction. Sixty-three percent of beneficiaries live in an area where they have a choice of at least one HMO in addition to fee-for-service Medicare, and 50 percent have a choice of more than one HMO. The President's Budget would further expand the options available to Medicare beneficiaries by contracting with PPOs and PSOs. These options are currently being tested with Medicare beneficiaries in the Medicare Choices demonstration.

Comparative Information

As in FEHBP, the budget proposes to distribute comparative information on plan options to beneficiaries through a neutral broker, ensuring that all beneficiaries are aware of the advantages and additional benefits that many managed care plans offer. The President's Budget also includes a proposal to work with the National Association of Insurance Commissioners to standardize some of the additional benefits provided by managed care plans so that Medicare beneficiaries can make

an "apples to apples" comparison when evaluating their coverage options.

Quality of Care

To monitor quality, OPM surveys members concerning their satisfaction with plans, and makes these reports available to FEHBP eligibles during the open enrollment season. Under the President's plan, the Secretary, in consultation with consumers and the industry, would 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.

The Administration will be pushing for these provisions during the reconciliation process.

STRUCTURAL CHANGES

Submission of Bids by Health Plans

The FEHBP accepts bids from national plans, and then negotiates rates locally with managed care plans. HCFA is trying to move Medicare in this direction with the Medicare Managed Care Competitive Pricing Demonstration project, although they are encountering resistance from the managed care industry. The demonstration would test how Medicare can take advantage of competitive market forces in setting the rates it pays managed care plans. HCFA would use bids submitted by local plans to set the rate Medicare pays plans in that area. On May 16th, however, a federal judge granted an order precluding HCFA from reading the bids that it has received in this demonstration, pending a hearing on June 12th.

Geographic Variation in Payments

FEHBP negotiates rates for plans over relatively large geographic areas, and pays some insurers national rates. As a result, there is less geographic variation in payments to managed care providers in FEHBP than in Medicare. The President's Budget includes a proposal to reduce the geographic variation in payments. This would reduce incentives for plans to operate on a county-by-county basis.

TALKING POINTS ON THE BUDGET AGREEMENT

MEDICARE

The budget agreement will make important changes that will improve the program without eroding the health care protection that it provides to older Americans and the disabled. The agreement will modernize Medicare, make it more efficient, and extend its solvency to the year 2008. At the same time, it adds important preventive care to the basic benefit package, and it protects beneficiaries financially.

- The Medicare provisions build on proven methods of structural reform. These include:
 - ▶ Building on our success with the inpatient hospital prospective payment system to create a prospective payment system for home health services, skilled nursing facilities, and outpatient departments:

Before PPS was implemented for hospitals, per capita Medicare spending on hospital care was growing well above the private insurance average. Following implementation of PPS Medicare's per capita growth rate for hospital spending dropped and remains at a level similar to the private insurance average.
 - ▶ Offering consumers more choices for managed care, by creating new Preferred Provider Organizations and Provider Sponsored Organizations options. These options are currently being tested in the Medicare Choices demonstration, and would be extended to all beneficiaries under the budget agreement. In addition, Medicare beneficiaries will be provided with comparative information about their health care options, similar to the information provided by FEHBP.
 - ▶ Taking steps to even out the geographical disparity in Medicare payments to managed care plans that has limited the availability of options in rural areas.
- The agreement adds critical preventive benefits to the health coverage Medicare beneficiaries receive. The new benefits include:
 - ▶ Screening for breast and colon cancer. This will allow beneficiaries and their doctors to detect these diseases earlier. Early detection can result in less costly treatment, enhanced quality of life, and in some cases, greater likelihood of curing the disease.
 - ▶ Training and supplies for better management of diabetes.
 - ▶ Increased reimbursement rate for immunizations to protect seniors from pneumonia, influenza, and hepatitis. This may improve the likelihood that some seniors will be vaccinated.

- The agreement protects beneficiaries financially.
 - ▶ It maintains the premium at its current level, 25 percent of program costs.
 - ▶ It phases home health into the Part B premium over seven years. It includes \$1.5 billion in Medicaid funds to expand the number of low-income beneficiaries who will not have to pay any Part B premium.
 - ▶ It begins to correct the high copayment rates for outpatient hospital services.

MEDICAID

In the Medicaid program, the agreement preserves the federal entitlement to coverage for our nation's most vulnerable people, restores some of the benefits that were wrongfully stripped from legal immigrants, and invests in additional coverage for children. The agreement includes achievable reductions in Medicaid, equivalent to about 2.2% of total projected Medicaid spending.

- The agreement preserves our commitment to the most vulnerable by maintaining the federal entitlement to Medicaid. The agreement does not embrace block grants or other options that would threaten access to coverage for the poorest of our citizens.
- The agreement restores and extends benefits for some of the most vulnerable people in our population. Funds are included to:
 - ▶ Restore SSI and Medicaid disability benefits to legal immigrants who entered the country before August 23, 1996, if they are or become disabled, and to all legal immigrants who are on the rolls before June 1, 1997,
 - ▶ Expand the number of low-income elderly whose Part B premiums are paid by Medicaid, and
 - ▶ Cover uninsured children, possibly through expansions of the Medicaid program and efforts to enroll currently eligible children who have not enrolled.
- The reductions required from Medicaid are necessary to control the growth of the program into the future. However, the per capita cap policy that so many States disliked because of the restrictions it would have imposed on their programs was dropped from the budget agreement. Instead, cuts are to come from the Disproportionate Share Hospital program. Although this program provides needed funds to hospitals, there is room for reform:
 - ▶ States increased DSH spending from \$400 million in Federal funds in 1989 to

\$10.1 billion in 1992.

- ▶ DSH spending is still largely unrelated to the distribution across States of uncompensated care.
 - In 1995, the Urban Institute concluded that the best indicator of the size of a State's DSH program appeared to be the State's assertiveness in developing these arrangements before the 1991 Federal restrictions were enacted.
 - In fact, even in FY 1995, the latest, most complete year of DSH spending available, 54.3% of all federal DSH funds went to just six states.
 - The same study indicates that about one-third of DSH funds were used for other government services, and may never be received by the hospitals the program is intended to help.
- ▶ The CBO baseline for 1998 through 2002 projects a total of \$59.6 billion in DSH spending; the budget agreement proposes to cut only \$16.4 billion of that amount, or approximately 27%.
- The agreement also includes Medicaid reforms intended to give States more flexibility to manage their Medicaid programs, including the ability to implement managed care programs without seeking a federal waiver.

KIDS

- The agreement includes \$16 billion for the President's goal of providing health insurance for up to five million children who are currently uninsured. This is a major breakthrough in our efforts to move toward coverage for all Americans.
- We must be creative and flexible in overcoming the barriers to covering these children. There is no single reason why these children are uninsured, and no single solution to their coverage exists. We will need to cast a comprehensive net. We will continue to work with the Congress, the States, and the private sector to determine how these funds can be best spent to extend comprehensive health insurance coverage to the greatest number of currently uninsured children.
- Options that we should pursue include restoring Medicaid for currently disabled children losing SSI because of the new, more strict definition of childhood disability, guaranteeing a full year of Medicaid coverage to eligible children, providing funds to state initiatives aimed at uninsured children, and improving our outreach efforts to identify and enroll children who are eligible but not enrolled in Medicaid.

Gramm Medicare Proposal File

Program Spending

The impact on overall program spending is negligible, with the difference being a yearly savings in the range of \$500 million.

The primary effect on overall spending is a significant shift towards higher Part A spending. There would be \$4 billion more in yearly Part A spending (and about \$4.5 billion less in Part B spending).

Program spending on expenses of the dual eligible (Medicare-Medicaid) would increase by \$1.3 billion per year, as cost sharing expenses are reduced by that level for this population.

Number of Beneficiaries Affected

Overall, 70% of beneficiaries would have higher Medicare cost sharing expenses; 17% would have lower Medicare cost sharing expenses; and 12% would see no effect.

Among users of services, 80% would have higher Medicare cost sharing expenses.

How People Are Affected

Average Medicare cost sharing expenses for all beneficiaries will remain unchanged, but there are differences among categories of beneficiaries, with a reduction of approximately 7 percent for the lowest income group to an increase of approximately 16 percent for the highest income group. Average amount of increase in cost sharing is \$309, and average amount of decrease is \$1,242.

As noted above, Medicaid beneficiaries will have a reduction in Medicare cost sharing expenses. The reduction averages 20% (from \$1209 per person per year to \$975).

Individuals with no supplemental coverage will see an average 2.5% reduction in cost sharing expenses, from a yearly average of \$567 to \$552.

Effects by Expenditure Categories

As illustrated in the attached graphs, the proposal would most benefit the small number of individuals with Medicare cost-sharing expenses in excess of \$2,000. In calendar year 1994 there were about 2.7 million individuals in this category, accounting for 46% of all Medicare cost-sharing.

Analysis Description

1. Proposal - illustrative version of Senator Gramm's proposal for revising Medicare cost-sharing. Under this proposal there would be a \$1,000 deductible, applied jointly to Part A and Part B services, with a \$2,000 out-of-pocket maximum.
2. Data source is the 1993 Medicare Current Beneficiary Survey.
3. Medicare cost sharing expenses are defined as beneficiary liability before any reduction through supplemental coverage, and do not include Medicare or Medigap premiums.
4. Analysis assumes no change in supplemental coverage.

COLUMBIA UNIVERSITY PROPOSAL FOR IMPROVING MEDICARE COST SHARING
 SUBJECT: TEL# 11000 OUT-OF-POCKET MAX = \$2,000
 SOURCE: DMC'S 1993 COST & USE FILE

NUMBER OF MEDICARE PER-FOR-SERVICE BENEFACTARIES SUPPLEMENTARY BY STATUS	CURRENT LAW		PROPOSED LAW		PERCENT WITH INCREASE	PERCENT WITH DECREASE	PERCENT UNCHANGED	PERCENT WITH INCREASE	PERCENT WITH DECREASE	PERCENT UNCHANGED	USERS	PERCENT OF USERS WITH DECREASE	PERCENT OF USERS WITH INCREASE
	TOTAL	REIMB	TOTAL	REIMB									
TOTAL	34,018,140	6,054,745	24,477,245	4,262,649	47.4	70.3	12.3	30,152,411	10.8	89.0			
NO SUPPLEMENTAL COVERAGE	6,774,084	901,385	3,845,026	1,578,343	44.4	61.3	24.4	4,735,943	13.0	86.4			
EMPLOYER SPONSORED	10,257,817	1,941,771	7,389,754	1,316,593	15.1	72.0	12.9	6,970,267	17.3	82.4			
SELF PURCHASED	10,659,363	1,844,786	7,863,316	917,491	17.4	74.9	7.8	6,972,048	18.8	81.1			
BOTH	9,908,951	333,916	1,418,989	134,246	17.8	75.3	7.8	1,772,815	18.9	81.1			
UNEMPLOYED	11,104	0	11,104	0	0.0	100.0	0.0	11,104	0.0	100.0			
MEDICAID	5,734,000	1,419,159	3,802,314	682,067	24.5	66.9	8.5	3,754,753	26.8	73.0			

MEDICARE RETIREMENT AND COST SHARING EXPENSES

SUPPLEMENTARY BY STATUS	CURRENT LAW		PROPOSED LAW		TOTAL MEDICARE COST SHARING
	TOTAL	REIMB	TOTAL	REIMB	
TOTAL	\$131,007,431	\$49,889,475	\$81,108,973	\$26,608,179	\$104,500,794
NO SUPPLEMENTAL COVERAGE	19,704,831	4,197,079	6,207,529	3,554,117	16,443,264
EMPLOYER SPONSORED	11,703,644	1,814,742	11,288,109	1,974,530	30,100,375
SELF PURCHASED	26,119,813	24,729,731	14,692,057	8,114,500	39,363,479
BOTH	7,532,660	4,371,427	2,591,136	1,368,707	17,365,229
UNEMPLOYED	28,204	0	28,204	0	28,204
MEDICAID	34,017,738	72,174,399	10,841,523	9,331,771	34,354,675

PER CAPITA MEDICARE REIMBURSEMENT AND COST SHARING EXPENSES

SUPPLEMENTARY BY STATUS	CURRENT LAW		PROPOSED LAW		TOTAL AVERAGE MEDICARE COST SHARING
	TOTAL	REIMB	TOTAL	REIMB	
TOTAL	\$3,821	\$1,467	\$2,354	\$1,104	\$3,458
NO SUPPLEMENTAL COVERAGE	\$2,768	\$1,367	\$1,401	\$707	\$2,168
EMPLOYER SPONSORED	\$2,661	\$1,897	\$1,180	\$645	\$2,016
SELF PURCHASED	\$3,697	\$3,203	\$1,600	\$713	\$3,294
BOTH	\$3,947	\$2,405	\$2,942	\$1,311	\$3,654
UNEMPLOYED	\$2,409	0	\$2,460	\$1,050	\$2,319
MEDICAID	\$2,853	\$3,885	\$2,055	\$1,285	\$3,161

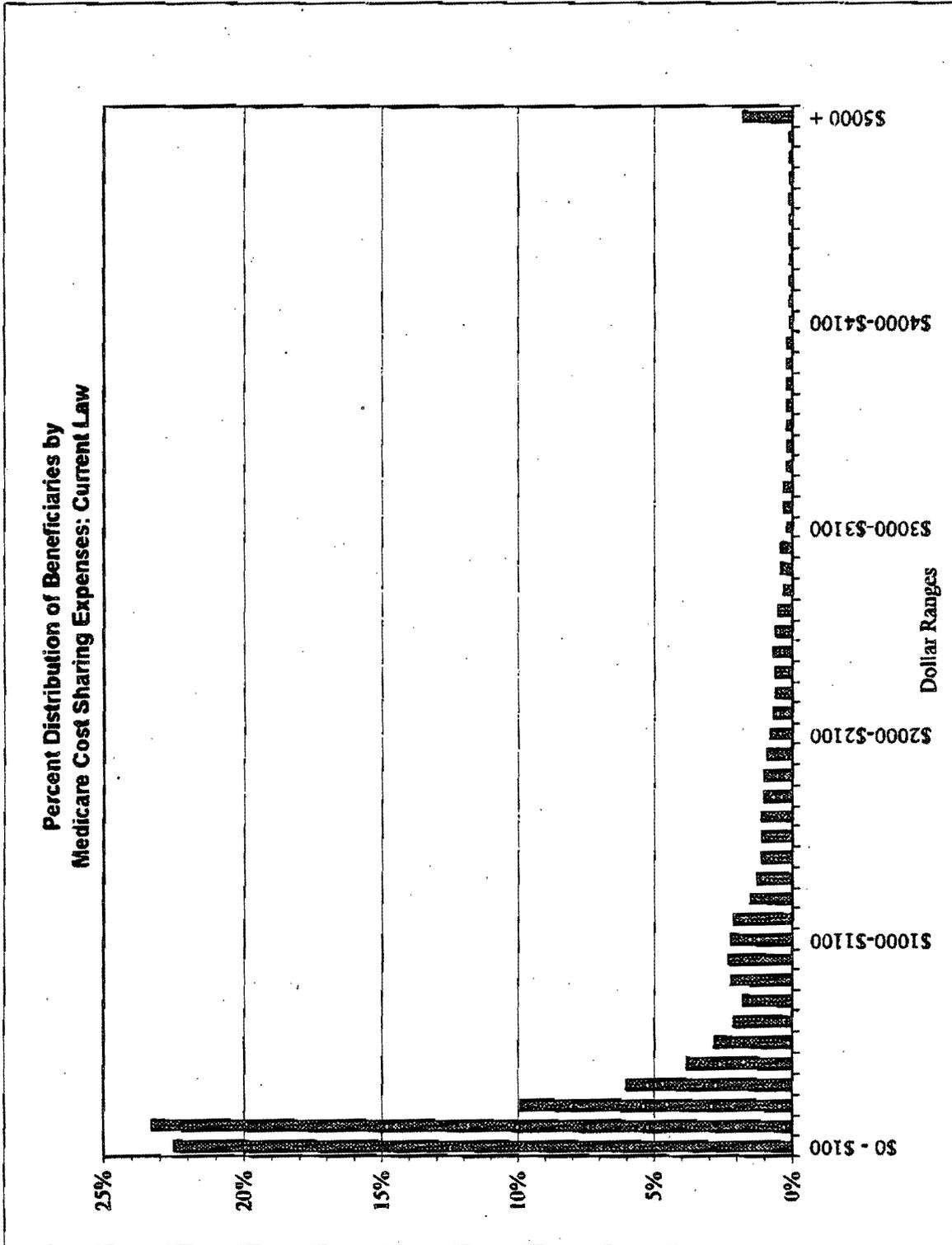
NOTE: 1. Differences in amounts were determined by the change in cost sharing expenses (see Note 2) between current law and proposed law.
 2. Most net cost sharing expenses are defined as total beneficiary liability less any reduction through supplemental coverage, and do not include the size of the group premium.
 3. Any job retention benefits with supplemental coverage under current law includes such coverage under the proposed and therefore would be subject to cost sharing effects.

GRAMM ILLUSTRATIVE PROPOSAL FOR REVISING
 MEDICARE COST SHARING
 DEDUCTIBLE=\$1,000 OUT-OF-POCKET MAX = \$2,000
 PER CAPITA MEDICARE REIMBURSEMENT AND COST SHARING EXPENSES BY INCOME

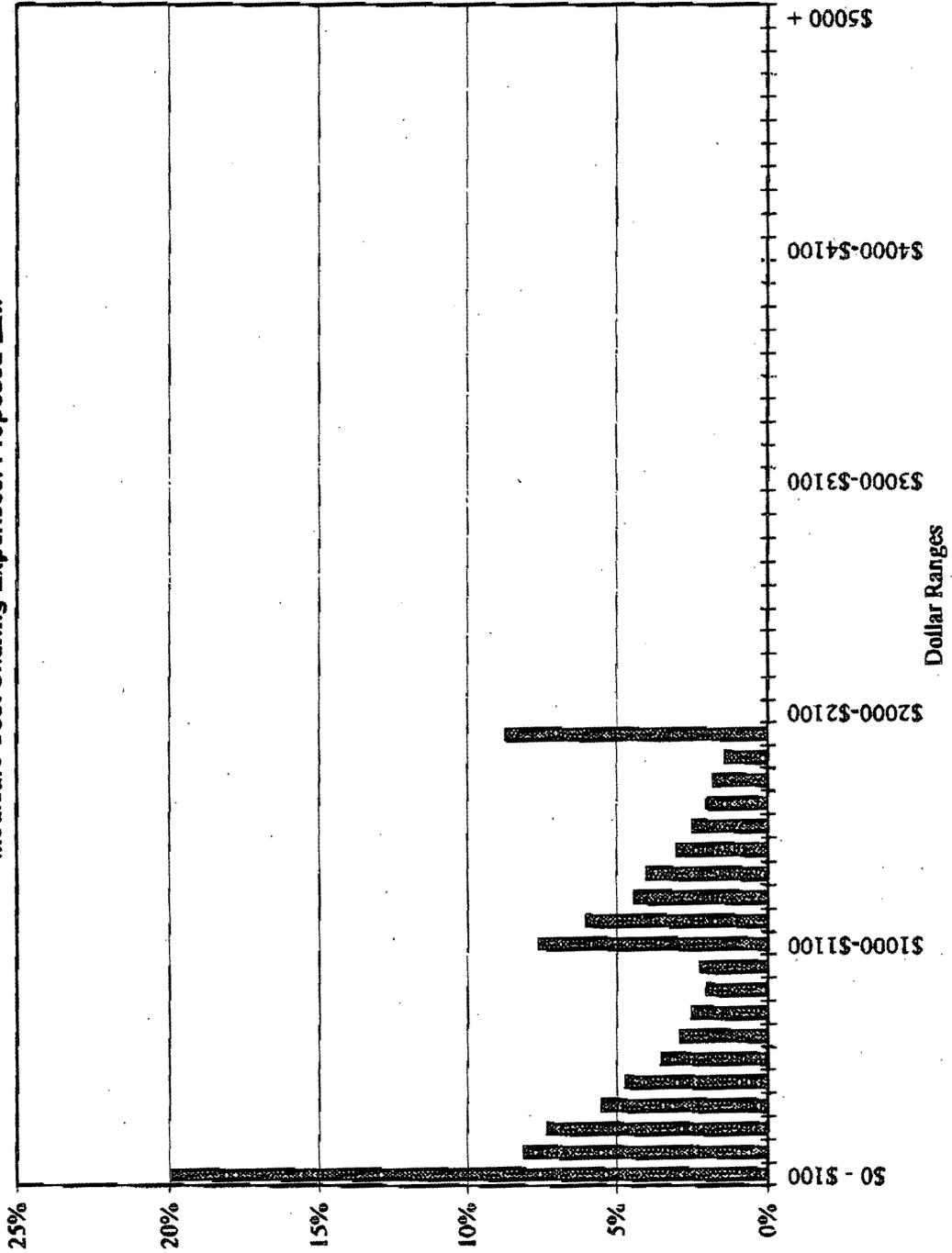
SOURCE: MCBS 1993 COST & USE FILE

INCOME GROUP	CURRENT LAW				PROPOSED LAW				CHANGE IN MEDICARE COST SHARING	
	TOTAL REIMB	PART A REIMB	PART B REIMB	AVERAGE MEDICARE COST SHARING	TOTAL REIMB	PART A REIMB	PART B REIMB	AVERAGE MEDICARE COST SHARING	AMOUNT	PERCENT
TOTAL POPULATION	\$3,780	\$2,413	\$1,367	\$771	\$3,766	\$2,527	\$1,238	\$772	\$1	0.13%
INCOME=UNDER \$10,000	\$4,453	\$2,917	\$1,536	\$677	\$4,504	\$3,075	\$1,478	\$815	(\$62)	-7.07%
INCOME=\$10,001 - \$25,000	\$3,665	\$2,317	\$1,318	\$749	\$3,631	\$2,444	\$1,187	\$756	\$6	0.80%
INCOME=\$25,001 - \$50,000	\$3,078	\$1,876	\$1,200	\$655	\$2,976	\$1,943	\$1,033	\$753	\$98	14.96%
INCOME=\$50,001 OR MORE	\$2,389	\$1,251	\$1,148	\$589	\$2,302	\$1,284	\$1,019	\$683	\$94	15.96%

NOTE: 1 Medicare cost sharing expenses are defined as beneficiary liability before any reduction through supplemental coverage, and do not include Medicare or Medigap premiums.
 2 Analysis assumes beneficiaries with supplemental coverage under current law maintain such coverage under the proposal and therefore would not be subject to any reduction effects



Percent Distribution of Beneficiaries by Medicare Cost Sharing Expenses: Proposed Law



Medicare ~~As Above~~ Income Related Program File

Medicare Reform

November 18, 1997

Penn, Schoen & Berland Associates, Inc.

Means Testing

Currently seniors of all income levels pay the same premium for Medicare. Would you strongly support, somewhat support, somewhat oppose, or strongly oppose means testing Medicare which would raise the premiums for Medicare for seniors with over \$75,000 in income?

- ✓ 61% support (45% strongly +16% somewhat)
- 35% oppose (26% strongly +9% somewhat)

One proposal would have all seniors with incomes over \$50,000 pay a higher premium. Currently all beneficiaries pay \$43.80 per month. This proposal would have those with annual incomes of greater than \$75,000 pay \$110 per month and those with incomes over \$100,00 would pay \$175 per month. The additional revenue would be used to strengthen the Medicare trust fund.

- ✓ 74% support (53% strongly +21% somewhat)
- 22% oppose (12% strongly +10% somewhat)

Some people say this will turn Medicare into a second class health care system. They argue that it will encourage some seniors to leave the program, which will decrease funds in the Medicare system overall. Given this do you strongly support, somewhat support, somewhat oppose, or strongly oppose means testing for Medicare?

- ✓ 64% support (33% strongly +31% somewhat)
- 33% oppose (18% strongly +15% somewhat)

43% say that this is something simple, and legislation should be passed now to implement means testing to help keep the Medicare system financially stable. 48% say that means testing should be addressed by the Medicare Commission and that no proposal should be discussed until the commission releases its findings in 1999.

MEDICARE PLAN SCORING
(Dollars in billion, FY)

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2000-04	2005-09	2000-09
DRUG BENEFIT: 50% up to \$5,000	0.0	0.0	6.1	13.0	15.0	17.9	20.7	23.0	24.9	26.9	34.1	113.4	147.5
60% Premium Subsidy			\$19	\$20	\$25	\$29	\$32	\$34	\$36	\$38			
SAVINGS													
Managed Care Reform	0.0	0.0	0.0	0.0	0.0	-0.4	-1.0	-1.4	-1.8	-1.9	0.0	-6.5	-6.5
Traditional Medicare Modernization	0.0	-0.5	-1.2	-1.9	-2.8	-3.8	-4.0	-4.4	-4.7	-5.0	-6.4	-21.9	-28.3
Provider Savings *	0.0	0.0	0.1	-1.1	-2.7	-4.4	-6.2	-8.2	-10.8	-13.4	-3.7	-43.0	-46.7
Provider Set-Aside **	0.4	1.7	1.1	0.7	0.5	0.6	0.6	0.7	0.7	0.8	4.4	3.3	7.7
Cost Sharing (No deductible) ***	0.0	0.0	-0.4	-0.7	-0.8	-0.9	-0.9	-1.0	-1.2	-1.3	-1.9	-5.3	-7.2
Income-Related Premium	0.0	-0.7	-3.0	-2.5	-2.7	-2.8	-3.0	-3.3	-3.5	-3.8	-8.9	-16.4	-25.3
Interactions	0.0	0.0	-0.1	-0.1	0.0	0.0	0.1	0.0	0.3	0.1	-0.2	0.5	0.3
Premium Offset ****	0.0	-0.1	0.1	0.2	0.4	0.7	1.0	1.3	1.4	1.8	0.7	6.2	6.8
TOTAL	0.4	0.4	-3.4	-5.4	-8.0	-11.1	-13.4	-16.3	-19.6	-22.8	-16.1	-83.1	-99.2
SHORTFALL / SURPLUS	0.4	0.4	2.7	7.6	7.0	6.8	7.3	6.7	5.3	4.1	18.0	30.3	48.3
<i>Ratio of Savings to Surplus</i>											<i>0.9 to 1</i>	<i>2.7 to 1</i>	<i>2.1 to 1</i>
<i>Surplus as percent of spending</i>											<i>53%</i>	<i>27%</i>	<i>33%</i>

* Adjusted: subtracted rural

** Placeholder: includes: (1) IME at 6.5% for 00-01; (2) OPD transition costs; (3) add-on to SNF RUGs; (4) therapy caps at \$2,000.

*** Subtracted Part B deductible index

**** Increased by 10%

Questions and Answers on OMB Scoring of BBA Medicare Policies

Medicare: Summary of OMB and CBO Scoring FY 1998 - FY 2002

(OACT standalone estimates, OMB calculations of managed care interactions)

	CBO Scoring	OMB Scoring	OMB over CBO
Managed Care	\$21.7 billion	\$45.5 billion	\$23.8 billion
Hospitals	\$39.9 billion	\$56.3 billion	\$16.4 billion
Medicaid Cost Sharing	(\$4.4 billion)	(\$2.3 billion)	\$2.1 billion
Part B Premiums	\$14.8 billion	\$16.3 billion	\$1.5 billion
SNF/Hospice	\$9.7 billion	\$10.4 billion	\$0.7 billion
Home Health	\$16.2 billion	\$16.7 billion	\$0.5 billion
Physicians	\$4.9 billion	\$5.3 billion	\$0.4 billion
Fraud and Abuse	\$0.1 billion	\$0.3 billion	\$0.2 billion
Other Policies	(\$1.7 billion)	(\$1.8 billion)	(\$0.1 billion)
MSP	\$7.9 billion	\$6.8 billion	(\$1.1 billion)
New Benefits	(\$3.9 billion)	(\$6.5 billion)	(\$2.6 billion)
Other Part B	\$6.9 billion	\$3.0 billion	(\$3.9 billion)
Total	\$112.1 billion	\$149.8 billion	\$37.7 billion

- **What is the difference between OMB and CBO scoring of the BBA Medicare provisions?**

OMB (the HCFA Actuaries) scored \$149.8 billion in savings over five-years and \$513.0 billion in savings over ten-years to the BBA Medicare policies. CBO scored the same policies at \$112.1 billion (\$37.7 billion less than OMB) over five-years and \$386 billion (\$127 billion less than OMB) over ten-years.

- **Explain the difference between OMB and CBO scoring.**

The bulk of the difference occurs in the estimates for Medicare+Choice and hospitals.

Medicare+Choice. OMB scores \$23.8 billion more savings to Medicare+Choice than does CBO (\$45.5 billion from OMB vs. \$21.7 billion from CBO). Disagreement about the effects of the BBA's mandated risk adjustment of Medicare+Choice payments accounts for \$10 billion of this difference: OMB scores \$10 billion in savings to this provision, while CBO scores no savings. Some of the remaining difference can be explained by larger OMB savings from fee-for-service providers and other differences in pricing methodologies. For example, due to the link between fee-for-service growth and Medicare+Choice payments every cut to a fee-for-service provider also results in a cut in managed care payments. Thus, OMB's higher level of fee-for-service savings automatically results in a higher level of managed care savings.

Hospitals. OMB scores \$16.4 billion higher savings from the hospital provisions than does CBO (\$56.3 billion from OMB vs. \$39.9 billion from CBO). CBO and OMB scoring differed significantly for 4 of the approximately 20 hospital policies in the BBA:

- *The PPS update* (+\$5.7 billion over CBO) and *PPS capital* (+\$1.9 billion over CBO). These differences are explained by the fact that CBO and OMB use different baseline assumptions and pricing methodologies for hospital policies.
- *Hospital Transfers* (+\$3.9 billion over CBO). The final BBA policy was limited to 10 DRGs for two years, with an option to expand beyond the 10 DRGs at the end of the two years. OMB assumes that this policy will be expanded, whereas CBO believes that the policy will remain limited for a longer period of time.
- *Graduate Medical Education* (+\$3.1 billion over CBO). The main focus of the GME policy is a cap on residents. Without the BBA policy, OMB assumes that resident slots will grow by between 3-4 percent per year while CBO assumes a growth rate of approximately 2 percent. Thus, OMB achieves more savings.

MEDICARE GROWTH RATES
Comparison of OMB and CBO BBA Impacts on Net and Per Capita Spending
Five and Ten Years, All Mandatory Outlay, \$\$ in billions

CBO January Baseline

	FY 1997 - FY 2002	FY 1997 - FY 2007
Baseline Spending	1,418.5	3,290.7
Spending Growth	8.8%	8.6%
Per Capita Growth	7.5%	7.2%
Post-BBA Spending	1,306.4	2,904.4
Spending Growth	5.6%	7.1%
Per Capita Growth	4.3%	5.6%
Spending Difference	(112.1)	(386.3)
Spending Growth (pct pt)	(3.3)	(1.6)
Per Capita Growth (pct pt)	(3.3)	(1.5)

OMB FY 1998 MSR Baseline

	FY 1997 - FY 2002	FY 1997 - FY 2007
Baseline Spending	1,432.7	3,262.8
Spending Growth	8.9%	8.7%
Per Capita Growth	7.6%	7.2%
Post-BBA Spending	1,282.9	2,749.0
Spending Growth	4.9%	6.2%
Per Capita Growth	3.6%	4.8%
Spending Difference	(149.8)	(513.8)
Spending Growth (pct pt)	(4.0)	(2.5)
Per Capita Growth (pct pt)	(4.0)	(2.5)

OMB/CBO Difference, Pct. Point

	FY 1997 - FY 2002	FY 1997 - FY 2007
Baseline Spending	14.2	(27.9)
Spending Growth	0.1	0.1
Per Capita Growth	0.1	0.1
Post-BBA Spending	(23.5)	(155.4)
Spending Growth	(0.7)	(0.9)
Per Capita Growth	(0.7)	(0.9)
Spending Difference	(37.7)	-127.5
Spending Growth (pct pt)	(0.8)	(1.0)
Per Capita Growth (pct pt)	(0.7)	(0.9)



1412.7?

why is
 97-02
 baseline
 higher
 (CBO 97-07
 lower

40

MEDICARE: Comparison of 1995 Conference Agreement (CBO) and 1997 BBA (OACT) Seven Year Scoring
 (fiscal year, dollars in billions)

DRAFT

Fiscal Year	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	Total	
											FY96-FY02	FY98-FY04
CBO -- SEVEN YEAR SAVINGS FROM 1995 VETOED CONFERENCE AGREEMENT												
Net Mandatory Outlays, CBO 12/95 /1	157.0	176.6	194.9	213.1	233.3	254.7	278.3	303.7	328.3	356.5	1,654.6	1,967.9
Growth	-	12.5%	10.4%	9.3%	9.5%	9.2%	9.3%	9.1%	8.1%	8.6%	9.9%	9.0%
Per Capita	\$ 4,180	\$ 4,632	\$ 5,039	\$ 5,448	\$ 5,897	\$ 6,363	\$ 6,872	\$ 7,415	\$ 7,922	\$ 8,496		
Growth	-	10.8%	8.8%	8.1%	8.2%	7.9%	8.0%	7.9%	6.8%	7.2%	8.5%	7.7%
Net Medicare Cut /2	-	6.4	13.8	22.8	34.2	41.8	50.0	57.8	62.4	67.7	226.8	336.7
Percent of Baseline	-	3.6%	7.1%	10.7%	14.7%	16.4%	18.0%	19.0%	19.0%	19.0%	13.7%	17.1%
Revised Net Mandatory Outlays	157.0	170.2	181.1	190.3	199.1	212.9	228.3	245.9	265.9	288.8	1,427.8	1,631.2
Growth	-	8.4%	6.4%	5.1%	4.6%	6.9%	7.2%	7.7%	8.1%	8.6%	6.6%	6.9%
Per Capita	\$ 4,180	\$ 4,464	\$ 4,683	\$ 4,865	\$ 5,032	\$ 5,319	\$ 5,637	\$ 6,004	\$ 6,417	\$ 6,882		
Growth	0.0%	6.8%	4.9%	3.9%	3.4%	5.7%	6.0%	6.5%	6.9%	7.2%	5.3%	5.7%
Spending Growth Rate Change	-	(4.1)	(4.0)	(4.3)	(4.9)	(2.2)	(2.0)	(1.4)	0.0	0.0	(3.3)	(2.1)
Per Capita Growth Rate Change	-	(4.0)	(3.9)	(4.2)	(4.8)	(2.2)	(2.0)	(1.4)	0.0	(0.0)	(3.2)	(2.1)
OACT -- SEVEN YEAR SAVINGS FROM 1997 BBA												
Net Mandatory Outlays, OACT FY 98 MSR	159.8	174.2	187.8	204.7	224.0	243.6	264.9	287.8	312.4	339.0	1,586.9	1,876.4
Growth	-	9.0%	7.8%	9.0%	9.4%	8.8%	8.7%	8.7%	8.6%	8.5%	8.8%	8.8%
Per Capita	\$ 4,254	\$ 4,569	\$ 4,856	\$ 5,233	\$ 5,661	\$ 6,087	\$ 6,541	\$ 7,027	\$ 7,539	\$ 8,079		
Growth	-	7.4%	6.3%	7.8%	8.2%	7.5%	7.5%	7.4%	7.3%	7.2%	7.4%	7.5%
Net Medicare Cut	-	-	-	8.7	18.7	31.4	41.3	49.6	56.5	64.1	149.8	270.3
Percent of Baseline	-	-	-	4.2%	8.4%	12.9%	15.6%	17.2%	18.1%	18.9%	9.4%	14.4%
Revised Net Mandatory Outlays	159.8	174.2	187.8	196.0	205.2	212.2	223.5	238.2	256.0	274.9	1,437.2	1,606.1
Growth	0.0%	9.0%	7.8%	4.4%	4.7%	3.4%	5.4%	6.6%	7.5%	7.4%	5.9%	5.6%
Per Capita	4,254	4,569	4,856	5,012	5,188	5,301	5,520	5,816	6,176	6,552		
Growth	0.0%	7.4%	6.3%	3.2%	3.5%	2.2%	4.1%	5.4%	6.2%	6.1%	4.6%	4.4%
Spending Growth Rate Change	-	-	-	(4.6)	(4.7)	(5.4)	(3.4)	(2.1)	(1.1)	(1.1)	(2.9)	(3.2)
Per Capita Growth Rate Change	-	-	-	(4.6)	(4.7)	(5.3)	(3.3)	(2.1)	(1.1)	(1.1)	(2.9)	(3.2)
Enrollment	37.6	38.1	38.7	39.1	39.6	40.0	40.5	41.0	41.4	42.0		

Notes:

1/ FY 03 and FY 04 CBO 12/85 baseline grown by growth rates for those years in the 1/97 CBO baseline

2/ FY and FY 04 savings amounts are estimated as the same baseline reduction from FY 02 (19 percent).

All per capitas are calculated using OACT's unduplicated count of beneficiaries.

1 thoughts are used part 4 BBA

5:29 PM

OACTCBO.XLS

8/28/97

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Questions & Answers on Medicaid and Children's Health in the Mid-Session Review

- What are the differences in OMB and CBO scoring of the Medicaid provisions?

Net Medicaid savings from the BBA are \$14 billion over five years under CBO scoring and \$8.8 billion over five years under OMB scoring. The scoring of four policies (DSH, Boren Amendment, FQHC reimbursement, and Medicaid rates for Medicare cost sharing) contribute to most of the difference in the savings estimates. In general, the savings are lower under OMB scoring because the OMB Medicaid baseline is lower than the CBO baseline.

- Explain the Children's Health estimates.

Both OMB and CBO scored the Children's Health provisions with \$24 billion in costs over five years. Of the \$24 billion, roughly \$20 billion is for grants to States for the new program and \$4 billion is from Medicaid interactions with the new program.

- Why are five-year Medicaid savings \$0 in the Mid-Session Review?

The Balanced Budget Agreement format was a convenient way for the Administration and Congress to track the major categories of spending and savings during the budget negotiations. In addition to the Medicaid savings policies, many other parts of the budget (e.g., changes for immigrants and Veterans' programs) affected Medicaid indirectly. At the time, these effects were tracked separately.

When you shift to a more traditional budget accounting structure, with all of the changes to Medicaid tracked on a unified basis, OMB estimates that the total net effect on the Medicaid baseline will be \$0 over five years. CBO would estimate that the total net effect on the Medicaid baseline would be approximately \$7.2 billion in savings over the same period.

Medicaid and Children's Health
(Costs/Savings, \$ in Billions)

	Budget Agreement		CBO Scoring of BBA		OMB Scoring of BBA	
	98-02	98-07	98-02	98-07	98-02	98-07
Medicaid	-13.6	-65.5	-14.0	-48.0	-8.8	-31.0
Children's Health	16.0	38.9	23.9	48.1	24.3	51.5
Medicaid Immigrants	1.7	3.0	2.0	3.5	3.5	8.0
VA-Medicaid Costs	1.1	1.1	1.1	1.1	1.2	1.2

- The Budget Agreement called for net Medicaid savings of \$13.6 billion over five years. CBO scored net Medicaid savings of \$14.0 over five years from the BBA. OMB (the HCFA Actuaries) scored net Medicaid savings of \$8.8 billion over five years.

consistent DEFINITION?

- Four Medicaid savings proposals contribute to most of the difference in OMB and CBO scoring. Because the OMB Medicaid baseline is lower than the CBO baseline, the HCFA Actuaries assume less savings from: the new disproportionate share hospital (DSH) payment limits; the repeal of the Boren Amendment; the elimination of 100 percent of cost reimbursement for Federally-qualified Health Centers; and allowing States to pay Medicaid rates for Medicare cost-sharing obligations.

*CP DJH =
OMB = 57.2
CBO = 59.6*

- OMB and CBO scoring of the Children's Health proposals is roughly the same. Of the \$24 billion in spending on children's health over five years, approximately \$20 billion is for grants to States and approximately \$4 billion is from increased Medicaid spending related to children's health. The Budget Agreement called for \$16 billion in spending over five years. The BBA included a tobacco tax, which increased spending on Children's Health to \$24 billion over five years.

- The FY 1998 Mid-Session Review will include OMB scoring of Medicaid and Children's Health provisions in the BBA. Medicaid and Children's Health scoring will be displayed two different ways in the document. The document will show savings and spending that match the categories outlined in the Budget Agreement. The document will also show a total Medicaid savings estimate that includes the effects of all of the BBA proposals (Medicaid, Children's Health, Immigration, and Veterans' proposals) on Medicaid.

- The following tables show the two ways Medicaid savings will be displayed.

Display Similar to the Budget Agreement (Costs/Savings, \$ in Billions)

	1998- 2002	1998-2007
Net Medicaid Savings	-8.8	-31.0
Children's Health*	24.3	51.5
Immigration (total will include Medicaid and SSI costs)	total will include 3.5 in Medicaid	total will include 8.0 in Medicaid
Net Savings from Veterans' Proposals (total will include VA savings and Medicaid costs)	total will include 1.2 in Medicaid	total will include 1.2 in Medicaid

* Children's Health total includes \$4 billion in Medicaid costs over five years, and \$11.8 billion over ten years.

Display Showing a Comprehensive Medicaid Total (Costs/Savings, \$ in Billions)

	1998-2002	1998-2007
Total Medicaid Savings	0.0	-10.0
Children's Health	20.3	39.7

**Medicaid Baseline Comparison - OMB and CBO Post-Reconciliation Baselines
(Fiscal Years, \$ in Billions)**

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total 98-02	Growth 97-02	Total 98-07	Growth 97-07
OMB Baseline															
FY 1998 Mid-Session Review Baseline	97.5	103.7	110.7	119.2	128.6	138.6	150.3	163.1	177.3	192.5	209.0	600.8		1,493.0	
Growth		6.3%	6.8%	7.6%	7.9%	7.8%	8.4%	8.5%	8.7%	8.5%	8.6%		7.3%		7.9%
Total Medicaid Effects of 1997 BBA*	0.0	1.1	0.7	-0.1	-0.7	-1.1	-1.6	-1.8	-2.0	-2.1	-2.3	0.0		-10.0	
FY 98 MSR "Post-BBA" Baseline	97.5	104.8	111.5	119.0	127.9	137.6	148.7	161.3	175.3	190.3	206.7	600.7		1,483.0	
Growth		7.4%	6.4%	6.8%	7.5%	7.5%	8.1%	8.5%	8.7%	8.6%	8.6%		7.1%		7.8%
CBO Baseline															
January 1997 CBO Baseline	98.6	105.3	113.6	122.9	132.8	143.8	155.9	168.7	183.1	198.9	216.2	618.4		1,541.2	
Growth		6.8%	7.9%	8.1%	8.1%	8.3%	8.4%	8.2%	8.6%	8.6%	8.7%		7.8%		8.2%
Total Medicaid Effects of 1997 BBA*	0.0	0.6	-0.4	-1.4	-2.9	-3.7	-4.5	-5.2	-5.8	-6.7	-7.7	-7.7		-37.7	
CBO "Post-BBA" Baseline	98.6	105.9	113.2	121.4	129.9	140.1	151.3	163.5	177.3	192.2	208.6	610.6		1,503.5	
Growth		7.4%	6.9%	7.3%	7.0%	7.9%	8.0%	8.1%	8.4%	8.4%	8.5%		7.3%		7.8%

*Includes Medicaid effects of Children's Health, Welfare, Medicare, and Veterans' Provisions



BACKGROUND DETAILS

We adjusted CBO scoring of the Conference Agreement policies to account for baseline changes and the passage of time (i.e., we assumed the Conference Agreement policies were enacted in 1997 and were scored off of CBO's latest baseline).

With this adjustment, we found that the Conference Agreement would have reduced Medicare spending by \$135.7 billion, or 11 percent of total spending, over five years (FY98-FY02), and \$256.6 billion, or 14 percent of total spending, over seven years (FY98-FY04). By comparison, the BBA reduces spending by \$112.0 billion, or 9 percent of total spending, over five years (FY98-FY02), and \$200.1 billion, or 11 percent of total spending, over seven years (FY98-FY04).

CBO estimated a pre-BBA Medicare per capita growth rate of 7.6 percent for the period FY 1998-2002 and 7.5 percent for the period FY 1998-2004. Under the BBA, the per capita growth rate slows to 4.3 percent (a 43 percent reduction compared to the pre-BBA per capita growth rate) over the five year period and 5.3 percent (a 30 percent reduction) over the seven year period. Under the adjusted Conference Agreement, the per capita growth rate slows to 3.8 percent (a 50 percent reduction) over the five year period and 4.3 percent (a 42 percent reduction) over the seven year period. That is, over the seven year period, the Conference Agreement would slow growth about 1 and a half times more than the BBA.

Net Medicare Per-capita Growth, 1998-2004

