

HCFA LEGISLATIVE SUMMARY

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CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 P.L. 99-272

On April 7, 1986 the President signed into law H.R. 3128, the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272). Summaries of the Medicare and Medicaid provisions are attached.



Ellen Shillinglaw
Director
Office of Legislation and Policy



CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985
(Public Law 99-272)

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Rate of Increase in Payments for Inpatient Hospital Services (Section 9101)

Current Law: The current law provides for an annual update of the Medicare prospective payment rates. The update for FY 1986 should take into account amounts necessary for efficient and effective delivery of medically appropriate and necessary care of high quality, but may not exceed the rate of increase in the hospital market basket index plus one quarter of one percentage point. The Secretary published final regulations freezing Medicare payments for FY 1986 at 1985 levels. Initially, the Emergency Extension Act of 1985 amended current law to provide that the payment rates in effect September 30, 1985, should remain in effect through November 14, 1985. Further extensions ultimately provided for continuation of those rates through March 14, 1986.

Modification: The Act requires the Secretary to provide an increase of ½ percent in the PPS rates applicable to discharges occurring during: (1) the last 5 months of Federal FY 1986 for the Federal portion of the DRG payment and (2) the last 5 months of the cost reporting period beginning in FY 1986 for the hospital-specific portion of the DRG payment. The current frozen payment rates are extended through April 30, 1986, for the Federal portion of the DRG payment and through the first 7 months of the hospital's cost reporting period beginning in FY 1986 for the hospital-specific portion of the DRG payment.

For PPS-exempt hospitals, the applicable percentage increase to the target rates will be 5/24 of 1 percent for cost reporting periods beginning in FY 1986.

Finally, the provision restricts the applicable percentage increase in FY 1987 and FY 1988 to no greater than the increase in the hospital market basket.

Effective Date: May 1, 1986, for hospitals with October 1 cost reporting years. All other hospitals will effect the change the eighth month of their cost reporting periods.

One-Year Extension of PPS Transition (Section 9102)

Current Law: The Social Security Amendments of 1983 provided for a three year transition from payments based on hospital-specific costs to payments based on national diagnosis related group (DRG) rates. During this period, a declining portion of the total prospective payment will be based on a hospital's historical reasonable costs, and an increasing portion will be based on a combination of regional and national DRG rates. The blend of the historical cost (hospital specific) portion of the payment rate is changed with the beginning of the hospital's cost reporting period. In the fourth year of the program and thereafter, Medicare payments will be determined under a totally national DRG payment methodology.

The Federal DRG component is comprised, for the first three years, of a combination of national and regional rates. This phase-in takes account of current differences in hospital costs across regions; different payment levels are provided for nine census regions of the United States. Changes in the blend and the amounts of the national/regional components of the Federal DRG payment rates are made

on the Federal fiscal year basis. The prospective payment rate transition started with each hospital's first cost reporting period that began on or after October 1, 1983. The current transition schedule is:

Fiscal Year	Hospital-specific Portion (Percent)	Federal Portion (Percent)
1984.....	75	25 (100 percent regional)
1985.....	50	50 (25 national, 75 regional)
1986.....	25	75 (50 national, 50 regional)
1987.....	0	100 (100 national)

The Emergency Extension Act of 1985 amended current law to provide that hospital payment rates in effect September 30, 1985, should remain in effect for an additional 45-day period. The change also suspended the transition at the 50 percent hospital specific/50 percent Federal payment level for the extension period. Additional extensions continued payment at the FY 1985 level through March 14, 1986.

Modification: The transition to fully Federal rates is extended for one additional year. For the first seven months of cost reporting years beginning in FY 1986, payments will continue to be based on 50 percent hospital-specific (HSP) and 50 percent Federal rates. Beginning with the eighth month of a hospital's reporting year, the blend will change to 45 percent HSP and 55 percent Federal. For cost reporting periods beginning in FY 1987, the blend will change to 25 percent HSP and 75 percent Federal; for reporting periods beginning in FY 1988 payments will be 100 percent Federal.

The national/regional proportion within the Federal rate will continue at 25 percent national/75 percent regional through September 30, 1986. Beginning October 1, 1986, the proportion will change to 50 percent national/50 percent regional; beginning October 1, 1987, the Federal portion will be fully national.

An exception to this provision has been made for Oregon hospitals, which will continue under the transition as defined prior to COBRA. That is, for the first seven months of cost reporting years beginning in FY 1986, Oregon hospitals will be paid based on 50 percent HSP and 50 percent Federal rates; however, beginning with the eighth month, hospitals will be paid a blend that is 25 percent HSP and 75 percent Federal. For cost reporting years beginning in FY 1987 and thereafter, Oregon hospitals will be paid 100 percent Federal rates. In addition, the composition of the Federal rate will change from 75 percent regional and 25 percent national for discharges between October 1, 1985, and April 30, 1986, to 50 percent regional and 50 percent national for discharges during the remainder of FY 1986. For discharges during FY 1987 and thereafter, there is no regional component to the Federal rate.

Effective Date: As described above.

Application of Revised Hospital Wage Index (Section 9103)

Current Law: As an integral part of PPS for hospitals, the Federal portion of the prospective payment rates is adjusted to take into account differences in wages from area to area. This is accomplished by means of an area wage index applied to all PPS hospitals in urban and rural areas. The initial hospital wage index was constructed from a national data base of hospital wage records maintained by the Bureau of Labor Statistics (BLS). There are a number of technical flaws in this index, principally that it fails to recognize differences at the local level regarding the number of part-time hospital workers.

In response to requirements in the Deficit Reduction Act of 1984 (DEFRA), HCFA developed a new "gross hospital wage index," based on a more refined survey of hospital wage costs. This index is derived from total gross hospital wages including salaries of interns and residents, personnel employed in areas other than the inpatient area, hospital-based physicians and all other salaries paid to hospital employees. DEFRA required that any new wage index be implemented retroactive to October 1, 1983. According to the PPS final regulations published September 3, 1985, HCFA planned to implement the new wage index October 1, 1985, retroactive to October 1, 1983.

The Emergency Extension Act of 1985 and subsequent extensions amended current law to provide that hospital payments would continue to be determined on the same basis as they were on September 30, 1985.

Modification: The Act requires the Secretary to implement the new "gross wage index" for payment amounts to hospitals to account for wage differences from area to area.

The Secretary is also required to work with ProPAC to study and develop one or more methods to permit the adjustment of wage indices to more accurately reflect hospital labor markets. Variations in wages and wage-related costs between the central city portion of urban areas and other parts of urban areas are specifically to be addressed.

Effective Date: The new wage index will apply to discharges on or after May 1, 1986. The report to Congress on information collected and methodologies developed is due by May 1, 1987.

Payments to Hospitals for Indirect Costs of Medical Education (Section 9104)

Current Law: The Medicare program provides reimbursement for both the direct and indirect costs of medical education incurred by teaching hospitals. The direct costs of approved medical education programs (such as salaries for residents, teachers and classroom costs) are excluded from the prospective payment system (PPS), and are reimbursed on a reasonable cost basis. The indirect costs reflect increased patient care costs associated with teaching programs.

A proxy measure, defined as the hospital's ratio of the number of interns and residents divided by the number of beds (IRB), has been used to adjust Medicare prospective payments for indirect medical education costs. An adjustment factor for indirect medical education costs was estimated statistically based on the increase in the IRB ratio. When Congress enacted the PPS system it established the indirect teaching adjustment factor at double the factor in effect as of January 1, 1983. After calculating the factor it was estimated, on a linear basis, that a 0.1 increase in the IRB ratio would result in a 5.795 percent increase in a hospital's cost per discharge; doubled, the indirect teaching factor was established at 11.59 percent. The adjustment is made to the Federal DRG portion of the PPS rate only. The doubling of the indirect teaching adjustment from 5.795 percent to 11.59 percent was done on a budget-neutral basis, which means the DRG payments were adjusted downward overall to account for the doubling of the indirect teaching adjustment.

Modification: Payment for Indirect Costs of Medical Education: Provides that the indirect teaching adjustment factor be reduced from 11.59 percent to 8.1 percent for discharges occurring during the period May 1, 1986, to September 30, 1988, and to 8.7 percent for discharges occurring after September 30, 1988. The statutory language includes a specific mathematical formula so that the adjustment is applied on a curvilinear rather than linear basis.

Requires that interns and residents assigned to outpatient departments be included in the count of interns and residents.

Prohibits distinguishing between interns and residents who are employees of a hospital and those who furnish services to a hospital but are not employees of the hospital.

Adjustment of payment amounts: Requires restandardization of the DRG payment rates by excluding, for discharges occurring after September 30, 1986, the reduced indirect medical education payment amounts based on the indirect teaching adjustment authorized by this provision, that is, 8.1 percent in fiscal years 1986 and 1987, and 8.7 percent in fiscal years 1988 and thereafter.

Requires an additional adjustment to the average standardized amounts effective for discharges after September 30, 1986, to achieve budgetary savings equivalent to reducing the indirect teaching adjustment factor from 11.59 percent linear to 8.7 percent curvilinear. This additional adjustment is to be done proportionately to reflect the differing effects of the restandardization across regions and urban/rural categories.

Effective date: All provisions except the restandardization and additional reduction of standardized amounts would be effective for discharges occurring after April 30, 1986; however, the changes will not apply if the disproportionate share adjustment (also effective after April 30, 1986) is not implemented. The restandardization and additional reduction of standardized amounts would be effective for discharges occurring after September 30, 1986.

Payments for Hospitals Which Serve a Disproportionate Share of Low Income Patients (Section 9105)

Current Law: Under the Social Security Amendments of 1983, the Secretary is required to make adjustments to the PPS rates as the Secretary deems appropriate for hospitals that serve a disproportionate number of low income or Medicare part A patients. The Deficit Reduction Act of 1984 required the Secretary, prior to December 1, 1984, to develop and publish a definition of disproportionate share hospitals, to identify such hospitals, and to make the list available to the Committees with legislative jurisdiction over part A. The Secretary published definitions of disproportionate share hospitals in the Federal Register December 31, 1985, and supplied the appropriate Committees with lists of hospitals meeting those definitions.

Modification: The Federal portion of the DRG payment will be adjusted to achieve increased payments to hospitals serving a disproportionate share of low income patients. The additional payment equals the Federal portion of the DRG payment multiplied by the applicable disproportionate share adjustment percentage determined as follows:

- | | |
|--|--|
| --For urban hospitals with at least 100 beds | If the disproportionate patient percentage is at least 15 percent, the disproportionate share adjustment percentage equals 2.5 percent plus an additional 0.5 percent for each one percentage point that the disproportionate patient percentage exceeds 15 percent. The maximum allowed disproportionate share adjustment percentage is 15 percent. |
| --For other urban hospitals | If the disproportionate patient percentage is at least 40 percent, the disproportionate share adjustment percentage equals 5 percent. |
| --For rural hospitals | If the disproportionate patient percentage is at least 45 percent, the disproportionate share adjustment percentage equals 4 percent. |

The disproportionate patient percentage is defined as the sum of: (1) the percentage of a hospital's total Medicare patient days attributable to Medicare patients who also are Federal Supplemental Security Income beneficiaries (excluding State supplement only beneficiaries), and (2) the percentage of the hospital's total patient days attributable to Medicaid (but not part A Medicare) benefits.

The provision requires the restandardization of the DRG payment rates for each hospital effective for discharges occurring after September 30, 1986, and before

October 1, 1988, to exclude the additional payments estimated to be made as a result of the disproportionate share adjustment.

It also requires an exception process for certain urban hospitals with at least 100 beds which can demonstrate that more than 30 percent of net inpatient care revenue is provided by State or local government for the inpatient care of low income patients not reimbursed by Medicare or Medicaid (these hospitals have been termed "Pickle" hospitals). Hospitals that qualify in this manner would have a disproportionate share adjustment percentage of 15 percent.

The Congressional Budget Office is required to study the impact of payments to disproportionate share hospitals, including the advisability of making the additional payments to "Pickle" hospitals and report to Congress by January 1, 1987.

Effective Dates: The Act requires disproportionate share payments to be made for all discharges occurring after April 30, 1986, and before October 1, 1988. Restandardization of the DRG amounts is required for all discharges occurring after September 30, 1986, and before October 1, 1988.

Treatment of Certain Rural Osteopathic Hospitals as Rural Referral Centers (Section 9106)

Current Law: Rural hospitals that meet certain requirements can qualify to receive the urban standardized payment amount adjusted by the rural wage index applicable for the geographical area. The adjustment was permitted because data indicated that large rural hospitals with high case mix indexes had costs which were similar to those of urban hospitals.

In order to qualify, a hospital's number of discharges in its most recently completed cost reporting period would have to be at least 5,157 or equal to the median number of discharges for urban hospitals in the census region. The hospital must also meet a specified case mix index and other minor requirements.

Modification: This provision lowers the discharge criteria for certain hospitals to qualify for rural referral center status. Osteopathic hospitals would meet the rural referral center standard if they had a least 3,000 discharges in a cost reporting period as long as they met all the other rural referral center requirements as specified by the Secretary.

Effective Date: Retroactive application for cost reporting periods starting on or after January 1, 1986.

Return on Equity Capital for Inpatient Hospital Services and Other Services (Section 9107)

Current Law: A return on equity capital invested and used in providing patient care is considered a Medicare allowable cost for proprietary, or for-profit, health

care providers. Equity capital is the net worth of a hospital excluding those assets and liabilities not related to patient care. Specifically, equity capital includes: (1) the investment in the plant, property, and equipment (net of depreciation) related to patient care, plus deposited funds required in connection with leases; and (2) working capital maintained for necessary and proper operation of patient care facilities.

The level of payment for return on equity formerly was set at a rate of no more than 1.5 times the average rate of return on trust fund investments. In the Social Security Act Amendments of 1983, Congress reduced the level of payments for hospitals to the average rate of return on trust fund investments. The rate of return for other providers was not affected.

Modification: For inpatient hospital services, the provision phases out Medicare payments for return on equity over 3 years, eliminating all payments by FY 1990 (i.e., 75 percent in FY 1987, 50 percent in FY 1988 and 25 percent in FY 1989).

For skilled nursing facilities, the rate of return is reduced from 1.5 times the interest rate paid on the HI Trust Fund to 1.0 times the Trust Fund rate.

For other facilities, if return on equity is paid, it must be paid at the interest rate paid on the HI Trust Fund.

Effective Date: For inpatient hospital services, the modification applies to cost reporting years beginning on or after October 1, 1986.

For skilled nursing facilities, outpatient facilities and other facilities, the modification applies to cost reporting years beginning on or after October 1, 1985.

Continuation of Medicare Reimbursement Waivers for Certain Hospitals Participating in Regional Hospital Reimbursement Demonstrations (Section 9108)

Current Law: A permanent waiver of the Medicare prospective payment system requirements is permitted for hospitals in States whose hospital cost containment programs meet a number of requirements, including the requirement that costs under the State program not exceed those that would have been incurred without the waiver.

Modification: The provision would allow a waiver from the Medicare prospective payment system to continue for hospitals operating approved cost control systems in States which have received the Secretary's approval of their request to continue the waiver, as long as other requirements are met.

This system must include substantially all acute care hospitals in the area served by such system. In addition, a review must be conducted of at least 75 percent of all revenues or expenses for inpatient hospital services that are provided under an approved state Medicaid plan. Furthermore, Medicare's costs must not exceed what they otherwise would have been under the Medicare PPS systems.

Effective Date: On enactment for all demonstrations that were being carried out on January 1, 1985.

Four-Year Test for State Waivers for Certain States (Section 9109)

Current Law: Under present law, States may request a waiver of Medicare's reimbursement rules for a statewide hospital reimbursement control system. A number of requirements must be met before such a waiver request is granted. One requirement is that the State demonstrate, to the Secretary's satisfaction, that the Medicare expenditures made under the waiver would not exceed the amounts that otherwise would have been paid over a 36-month period under Medicare if the State were not under a statewide reimbursement waiver.

Modification: The provision extends the test period of a State's system of reimbursement for an additional 12 months to 48 months. This option is limited to States that requested a waiver prior to December 31, 1984.

The Secretary is prohibited from discontinuing payments under the State's system prior to July 1, 1986, because the Secretary has reason to believe that the State's level of payments would have been more under its existing system than under the national Medicare system.

The only State that meets these criteria is New Jersey

Effective Date: Upon enactment.

Asset Valuation for Donations of State Property to Nonprofit Corporations (Section 9110)

Current Law: The Deficit Reduction Act of 1984 (DEFRA) limited the basis for which Medicare depreciation is allowed when a change of ownership occurs. The new owner's basis is the lesser of (1) the historical cost, net of depreciation (cost to the previous owner), or (2) the purchase price.

Modification: This provision creates a special rule for treatment of certain transfers. When a hospital is donated by a State government (donor) to a non-profit corporation (donee), the basis from which the capital-related costs to the donee is calculated would be the donor's historical cost (net of depreciation).

Effective Date: To be applied as though originally included in DEFRA of 1984.

Payments to Sole Community Hospitals (Section 9111)

Current Law: A special PPS payment formula is provided for hospitals that, due to special circumstances such as isolated location, are the sole source of inpatient services reasonably available in a given geographic area. Such hospitals were paid on the same basis as all other PPS hospitals during the first year of the transition period: 75 percent based on the hospital-specific rate and 25 percent on the national DRG rate. Unlike other hospitals under PPS, which will eventually be paid totally according to a national DRG rate, sole community hospitals will remain at the 75/25 ratio.

Modification: Payment provision -- The Secretary will make an adjustment to the PPS rates to reasonably compensate sole community hospitals that experience a significant increase in operating costs in cost reporting periods after the base period due to the addition of new inpatient facilities or services (including the opening of a special care unit).

Study -- The Secretary will review the effects of this reimbursement provision and make recommendations to Congress by January 1, 1987, on a permanent mechanism which accounts for needed expansions of sole community hospital services and the hospital-specific rates of such hospitals.

Effective Date: Payment provision -- cost accounting years beginning on or after October 1, 1983, and before October 1, 1989.

Study -- Due to Congress prior to January 1, 1987.

Indirect Teaching Adjustment for Certain Clinics (Section 9112)

Current Law: For the first three years of the prospective payment system a special exception is applied to hospitals which had traditionally been allowed direct billing under part B so extensively that it would have been disruptive to immediately require them to bill for all such services under part A. These hospitals are, in effect, allowed to have part of their PPS payments paid through part B billings and the remainder paid to the hospital under part A. In such split payment cases, the indirect teaching adjustment applies only to the portion of the Medicare payment that is paid through part A.

Modification: The provision would clarify that the split payment provision was only intended to provide a temporary billing accommodation for certain hospitals and that the indirect teaching adjustment should be applied as if the entire PPS payment had been made under part A.

In addition, an entity billing part A services under part B will be paid at 100 percent of the reasonable charge (or other applicable basis of payment) and must accept such payment as payment in full.

Effective Date: Payment for indirect medical education is effective for cost reporting periods beginning on or after January 1, 1986. Payment for part A services billed under part B is effective for services provided 10 days after enactment.

Report on Impact of Outlier and Transfer Policy on Rural Hospitals (Section 9113)

Current Law: Outlier -- Under the present law the Secretary is required to make additional payments to hospitals under PPS when there is either an unusually long length of stay or the stay is excessively costly.

Transfer -- Current policy requires that payment be made to each facility in cases of a Medicare beneficiary being transferred from one facility and readmitted to a different facility. Regulations provide three types of conditions under which a payment will be made to each facility in cases involving transfers: transfers between hospitals that are paid under the PPS; transfers between a PPS hospital and a hospital which has not yet implement PPS but will at a later date; and transfers between a PPS hospital and a hospital or unit not required to participate in PPS.

Modification: The Secretary is required to review the impact of the outlier and transfer policies under the PPS system as they relate to rural hospitals, particularly rural hospitals with less than 100 beds. A report will be sent to Congress on review findings with comments on changes needed in these policies to the extent that they adversely affect rural hospitals.

Effective Date: Report is due to Congress by January 1, 1987.

Information on Impact of PPS Payments on Hospitals (Section 9114)

Current Law: Under the Congressional Budget Act of 1974, the Congressional Budget Office (CBO) is entitled to the most recently available cost reports submitted by Medicare-participating hospitals to the Department.

Modification: The Secretary is required to make available to the Prospective Payment Assessment Commission (ProPAC), the Congressional Budget Office, the Congressional Research Service, and the General Accounting Office, the most current PPS payment information. The information shall be made available in a manner that permits examination of the impact of PPS on hospitals and will be treated as confidential, not subject to further disclosure that permits identification of individual hospitals.

Effective Date: Enactment.

Special Rules for Implementation (Section 9115)

Current Law: The Paperwork Reduction Act requires the Secretary to send all regulations concerning collection of information to the Executive Office of Management and Budget (EOMB) for review and approval.

The President issued Executive Order 12291 as a means to minimize duplication and conflict in regulations, and to reduce the burden of existing regulations. There is no statutory authority for Executive Order 12291. This order requires that all regulations be cleared by EOMB, and include an impact statement if the economic impact exceeds \$100 million.

Modification: The provision specifies that the Paperwork Reduction Act will not apply to information required to implement the hospital prospective payment provisions. However, the executive order analyses for Executive Order 12291 will continue to be required.

The Secretary is provided authority to issue interim final regulations as may be necessary to implement the hospital reimbursement provisions.

Effective Date: Enactment.

Responsibilities of Medicare Hospitals in Emergency Cases (Section 9121)

Current Law: Hospitals that participate in Medicare have to meet defined conditions of participation and enter into participation agreements. The participation agreement contains no specific requirements relating to the appropriate treatment of emergency patients.

Modification: All participating hospitals with emergency departments must provide an appropriate medical screening examination or treatment for any individual who requests it (or has a request made on his behalf) to determine whether an emergency medical condition exists or if the patient is in active labor, as long as it is within the capability of the hospital's emergency department to perform such an exam or to provide appropriate treatment.

All participating hospitals must, when there is an emergency condition or the patient is in active labor, (1) provide further examination and treatment to stabilize the patient, unless such treatment is refused, or (2) provide an appropriate transfer to another medical facility, unless the transfer is refused by either the patient or a person responsible for the patient.

A hospital may not transfer a patient who has not been stabilized or is in active labor unless qualified medical personnel sign a certificate that the benefits of such a transfer outweigh the risks of the transfer and that the transfer is appropriate. The patient or a family member could also request a transfer.

Hospitals that fail to meet the requirements would either be terminated or suspended from participation for a specific period of time. Hospitals and physicians that knowingly violate the provisions would also be liable for a civil monetary penalty and civil enforcement.

The provision does not preempt State or local law requirements unless there is a direct conflict.

The Secretary is required to report to Congress on methods for monitoring and enforcing compliance with the provision within six months after enactment.

Effective Date: Appropriate treatment for emergency patients becomes effective 90 days following enactment.

Requirement for Medicare Hospitals to Participate in CHAMPUS and/or CHAMPVA Programs (Section 9122)

Current Law: Current law contains no requirement that Medicare-participating hospitals accept beneficiaries of the Civilian Health and Medical Program of the

Uniformed Services (CHAMPUS) or the Civilian Health and Medical Program of the Veterans Administration (CHAMPVA). In addition, the current law imposes no requirement on such hospitals regarding acceptance of payment amounts under these programs as payment in full.

Section 931 of the Department of Defense Authorization Act for fiscal year 1984 included a provision authorizing CHAMPUS and CHAMPVA to utilize Medicare reimbursement procedures in paying for care under these programs.

Modification: Medicare-participating hospitals will be required to participate in the CHAMPUS and CHAMPVA programs and to accept payment made under both programs as payment in full.

Admission practices, payment methodologies and amounts would be prescribed in regulations jointly issued by the Secretary of Health and Human Services and the Secretaries of Defense and Transportation. The Secretary of Defense is required to identify those hospitals which fail to meet this condition and submit that information to the Secretary of HHS for appropriate action.

The Secretary of HHS is required to report to Congress periodically on the number of hospitals that have terminated or failed to renew an agreement because of this additional requirement.

Effective Date: Applies to agreements entered into or renewed on or after enactment, and inpatient hospital services rendered on or after January 1, 1987.

Extension and Payment for Hospice Care (Section 9123)

Current Law: Under current law, individuals who are entitled to Medicare part A benefits and who are certified to be terminally ill may elect to receive part A reimbursement for hospice care services, in lieu of certain other services. Public Law 97-248, the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), which authorized this hospice benefit, mandated a report to Congress by the Secretary on January 1, 1986, evaluating the hospice benefit experience. Current authority for the Medicare hospice benefit is scheduled to expire on October 1, 1986.

In implementing the TEFRA hospice benefit, the DHHS established a prospective payment system and set daily rates for each of four types of hospice care. Public Law 98-671, the amendment relating to payment rates for Hospice Routine Home Care and Other Services, restored the routine home care payment rate to \$53.17 (as originally proposed in regulations) per day for the fiscal year beginning October 1, 1984, and required the Secretary to review and adjust the hospice rates annually, beginning October 1, 1985.

Modification: The bill would repeal the sunset provision of present law and sets the daily rate of payment per day for routine home care at \$63.17. The daily rate of payment for other services of hospice care would also be increased by \$10.00. The Secretary is given an additional year, until October 1, 1986, to review the hospice rates and make annual adjustments on the basis of costs.

Requires the Secretary to report to Congress October 1 of each year on the adequacy of the rates in insuring participation in Medicare by an adequate number of hospice programs.

Effective Dates: Elimination of Sunset - Effective upon enactment.

Daily Payment Rates - Routine home care provided on or after April 1, 1986; and for all other hospice care services retroactively applied to services furnished as of July 1, 1985.

Limiting the Penalty for Late Enrollment in Part A (Section 9124)

Current Law: Part A under Medicare is available on a voluntary basis to individuals 65 or over who are not otherwise entitled to coverage. These individuals may obtain Medicare part A coverage by paying a monthly premium. Anyone purchasing part A coverage after the third month after the month in which he becomes eligible is charged a late penalty of 10 percent of the standard premium for each 12 months he is late in enrolling; that is, for each 12 months during which he could have been, but was not enrolled. This penalty is paid each and every month of coverage for the rest of the beneficiary's life.

Modification: The part A premium penalty is limited to 10 percent no matter how late the individual enrolled. The period during which the penalty is paid is limited to twice the number of years enrollment was delayed. Following the penalty period, the premium would revert to the standard monthly premium in effect at that time. The provision will also apply to beneficiaries currently paying a penalty. Previous penalty payments will be taken into account in determining the month in which the premium would no longer be subject to a penalty increase.

Effective Date: Applies to premiums paid for months beginning with July 1986.

Promulgation of Inpatient Hospital Deductible (Section 9125)

Current Law: The Secretary is required to publish a notice of the projected increase in the inpatient hospital deductible for the subsequent calendar year by October 1 of each year.

Modification: The Secretary is required to publish the notice of the projected increase in the inpatient hospital deductible for the subsequent calendar year by September 15 of each year.

Effective Date: The requirement applies to calendar years after 1985.

Access to Skilled Nursing Facilities (Section 9126)

Current Law: Limits on skilled nursing facility (SNFs) rates are set prospectively based on estimates of costs necessary for efficient delivery of needed health services. Limits are set on per diem inpatient routine services costs for hospital-based and free standing SNFs, by urban and rural area location. The limits contain

provisions relating to a market basket index reflecting changes in the price of goods and services purchased by SNFs; adjustments by an area wage index and location of the SNF (e.g., hospital based, urban or rural), among other factors.

Provision: This provision would create a prospective rate, available by election of the facility, for SNFs providing fewer than 1500 days of care reimbursed by Medicare a year. The rate would be set at 105 percent of the regional mean for all SNFs in the region (that is, not differentiated by hospital-based vs. free-standing). The rate would be calculated separately for urban and rural areas, would be adjusted for differences in wages between urban and rural areas, and would include both capital and routine operating costs. (Ancillary costs could continue to be passed through.) The rate for any facility could not exceed its cost limit adjusted for capital costs.

In addition, the provision would require reinstatement of the waiver of liability presumption for SNFs for a thirty month period after enactment.

Effective Date: October 1, 1986.

Additional Members of Prospective Payment Assessment Commission (Section 9127)

Current Law: The Social Security Amendments of 1983 provide for the establishment of the Prospective Payment Assessment Commission (ProPAC) consisting of 15 members appointed by the Director of the Office of Technology Assessment, generally to serve for 3-year terms.

Modification: Expands ProPAC membership by two. It is intended that the two new members will represent nurses and rural hospitals.

Effective Date: The new members are to be appointed no later than 60 days after enactment, for terms of three years.

Sense of the Senate with Respect to Inpatient Hospital Deductible (Section 9128)

Current Law: The statute specifies the formula to be used to determine the inpatient hospital deductible amount, based on the average costs of a day of hospital care. Reduced lengths of stay and lower hospital occupancy rates have reduced costs per admission but have increased the costs of care per day and thus the inpatient deductible.

Provision: It is the sense of the Senate that the Committee on Finance should report legislation which will reform calculation of the annual increase in the deductible so that it is more consistent with annual increases in Medicare payments to hospitals.

Effective Date: Enactment.

Medicare Coverage of State and Local Employees (Section 9129)

Current Law: Under present law, there is no Federal requirement that State and local government employees pay the hospital insurance tax. Most State and local

government employment is already covered as a result of voluntary agreements for such coverage entered into by the States. About 25-30 percent of such employment is not currently covered.

Modification: Newly Hired - Extends Medicare coverage on a mandatory basis for all State and local government employees hired after December 31, 1985, individuals who are 65 or older, disabled and those with end-stage renal disease. The employers and their employees would become liable for the hospital insurance portion of the FICA tax and the employees would earn credit toward Medicare eligibility based on their covered earnings.

Medicare coverage and the hospital insurance tax are not extended to individuals hired by a State or political subdivision to relieve unemployment; patients or inmates working in a hospital, home, or other institution; temporary workers hired for certain emergencies; or certain students working in District of Columbia hospitals. Also excluded are employees who performed State or local government service before January 1, 1986, and whose employment relationship continued after this date.

Effective Date: Hospital Insurance Taxes - Applies to services performed after December 31, 1985. Treatment of Certain Disabilities - January 1, 1986. Optional

Extension of Working Aged Provision (Section 9201)

Current Law: The Age Discrimination in Employment Act (ADEA) requires employers of 20 or more people to offer employees and their spouses age 65-69 the same health insurance coverage they offer to younger employees and under the same conditions. Currently, ADEA applies only to persons between the ages of 40 and 70.

If the older employee chooses the employer's plan, Medicare becomes the secondary payor for beneficiaries and spouses age 65-69. Medicare continues to be the primary payor for those age 70 and over.

If the older employer chooses not to participate in the employer's plan, Medicare will be the primary payor. The employer is prohibited from offering a health plan designed to supplement Medicare (i.e., fill in Medicare's deductible and coinsurance.)

Modification: Removes the age 69 limit on the application of the current working aged provisions.

Makes Medicare secondary payor for all workers and workers' spouses who elect employer-based coverage through a large (20 or more employees) employer.

Amends ADEA to provide that the group health insurance requirement be exempted from the age limits.

Effective Date: May 1, 1986.

Payments to Hospitals for Direct Costs for Medical Education (Section 9202)

Current Law: Medicare program provides reimbursement for both the direct and indirect costs of medical education incurred by teaching hospitals. The direct costs of approved medical education programs (such as salaries for residents, teachers and classroom costs) are excluded from the prospective payment system (PPS), and are reimbursed on a reasonable cost basis. The final regulations, issued July 5, 1985, freeze the amount Medicare reimburses providers for their direct costs of approved medical education activities, for cost reporting periods beginning on or after July 1, 1985.

The freeze permits payment based on the lesser of a provider's allowable direct medical education costs for the current cost reporting period or for a base year (the provider's cost reporting period beginning on or after October 1, 1983), adjusted for changes in Medicare utilization.

Modification: Medicare payment methodology - Replaces current reasonable cost reimbursement for graduate medical education with payment based on hospital-specific per resident amounts. Approved full-time-equivalent (FTE) amounts would be derived from the first PPS year (FY 84) cost reports, and updated to 1985-86 for hospitals not on a July 1 cost-reporting year.

For the first cost-reporting period beginning on or after July 1, 1985, the updated FTE amounts would be increased by 1 percent. For subsequent cost-reporting periods, the approved FTE amounts would be increased by changes in the CPI.

Residency year limitations and limitations regarding certain foreign medical graduates (FMGs) - Uses weighting factors to reduce FTE amounts paid for residents beyond a maximum of 4 or 5 years. Geriatric residencies are excepted. Phases out payment for FMGs who have not passed the Foreign Medical Graduate Examination in Medical Sciences (FMGEMS) or earlier certifying examination.

Studies by the Secretary - Requires studies and reports by the Secretary on approved nursing and other health professions educational activities for which Medicare reimburses hospitals; advisability of continuing the geriatric exception; the uniformity in approved FTE amounts across hospitals; and on the use of FMGs for the provision of health care services to Medicare beneficiaries. Assigns the GAO a study on variation in Medicare payments across teaching hospitals, and between teaching and nonteaching hospitals.

Establishing physician identifier system - Requires the Secretary to develop a unique identifier for each physician who furnishes Medicare services by July 1, 1987.

Waiver of Paperwork Reduction Act - Provides that the Paperwork Reduction Act would not apply to information required to carry out this provision.

Prohibiting a limit on increases for direct medical education - Prohibits the Secretary from limiting the rates of increase in allowable costs for direct medical education, except as explicitly authorized, effective July 1, 1985.

Special treatment of States formerly under waiver - Permits States formerly on waivers to change their method of allocating administrative and general costs. The Secretary will adjust regional and hospital-specific portions accordingly, on the basis of the best available data.

Effective Date: Cost-reporting periods beginning on or after July 1, 1985, except as noted differently. All studies except the study on geriatric residencies, are due by December 31, 1987. The geriatric residency study is due July 1, 1990.

Moratorium on Laboratory Payment Demonstration (Section 9204)

Current Law: Pursuant to demonstration authority in the present law, the Secretary has proposed to experiment with competitive bidding as a method of purchasing clinical laboratory services under the Medicare program. Independent laboratories have expressed the concern that under the experiments, unsuccessful bidders might not be eligible to participate in the Medicare program.

Modification: The provision precludes until January 1, 1987, the conduct of any demonstrations on purchasing clinical laboratory services under Medicare. During this moratorium, the laboratory industry and the Secretary, in consultation with GAO, could conduct a study to determine whether there is a less disruptive method of utilizing competitive market forces in setting Medicare payment levels.

Effective Date: Enactment.

Home Health Waiver of Liability (Section 9205)

Current Law: Home health agencies with a "favorable presumption" are presumed to be acting in good faith (i.e., they believe services provided to beneficiaries are necessary and covered under the Medicare program), if their denial rate is under 2.5 percent. Regulations effective March 24, 1986 eliminated the favorable presumption for home health agencies (HHAs).

Modification: This provision requires the Secretary to reinstate the favorable presumption for HHAs until 12 months after the date on which the 10 HHA regional intermediaries begin operations.

Effective Date: Enactment.

Provision Relating to Health Maintenance Organizations and Competitive Medical Plans (Section 9211)

Current Law: Under current law, it is unclear who is responsible for payment when a Medicare beneficiary is an inpatient of a PPS hospital on the effective date of his/her enrollment in a Tax Equity and Fiscal Responsibility Act (TEFRA) Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP). A similar problem exists for disenrollment

Current law specifies the effective date of disenrollment from a TEFRA HMO/CMP to be the first calendar month following a full calendar month after the request is made for termination.

There are no current law provisions relating to review of marketing material.

In order to establish the payment amounts to TEFRA HMO/CMPs the Secretary has developed a measure termed the Average Adjusted Per Capita Cost (AAPCC). There are no current law requirements relating to the specific date of publication of the AAPCC.

Modification: Financial Responsibility for Patients Hospitalized on the Effective Date of an Enrollment or Disenrollment - This provision assigns financial responsibility for payment for the inpatient stay to the party (HMO/CMP or Medicare) that was responsible on the day of admission. If enrollment becomes effective during a PPS hospital stay, Medicare is responsible for payment; the HMO/CMP is not responsible. If disenrollment becomes effective during a PPS hospital stay, the HMO/CMP is responsible for payment; Medicare is not responsible.

This provision addresses only payment for the inpatient stay. Responsibility for payment for any other services covered under Medicare, such as physician services during the inpatient stay, changes on the date of enrollment or disenrollment.

Disenrollments - Disenrollment would be effective the beginning of the month following the month the disenrollment request was made. For example, any disenrollment request made during March is effective April 1.

Review of Marketing Material - Requires all marketing materials to be submitted to the Secretary at least 45 days before issuance. HMOs/CMPs may assume approval after 45 days unless otherwise informed by the Secretary.

Prompt Publication of AAPCC - Requires the Secretary to publish the AAPCC no later than September 7 of each year.

Effective Dates: Financial responsibility for patients hospitalized: Enactment.
Disenrollments: Disenrollment requests submitted on or after May 1, 1986.
Review of marketing materials: Material distributed after July 1, 1986. **Prompt publication of the AAPCC:** Rates for 1987 and subsequent years.

Removal of Prohibition on Comments by Medicare and Social Security Actuaries Relating to Economic Assumptions (Section 9213)

Current Law: Annual reports that are required of the Board of Trustees on the financial status of the Social Security trust funds, including the Medicare trust funds, must include an actuarial opinion certifying that the assumptions and cost estimates used in the report are reasonable. According to the provisions in the Social Security Amendments of 1983, this certification may not refer to the economic assumptions underlying the trustees report.

Modification: This provision would allow the actuaries to comment on the economic assumptions underlying the annual reports of the Board of Trustees on the financial status of trust funds

Effective Date: Enactment.

Limitation on Merger of End-Stage Renal Disease Networks (Section 9214)

Current Law: Present law requires the Secretary to establish network organizations to assure effective and efficient administration of the end-stage renal disease (ESRD) program. The network organizations are responsible for coordinating and evaluating ESRD services provided within assigned geographic areas. Thirty-two network organizations have been established.

Modification: Prohibits the Secretary from merging the ESRD network organizations into any other organization or entity. However, the Secretary is permitted to consolidate the network areas and organizations in order to achieve efficiencies in the administration and operation of these organizations, provided the number of network organizations is not reduced to less than fourteen.

Effective Date: Enactment.

Extension of Certain Medicare Municipal Health Services Demonstration Projects (Section 9215)

Current Law: Current law permits waiver of certain Medicare requirements when the Health Care Financing Administration enters demonstrations under its general demonstration authority. The municipal health services demonstrations were authorized under the general demonstration authority and would have expired in December 1985. Further continuing appropriations for FY 1986 extended the municipal health services demonstration projects in Baltimore, Cincinnati, Milwaukee, and San Jose for one additional year to December 1986.

Modification: Requires the Secretary to extend for three additional years, approval of the four municipal health services demonstration projects.

Effective Date: Enactment.

Audit and Medical Claims Review (Section 9216)

Current Law: Medicare contractors are responsible for performing certain audit and medical review activities. Under TEFRA, \$45 million was provided these activities for FYs 83-85.

Modification: This provision would add \$60 million, above funds already appropriated, for the program management account for review and audit activities. The provision would also expand the permissible activities to include recovery of third party liability payments.

Effective Date: October 1, 1985.

Liver Transplants (Section 9217)

Current Law: Section 1862 of the Social Security Act excludes from Medicare coverage any items or services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. This section has been interpreted to exclude from coverage items and services that are considered to be experimental and that do not have a proven medical benefit. On February 9, 1984, the Secretary announced that liver transplants for persons under 18 years of age with certain specified conditions were no longer considered experimental and would, therefore, be covered under Medicare.

Modification: Expresses the sense of the Senate, given available information, that liver transplant services are to be covered under Medicare when reasonable and medically necessary and that the Secretary reconsider coverage of liver transplant services for individuals over 18 years of age.

Also, expresses the sense of the Senate that the Secretary shall place appropriate limiting criteria on coverage of liver transplants, including those relating to the patient's condition, the disease state, and the institution providing the care, so as to ensure the highest quality of medical care demonstrated to be consistent with successful outcomes.

Effective Date: Not applicable.

Studies Relating to Physical Therapists and Other Professionals (Section 9218)

Current Law: Under current law, part B of Medicare covers the service of a qualified physical therapist in independent practice when furnished by the physical therapist or under the physical therapist's direct supervision in the office or the patient's home. These services must be prescribed by a physician and furnished under a written plan of treatment established by a physician or a qualified physical therapist.

The Secretary is required to establish conditions that an independently practicing physical therapist must meet in order to receive Medicare reimbursement. The Secretary, by regulation, requires that a physical therapist in independent practice maintain an office space with the necessary equipment to provide an adequate program of physical therapy. This requirement is applied even to those therapists who operate exclusively in the beneficiaries' homes.

Current law also requires that home health services be provided under the supervision of a physician or registered nurse.

Modification: Office Requirement - The Secretary will study and report to Congress on the advisability of deleting the Medicare requirement that a physical therapist must have an office equipped with specified equipment, even if the therapist provides all services in patients' homes.

Supervision of Home Health Services - The Secretary will study and report to Congress on the advisability of changing the requirements to allow home health services to be provided under the supervision of a physical therapist or other health care professional, rather than requiring the supervision of a physician or registered nurse.

Effective Date: Reports on both studies are due to Congress prior to October 1, 1986.

Technical Corrections (Section 9219)

Current Law: Current Medicare law contains a number of technical errors in provisions dealing with the working aged (premium penalty, special enrollment periods, and effective dates) and other miscellaneous sections.

Modification: Corrects problems with the Medicare special enrollment period and the premium penalty forgiveness for the working aged. The current anomaly under which certain individuals who are working and covered by an employer group health plan (EGHP) receive only one special enrollment period while others receive more than one would be corrected.

Clarifies that an individual would be eligible for forgiveness of the Medicare premium penalty for any period during which he or she was over 65 and covered by an employer group health plan. (Both this provision and the provision above would apply to workers and workers' spouses who are not covered under the working aged provisions, i.e., their employer has less than 20 employees. The working aged provisions apply only to employers with 20 or more employees.)

Makes corrections in spelling, language, and indentation.

Effective Date: Special enrollment period and premium penalty forgiveness for working aged: First month beginning more than 90 days after date of enactment, with certain exceptions.

Premium penalty forgiveness for all persons with EGHP coverage: Affects premiums for months beginning with the first month that begins more than 30 days after the date of enactment.

Spelling, language and indentation: Generally would be effective as though they had been included in the public laws that they correct.

Extension on On Lok Waiver (Section 9220)

Current Law: Under OBRA of 1985, the Secretary approved a 36 month extension of Medicare and Medicaid waivers for On Lok Senior Health Service and the California Department of Health Services to carry out a demonstration project for capitated reimbursement of comprehensive long-term care services.

Modification: This provision requires the Secretary to extend these waivers under the same terms and conditions that applied to the original approval except that:

- o The requirement for collection and evaluation of information for demonstration purposes no longer applies.
- o The waivers will remain in effect until the Secretary finds the applicants no longer meet the requirements of the project.

Effective Date: Enactment.

Continuation of "Access: Medicare" Demonstration Project (Section 9221)

Current Law: Section 1115 of the Act and Section 402(a) of the 1967 Amendments to the Act authorize the Secretary to waive compliance of certain Medicare and Medicaid requirements in order to conduct demonstrations and experiments to increase the efficiency and economy in the provision of health services while maintaining or improving quality in the provision of health services.

Modification: Requires the Secretary to approve any application for a waiver of any Medicare or Medicaid provisions necessary to continue the "Access: Medicare" demonstration by Monroe County Long Term Care Program, Inc. The conditions and terms must be the same as applied under August 31, 1985, agreement.

Effective Date: Enactment.

Medicare Physician Payment Provisions (Section 9301)

Current Law: Physician Fees -- Medicare pays for physicians' services on the basis of Medicare-determined reasonable charges." Reasonable charges are the lesser of: a physician's billed charge; the customary charge made by an individual physician for a specific service; or (3) the prevailing level of charges made by all physicians for services in a geographic area. The customary and prevailing charges are generally updated annually, on October 1. Increases in the prevailing charge levels are limited by an economic index, which reflects changes in the physicians' practice costs, changes in general earnings levels, and general inflation.

Under the Deficit Reduction Act of 1984, the Medicare customary and prevailing charges for all physicians' services provided during the 15-month period beginning July 1, 1984, were frozen at the levels that applied for the 12-month period ending June 30, 1984. The actual charges of nonparticipating physicians were also frozen during the 15-month period, at the levels in effect during April-June 1984.

Participating Physician and Supplier Program: The Deficit Reduction Act also instituted a Medicare participating physician and supplier program. Participating physicians and suppliers agree to accept assignment on all Medicare claims for the 12-month period beginning on October 1 of a year. Nonparticipating physicians and suppliers can decide on a claim-by-claim basis whether or not to accept assignment.

The carriers responsible for paying Medicare claims are required to monitor nonparticipating physicians' actual charges during the 15-month freeze. Physicians who knowingly and willfully bill beneficiaries in excess of what they charged during April-June 1984 can be subject to civil monetary penalties and/or exclusion from participation in Medicare.

The Emergency Extension Acts of 1985-1986 extended through March 15, 1986, the payment terms established in DEFRA. Physicians are bound during the extension period by the decisions they made regarding participation for the year beginning October 1, 1985, and are subject to the corresponding payment rules.

Modification: Extends through April 30, 1986, the freeze on customary and prevailing charges, and nonparticipating physicians' actual charges. Provides physicians with an opportunity during the month of April 1986 to sign or terminate participation agreements effective for an 8-month period, May 1 to December 31, 1986. Existing participation agreements are extended for three months (October to December 1986).

Changes participation and update cycles for physician services and other Part B services to a calendar year basis, beginning January 1, 1987.

Updates for the period May 1 through December 31, 1986:

- o Participating physicians: Receive full customary and prevailing charge updates that would have been provided October 1, 1985. One percentage point added to the Medicare Economic Index (MEI), for this period only.
- o Nonparticipating physicians: Freeze on customaries and prevailings is extended through this period. Freeze on actual charges at April-June 1984 base period levels, and monitoring, are also extended.
- o Drop-outs: Receive customary charge update only. Actual charges frozen at April-June 1984 levels.

For calendar years beginning 1987, participating physicians would receive customary and prevailing charge updates on January 1. Nonparticipating physicians would receive customary charge updates on January 1, but would be subject to prevailing charge levels applied to participating physicians in the previous year. This permanent one-year lag is built in. The freeze on actual charges expires on December 31, 1986.

Transfers \$18 million from the Part B trust fund for continued implementation of fee freeze and the physician and supplier participation program.

Establishes new participation incentives: improved directories, professional relations staff dedicated to participating physicians' problems, and Explanation of Medicare Benefits (EOMB) reminders of the participation program.

Eliminates the Deficit Reduction Act requirement for the publication of a physician assignment rate list (PARL).

Effective Date: Payment provisions effective for services furnished on or after May 1, 1986.

Payment for Clinical Laboratory Services (Section 9303)

Current Law: Outpatient clinical diagnostic laboratory services are reimbursed according to fee schedules established by Medicare carriers. The initial fee schedules, which went into effect on July 1, 1984, were established at a percentage of the prevailing charges that would have gone into effect on that date. The fee schedules are to be updated on July 1 of each year by the percentage change in the Consumer Price Index for all urban consumers (CPI-U).

The fee schedules are currently calculated and applied on the basis of a statewide or substate geographical area. Beginning July 1, 1987, a national fee schedule is to be established for tests performed in a physician's office, by a freestanding laboratory, or by a hospital (if the test is for a person who is not a patient of that hospital). The fee schedules are to expire July 1, 1987, for hospital laboratory tests performed for outpatients of the hospital; payment for these services would revert to cost-based reimbursement. Payment may only be made to the person or entity who performed such test.

Hospital laboratories and independent laboratories are subject to standards designed to protect the health and safety of patients and to monitoring of compliance with such standards. Laboratories located in physicians' offices are not subject to such standards or monitoring.

Modification: Moves the timing of the annual lab fee schedule updates from July 1 to January 1 of each year beginning in 1987. There is no update for July 1, 1986, but the January 1, 1987, update would take into account the change in the CPI-U occurring over the preceding 18-month period. The expiration date for the fee schedules for tests done by hospital-based laboratories would be delayed until January 1, 1988.

The Secretary would be required to establish a ceiling to be applied to carrier fees schedule amounts on a test-by-test basis. Carrier fee schedules for specific procedures would be limited to 115 percent of the national median, effective July 1, 1986, through December 31, 1987; then 110 percent of the national median, beginning on January 1, 1988. On January 1, 1988 the fee schedule for laboratory services become national.

The provision allows for a reasonable delay in application of the limits on fee schedules for lab tests where there is some discrepancy in the service reported for the procedure code.

Applies mandatory assignment requirements to physician office laboratories, effective January 1, 1987; however, beneficiary coinsurance and deductibles are waived.

The proficiency examination authority (section 1123 of the Social Security Act) is extended through September 30, 1987.

The Secretary is required to report to Congress within 12 months of enactment on standards that might be established for physicians' office laboratories.

Effective Date: Ceilings effective for services furnished on or after July 1, 1986. Mandatory assignment for physician office labs effective for services furnished on or after January 1, 1987. Report due to Congress within 12 months after the date of enactment on the standards that might be established for physicians' office laboratories.

Determinations of Inherent Reasonableness of Charges and Customary Charges for Certain Former Hospital Compensated Physicians (Section 9304)

Inherent Reasonableness

Current Law: Payment for items and services under part B is generally made on the basis of reasonable charges. The law provides for some flexibility in the determination of reasonable charges; the regulations allow the use of "other factors that may be found necessary and appropriate with respect to a specific item or service...in judging whether the charge is inherently reasonable."

Modification: The Secretary is required to publish regulations that describe the factors to be used in determining the cases in which reasonable charges, by virtue of either grossly excessive or grossly deficient amounts, are not inherently reasonable. The regulations must also specify the factors to be considered in establishing reasonable charges that are realistic and equitable.

Effective Date: Enactment

Hospital Compensated Physicians

Current Law: Carriers established compensation related customary charges (CRCCs) for certain hospital-based physicians when combined-billing arrangements were eliminated, effective October 1, 1983. The CRCCs provision was intended to be transitional; hospital-based physicians would have received customary charge updates on July 1, 1984 based on their actual charges had it not been for the general freeze on Medicare customary and prevailing charges for physicians' services instituted by the Deficit Reduction Act.

Modification: Specifies calculations for customary charges for hospital-based physicians who between October 31, 1982, and January 31, 1985, were in (and

within the same time period terminated) arrangements by which they were compensated by a hospital for part B service furnished to its patients. The calculation of customary charges is to be based on the physician's actual charges billed during the 12 month period ending on March 31, 1985.

In the case of a physician who was not a participating physician on September 30, 1985 and May 1, 1986, the customary charge shall be deflated by a factor of .85 to take in account the freeze on actual charges.

Physicians who come off compensation arrangements between February 1, 1985, and December 31, 1986, will be treated as new physicians.

Effective Date: This section applies to payment for physicians services during the 8-month period beginning May 1, 1986.

Physician Payment Review Commission and Development of Relative Value Scale (Section 9305)

Current Law: There currently exists no advisory body whose purpose it is to make recommendations regarding Medicare physician payment.

Modification: This provision establishes a Physician Payment Review Commission consisting of 11 individuals appointed by the Director of the Congressional Office of Technology Assessment. Membership shall include physicians, other health professionals, individuals skilled in the conduct and interpretation of biomedical health services, and health economics research, and representatives of consumers and the elderly.

The Commission shall make recommendations to the Congress by March 1 of each year, beginning in 1987, regarding Medicare physician payment. Recommendations would address, among other issues, adjustments to reasonable charge levels for physicians' services, and changes in the Medicare physician payment mechanism, including the development of a relative value scale.

The Secretary shall develop a relative value scale that establishes a numerical relationship among the various physicians' services. The Secretary shall report to Congress on the scale by July 1, 1987, with recommendation for the application of the scale to payment for physician services furnished on or after January 1, 1988.

Effective Date: Members of the commission shall be appointed by May 1, 1986.

Limitation on Medicare Payment for Post-Cataract Surgery Patients (Section 9306)

Current Law: Medicare Part B pays for certain combinations of prosthetic lenses for post-cataract surgery patients, if determined to be medically necessary by the physician. Generally, carriers are authorized to replace prosthetic lenses without a physician's prescription in cases of loss or irreparable damage and when supported

by a physicians prescription in cases of a change in patient's condition. Currently, there are no uniform limits on the number of replacements for which Medicare will provide reimbursement.

Physicians can bill Medicare for services related to cataract surgery in two ways: (1) a comprehensive service code covering the lenses, their fitting and evaluation, and short-term follow-up to assure their suitability; or (2) separate codes for the lenses and for the physicians services.

Modification: Each carrier shall provide for separate determinations of the payment for the eyeglasses and lenses and of the payment amount for the professional services of a physician. The Secretary shall apply inherent reasonableness guidelines in determining reasonableness for charges for prosthetic lenses.

Effective date: April 1, 1986.

Payment for Assistants at Surgery for Certain Cataract Operations and Other Operations (Section 9307)

Current Law: Currently, Medicare covers assistants at surgery when the patient's condition makes it medically necessary.

Modification: A surgeon must receive the prior approval of the Peer Review Organization or the carrier for the use of an assistant at surgery based on the existence of a complicating medical condition in a cataract operation. If a physician knowingly or willingly bills an individual for services as an assistant when those services have not been approved, the physician is subject to civil monetary penalties or exclusion.

The Secretary, after consultation with the Physician Payment Review Commission, shall develop recommendations and guidelines regarding other surgical procedures for which an assistant at surgery generally is not medically necessary and report to Congress on these recommendations.

Effective Date: Applies to services performed on or after April 1, 1986. The report to Congress is due not later than January 1, 1987.

Part B Premium (Section 9313)

Current Law: The Secretary is required to calculate and announce each September the amount of the monthly premium that will be charged in the following calendar year for people enrolled in the Supplementary Medical Insurance (part B) portion of Medicare. A temporary provision of law requires that for 1986 and 1987 the premium amount be calculated so as to produce premium income equal to 25 percent of program costs for enrollees age 65 and over.

Beginning in 1988, the premium calculation would revert to an earlier method under which the premium amount is the lower of: (1) an amount sufficient to cover one-half of program costs for the aged; or (2) the current premium amount

increased by the percentage by which cash benefits were most recently increased under the cost-of-living adjustment (COLA) provisions of the Social Security program.

Modification: Extends for calendar year 1988 the provision in current law, which is effective for 1986 and 1987, requiring that the portion of part B costs financed by enrollee premiums equals 25 percent of program costs of aged beneficiaries.

Retains the hold harmless provision under which no beneficiary will have his or her current net Social Security check reduced as a consequence of a part B premium.

Retains the requirement that if there is no Social Security cost-of-living adjustment, the monthly premium would not be increased that year.

Effective Date: Part B premiums for calendar year 1988.

Demonstration of Preventive Health Services Under Medicare (Section 9314)

Current Law: Section 402(a) of the 1967 Amendments to the Act authorize the Secretary to develop and engage in experiments to increase the efficiency and economy in the provision of health services while maintaining or improving quality in the provision of health services. Current law does not specify the experiments or demonstration to be accomplished.

Modification: The Secretary is required to establish a 4-year demonstration program to reduce disability and dependency through provision of preventive health services to Medicare beneficiaries.

Effective Date: Enactment.

Extension of GAO Reporting Date (Section 9315)

Current Law: The Deficit Reduction Act of 1984 requires the General Accounting Office (GAO) to study several aspects of Medicare contracting for claims processing. DEFRA required submission of the report to Congress within 12 months of enactment, i.e. by July 18, 1985.

Modification: The provision delays the date the GAO report on certain aspects of Medicare contracting for claims processing is due to Congress.

Effective Date: The report is due to Congress on May 1, 1986.

100 Percent Peer Review of Certain Surgical Procedures (Section 9401)

Current Law: Peer Review Organizations (PROs) are required to perform review activities subject to the terms of and specified by their individual contracts.

Modification: This provision requires that PRO contracts specify at least 10 surgical procedures to be subject to pre-admission and/or pre-procedure review for the purpose of requiring a second surgical opinion (SSO) where appropriate. No payment will be made under part A or part B for services which where required second opinions are not obtained. PROs will serve as referral centers for SSOs and maintain a list of physicians qualified to provide second opinions. PROs will also be required to study the SSO program and report to Congress 6 months after enactment of the Act. Beneficiary deductible and co-payments will be waived for the SSO.

Effective Date: Applies to items and services furnished on or after January 1, 1987.

Peer Review Organization Reimbursement (Section 9402)

Current Law: Peer review payment rates are established at an amount not less than 1982 levels, adjusted for inflation, and reimbursed according to the terms of the PRO's contract.

Modification: This provision eliminates the 1982 payment rates as a standard for current PRO reimbursement, establishing the aggregate floor for PRO payments at 1986 levels. This provision also requires that PROs be paid by the 15th of each month.

Effective Date: Payment provisions effective upon enactment; frequency of payment provision effective for contracts entered into/renewed after enactment.

Denial of Payment For Substandard Care (Section 9403)

Current Law: PROs may deny payment for services based on medical necessity and appropriateness of placement.

Modification: This provision authorizes PROs to deny payment for substandard care determined on the basis of criteria established by the Secretary in guidelines. Beneficiaries are protected from liability for denied services.

Effective Date: Enactment.

HMO Membership on PRO Boards (Section 9404)

Current Law: The Secretary may not contract with an organization which has on its board more than one member of an entity that directly or indirectly reimburses providers/practitioners for care (e.g., health maintenance organizations (HMOs) and competitive medical plans (CMPs)).

Modification: This provision removes the restriction on the number of members an HMO or CMP can have on PRO boards.

Effective Date: Enactment

PRO Review of Health Maintenance Organizations (Section 9405)

Current Law: Does not specifically refer to review in HMOs and CMPs, but provides PROs with the authority to review some or all of the professional activities, subject to the terms of their contract, of physicians and other health care practitioners and institutional and non-institutional services for which payment will be made under Title XVIII.

Modification: Specifies that PRO review extends to HMOs and CMPs.

Effective Date: January 1, 1987

Substitute Review Pending Termination of a PRO Contract (Section 9406)

Current Law: No statutory provision exists to provide for PRO review where an existing PROs contract is terminated.

Modification: Provides that during the period between giving notice of intent to terminate and entering into an agreement with another PRO, the Secretary may transfer review responsibilities to another PRO, intermediary, or carrier.

Effective Date: Enactment

Services for Pregnant Women (Section 9501)

Current Law: States cover, under Medicaid, from the date of medical verification of pregnancy, pregnant women who would be eligible for AFDC and Medicaid if their child were born or pregnant women in two-parent families where the principal breadwinner is unemployed. To be eligible, pregnant women would also have to meet State AFDC income and resource requirements.

Modification: 1) **Mandatory Coverage:** Requires States to cover under Medicaid pregnant women in two-parent families who meet AFDC income and resources requirements even where the principal breadwinner is employed; 2) **Targeting Services:** Specifies that components of Medicaid pregnancy-related services (including prenatal, delivery, and post-partum services), including services for pregnancy complications, which are targeted to eligible pregnant women, do not have to be extended to other beneficiaries; and 3) **Post-Partum Coverage:** Requires States to provide post-partum coverage to eligible pregnant women until the end of the 60-day period beginning on the last day of their pregnancy.

Effective Date: The mandatory coverage provision applies to Medicaid payments for calendar quarters beginning on or after April 1, 1986; the other two provisions are effective upon enactment. Where State legislation is necessary, the State shall not be considered out of compliance before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment.

Modifications of Waiver Provisions for Home and Community-Based Services (Section 9502)

Current Law: Section 1915(c) of the Social Security Act authorizes the Secretary of HHS to waive certain Medicaid requirements to allow States to provide a variety of home and community-based long-term care services to individuals who would otherwise require the level of care provided in a skilled nursing facility (SNF) or intermediate care facility (ICF) whose cost could be reimbursed under the State's Medicaid plan.

- (a) **Inclusion of Certain Services.** States may cover the following services under waivers: case management, homemaker/home health aid services, personal care, adult day health, habilitation services, respite care, and other services requested by the State and approved by the Secretary. Final regulations, published in March 1985, exclude coverage for prevocational and vocational training and educational activities as habilitation services.
- (b) **Eligibility for Ventilator-Dependent Persons.** Individuals requiring an inpatient hospital level of care are among those specified as eligible for alternative home and community-based services.
- (c) **Prohibition of Certain Regulatory Limits.** To receive approval for a waiver, States must provide a number of assurances to the Secretary, including one requiring that the estimated average per capita expenditure for medical

assistance under the waiver for those receiving waived services in any fiscal year not exceed the average per capita expenditure that the State reasonably estimates would have been incurred in that year for that population if the waiver had not been granted.

Final regulations published March 13, 1985 require States to assure that the actual total expenditures for home and community-based services under the waiver will not exceed the State's approved estimated expenditures and that the State will not claim Federal matching payment for expenditures exceeding the approved estimate.

- (d) Computation of Expenditures for Certain Disabled Patients. Waivers may be targeted to the aged and/or disabled, mentally retarded and/or developmentally disabled, the mentally ill, or any subgroup thereof that the State defines. Regulations require States to submit individual waiver requests for each target group (or subgroup). The statute does not contain this requirement.
- (e) Maintenance Needs Allowances. Regulations require the income of home and community-based care recipients to be applied to the cost of this care, after allowed deductions for maintenance needs have been made. Similar rules are applicable to all Medicaid recipients.
- (f) One-Year Waiver Extension. A home and community-based waiver is granted for an initial term of 3 years, and, upon the request of a State, can be renewed for additional 3-year periods, unless the Secretary determines that certain assurances have not been met.
- (g) Five-Year Waiver Renewals. Same as (e).
- (h) MCH Block Grant Coordination. Under the waiver authority, States are providing home and community-based services to a number of groups of individuals, including children. Title V of the Social Security Act, known as the Maternal and Child Health (MCH) Block Grant, authorizes grants to the States for a variety of maternal and child health services, including services for children with special health care needs.
- (i) Substitution of Participants. Regulations require that States, in their applications to provide home and community-based services, describe the group or groups of individuals to whom services will be offered and to estimate the unduplicated number of recipients who will receive services in a given year. This has been interpreted to mean that individuals who receive services in a given year and who die, enter a nursing home, or otherwise drop out of the home and community-based care program during that year, cannot be replaced in that year with other individuals who would be eligible to receive such services.

Modifications:

- (a) Inclusion of Certain Services. Defines habilitation services as services designed to assist individuals to acquire, retain, and improve the self-help,

socialization, and adaptive skills necessary to reside successfully in home and community-based settings, and includes prevocational, educational, and supported employment services. Habilitation services would not include special education and related services as defined in the Education of the Handicapped Act which otherwise are available through a local educational agency, nor would they include vocational rehabilitation services which otherwise are available through a program funded under the Rehabilitation Act of 1973.

- (b) Eligibility for Ventilator-Dependent Persons. Establishes eligibility for ventilator-dependent individuals who receive inpatient hospital services.
- (c) Prohibition of Certain Regulatory Limits. Clarifies that the estimated average per capita expenditure for medical assistance under the program in any fiscal year must not exceed 100 percent of the average per capita expenditures that the State reasonably estimates would have been incurred in that year if the waiver had not been granted.

Prohibits the Secretary from requiring that the actual total expenditures for home and community-based services under the waiver, and the associated claim for Federal matching payments, cannot exceed the approved estimates for these services.

Prohibits the Secretary from denying Federal matching payments for home and community-based services on the ground that a State has failed to limit actual total expenditures for home and community-based services under the waiver to the approved estimate for these expenditures.

- (d) Computation of Expenditures for Certain Disabled Individuals. Amends the waiver authority to clarify that in waivers for physically disabled individuals who are SNF or ICF inpatients, States may estimate the average per capita expenditure that would have been made for these individuals separately from the expenditures for other individuals in these facilities.
- (e) Maintenance Needs Allowance. Allows States to establish, for individuals receiving waived services in the community, a higher maintenance needs allowance than maximum amounts allowed under regulations in effect July 1, 1985.
- (f) One-Year Waiver Extension. Requires the Secretary to extend, for a period of not less than 1-year at a minimum or 5-years at a maximum, any waiver that expires during the 12-month period beginning September 30, 1985, if the State requests an extension. (This provision is not intended to exempt these waivers from Secretarial monitoring and compliance procedures applicable to all waivers.)
- (g) Five-Year Waiver Renewals. Requires the Secretary, beginning September 30, 1986, to renew home and community-based services waivers for additional 5-year periods if the Secretary approves the waiver renewal request.

- (h) MCH Block Grant Coordination. Amends the waiver authority to allow the State Medicaid agency, whenever appropriate, to enter into cooperative arrangements with the State agency administering the MCH Block Grant program of services for children with special health care needs, in order to assure improved access to coordinated services for children eligible for both programs.
- (i) Substitution of Participants. Amends the home and community-based waiver authority to specify that for waivers which contain a limit on the number of individuals who will receive home and community-based services, the State may substitute additional individuals for any individuals who die or become ineligible for services.

Effective Dates:

- (a) Inclusion of Certain Services. Effective for services furnished on or after enactment.
- (b) Eligibility for Ventilator-Dependent Persons. Effective for services furnished on or after October 1, 1985.
- (c) Prohibition of Certain Regulatory Limits. Effective for waiver or renewal applications filed before, on, or after the date of enactment, and for services furnished on or after August 31, 1981.
- (d) Computation of Expenditures for Certain Disabled Individuals. Effective for waiver or renewal applications filed before, on, or after the date of enactment, and for services furnished on or after August 13, 1981.
- (e) Needs Allowances. Effective for waivers or renewals approved on or after the date of enactment.
- (f) One-Year Waiver Extension. Effective for waivers expiring on or after September 30, 1985, and before September 30, 1986.
- (g) Five-Year Waiver Renewals. Effective on September 30, 1986.
- (h) MCH Block Grant Coordination. Effective on the date of enactment.
- (i) Substitution of Participants. Effective on the date of enactment.

Third Party Liability (Section 9503)

Current Law: Medicaid is intended to be the payer of last resort; that is, other available resources must be used before Medicaid pays for care of an individual enrolled in the Medicaid program. State plans must provide that:

- o the State or local agency administering the plan will take all reasonable measures to ascertain the legal liability of third parties to pay for care;

- o where such an agency knows that a third party has legal liability, it will treat the liability as a resource of the individual for purposes of eligibility determinations; and
- o the agency will seek reimbursement from liable third parties where payment has already been made and where the expected amount of recovery exceeds the costs of recovery.

States are generally required to have Medicaid management information systems (MMIS) that are reviewed and approved by HCFA each year. The Secretary is required to develop performance standards, system requirements and other conditions for use in approval of such systems.

Current law requires Medicaid beneficiaries to assign their rights to medical support payments and other payments for medical care to the State.

If a State makes erroneous excess payments exceeding allowable rates, Federal financial participation is reduced.

Modification: The provision amends the law to specify that the State will take all reasonable measures for ascertaining the legal liability of third parties which include:

- o collection of sufficient information (as specified in regulations) to enable the State to pursue claims at the point of eligibility determinations and redeterminations;
- o submission of a plan to the Secretary for pursuing claims. The Secretary shall monitor the plan as part of the review of the claims processing system and failure to meet conditions for approval shall be subject to reductions in Federal payments;
- o paying for and then pursuing third party payments for preventive pediatric care, including early and periodic screening, diagnosis and treatment services as well as prenatal care;
- o when child support enforcement is carried out by a State agency under Title IV-D for recipients, seeking to collect from the third party if, after 30 days of delivery of services, the provider has not received payment;
- o providing that the person furnishing the service to a Medicaid eligible may not collect cost-sharing amounts if total third-party liability at least equals the amount otherwise payable under Medicaid. Cost-sharing may not exceed the lesser of the amount the recipient would be required to pay if there were no third-party liability or the difference between the liability and the Medicaid payment amount; and,
- o providing that an individual may not refuse to furnish services to a Medicaid recipient because of a potential third-party liability.

In addition to any other sanction, a State may provide for a reduction of any payment amount otherwise due a provider in an amount up to three times the payment amount.

The provision requires the Secretary to develop performance standards for assessing States' third-party liability collection efforts which are to be integrated with and monitored as part of the review of each State's MMIS. These reviews may be conducted once every three years and may be either total reviews or focused reviews on areas which have demonstrated weakness in previous years.

The modification requires individuals as a condition of eligibility to cooperate with the State in identifying and pursuing liable third parties unless the individual has good cause for refusing to cooperate. The modification disregards, for purposes of calculating erroneous excess payments, errors resulting from failure of an individual to cooperate or give correct information relating to third-party liability shall not be included.

The Employee Retirement Income Security Act (ERISA) of 1974 is also amended to make it illegal to limit or exclude from coverage in employee health plans, benefits, or covered services for which employees might be eligible under Medicaid.

Effective Date: The Secretary shall promulgate final regulations necessary to carry out the provisions affecting State plan requirements and performance standards for MMIS within 6 months of enactment. The ERISA amendment shall be effective October 1, 1986, except as affected by collective bargaining agreements which could delay the effective date up to three years. All other amendments become effective with calendar quarters beginning on or after the date of enactment except that delay is permitted where State legislation is required.

Optional Hospice Benefits (Section 9505)

Current Law: States may cover under their State plans some services that are now included in the Medicare hospice benefit package, such as home health care and prescription drugs. Hospices, however, are not recognized as providers for Medicaid payment purposes and States may not pay for comprehensive hospice services as a package. In addition, States may not target services included in the hospice package to terminally ill Medicaid recipients without offering those same services to all recipients.

Modification: The provision allows State to furnish hospice care as an optional Medicaid service, targeted to terminally ill individuals who have voluntarily elected to receive hospice care in lieu of certain other services. Hospice care includes the services included under the Medicare hospice benefit. Hospice programs are required to meet Medicare requirements for organization and operation. Eligible individuals may elect to receive hospice services while they are residents of SNFs or ICFs; however, Medicaid payment will be made only for the hospice care. Elections of hospice care must be made in accordance with State-established procedures that are consistent with Medicare hospice procedures and

for a period or periods as established by the State. The individual may revoke or modify the hospice care election at any time. Election of hospice care also may be modified.

The provision specifies that the amount, duration, or scope of hospice services must not be less than benefits under Medicare. States choosing to cover hospice care under Medicaid must use Medicare's prospective payment methodology and reimburse at Medicare's rates. A separate rate may be established, however, to include the cost of room and board furnished by a SNF or ICF to residents electing hospice care and those who would be eligible for SNF or ICF care if they had not elected hospice care.

The provision allows eligibility for hospice care to be determined using the income standard the State uses for institutional eligibility (permitting eligibility at a higher income level than is allowed for most other Medicaid services). It also prohibits cost-sharing for hospice care patients.

Effective Date: Effective for services furnished on or after enactment.

Treatment of Potential Payments from Medicaid Qualifying Trusts (Section 9506)

Current Law: Under Medicaid, only income and resources actually available to an individual are considered in determining eligibility. The law contains no specific provision pertaining to income from trusts.

Modification: A Medicaid qualifying trust is defined as a trust, or similar legal device, established by an individual under which the individual is the beneficiary of all or part of the payments from the trust. A trustee has discretion as to distribution of payments to the individual. States would deem the amounts from the trust to be available to the person receiving or applying for Medicaid assets to be an amount equal to the maximum amount that the trustee could disburse, whether or not the trustee exercised his or full discretion with respect to the amount of funds disbursed under the terms of the trust. The provision applies whether or not the qualifying trust is irrevocable or is established for reasons other than to qualify for Medicaid services. A State may waive the application of this provision with respect to an individual if it determines an undue hardship would result.

Effective Date: Applies to medical services provided on or after the first day of the second month beginning after the date of enactment.

Written Standards for Provisions of Organ Transplants (Section 9507)

Current Law: No provision.

Modification: The provision denies Federal matching payments for organ transplant services provided to Medicaid beneficiaries unless the State plan provides for written standards for the coverage of such services and unless the standards treat similarly situated individuals alike. If such standards impose

restrictions on the facilities or practitioners who may provide such services, the restrictions must be consistent with the accessibility of high quality care to Medicaid patients.

Effective Date: Medical assistance provided on or after January 1, 1987.

Optional Targeted Case Management Services (Section 9508)

Current Law: Case management is not now included among the medical services which a State may cover under its State Medicaid plan. States may, however, include case management services under freedom-of-choice and home and community-based services waivers authorized under Section 1915(b) and 1915(c), respectively. In addition, States may receive administrative funds under their Medicaid plans for certain case management activities when offered to all Medicaid beneficiaries in all areas of the State.

Modification: The provision allows States to cover case management services as medical assistance without the need to obtain a waiver of requirements that Medicaid services be available throughout a State and that covered services be equal in amount, duration and scope for all Medicaid recipients. Case management services are defined as services which will assist Medicaid-eligible individuals in gaining access to needed medical, social, educational and other services.

The provision specifies that the furnishing of optional targeted case management services must not restrict individuals' freedom-of-choice of providers. (Such a restriction would continue to require a section 1915(b) waiver.) The provision also specifies that, with respect to family planning services, the right of individuals to choose their own providers may not be restricted under any waivers granted under section 1915(b).

Effective Date: Effective for services furnished on or after enactment.

Revaluation of Assets (Section 9509)

Current Law: Medicare payments to nursing homes may not be increased to reflect higher capital costs that result solely from the sale of such facilities. Capital costs recognized for reimbursement include depreciation, interest expense, and in the case of proprietary providers, return on equity.

Capital-related costs to the new owner are based on the lesser of (1) the allowable acquisition cost to the prior owner (i.e., the historical cost, net of depreciation), or (2) the acquisition cost to the new owner. Medicaid payments are subject to a similar limit with States required to provide assurances, satisfactory to the Secretary, that methodologies used to establish rates paid to nursing homes can reasonably be expected not to increase those rates more than they would under Medicare policy as a result of a change in ownership.

Modification: States shall provide assurances that the valuation of capital assets, for determining payments to skilled nursing facilities and intermediate care facilities will not be increased solely to reflect increases in their valuation due to changes in ownership. The revaluation, however, would be limited to the acquisition costs of the previous owner increased by one-half the percentage increase in the Dodge Construction Systems Costs for Nursing Homes applied in the aggregate to those facilities which have changed ownership, or one-half the percentage increase in the CPI, whichever is lower.

GAO would also be required to conduct a study of the effects of this amendment and to report the results two years after enactment.

Effective Date: Effective for medical assistance furnished on or after October 1, 1985 but only with respect to changes of ownership occurring on or after that date unless an enforceable agreement for a change of ownership was entered into prior to that date. Where State legislation is necessary, the State shall not be considered out of compliance before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment.

Beginning Date of Optional Coverage for Individuals in Medical Institutions (Section 9510)

Current Law: States may provide Medicaid coverage for individuals who are in medical institutions but who have too much income to qualify for cash payments under the Supplemental Security Income (SSI) program. The income standard which a State applies to this optional coverage group cannot exceed 300 percent of the SSI benefit amount payable to an aged, blind or disabled individual living in his or her own home who has no other income or resources. Implementing regulations specify that the State Medicaid agency shall apply the special income standard beginning the first full calendar month of institutionalization.

Modification: Requires that States electing to use the special income eligibility standard begin payments at the beginning of any 30 consecutive-day period of institutionalization rather than on a calendar month basis.

Effective Date: Applies to services furnished on or after October 1, 1985.

Optional Coverage of Children (Section 9511)

Current Law: States have the option to cover under Medicaid all, or reasonable categories of, poor children under age 18, 19, 20, or 21 living in poor, two-parent families. These are known as "Ribicoff children". DEFRA required States to cover all children born on or after October 1, 1983, up to age 5, who meet AFDC income and resources requirements regardless of family structure. The law requires that coverage for this population group be phased-in over a five-year period starting with the youngest children. Federal matching is not available for children under age five born prior to October 1, 1983, unless the State extends coverage to all Ribicoff children other than those added under DEFRA.

Modification: Allows States to extend eligibility for Medicaid immediately to children under 5 years of age who meet the AFDC income and resources requirements without having to cover all Ribicoff children under their programs.

Effective Date: Applies with respect to payments for services furnished on or after April 1, 1986.

Overpayment Recovery Rules (Section 9512)

Current Law: Collection of Medicaid overpayments paid by a State to nursing homes and hospitals is the State's responsibility and the Federal Government must be refunded the Federal share of any overpayments. The State is required to refund the Federal share immediately upon discovery of overpayment even where they are not collectible because the providers have gone into bankruptcy or out-of-business.

Modification: States would be given up to 60 days from the date of discovery to collect overpayments from providers and refund the Federal share. States would not be liable for the Federal share of overpayments that cannot be collected from bankrupt or out-of-business providers.

Effective date: Applies to overpayments identified for quarters beginning on or after October 1, 1985.

Regulations for Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) (Section 9514)

Current Law: States have the option to cover under their Medicaid programs intermediate care facility services for the mentally retarded. ICFs/MR must meet standards of participation as required in regulations issued by the Secretary. The standards for ICFs/MR have remained essentially the same since being published in 1974.

Modification: Requires the Secretary to publish, within 60 days of enactment, proposed revisions to the standards for ICFs/MR. (The Department published new standards as a notice of proposed rulemaking (NPRM) in the Federal Register on March 4, 1986.)

Effective Date: Upon enactment.

Life Safety Code Recognition (Section 9515)

Current Law: As part of the standards of participation for ICFs/MR under the Medicaid program, facilities must meet certain safety requirements to assure the well-being of residents. Current regulations refer to the 1981 edition of the Life Safety Code of the National Fire Protection Association (NFPA) as the standard for ICFs/MR.

Modification: Requires the Secretary to specify the 1985 edition of the Life Safety Code of the NFPA in the ICFs/MR regulations and allows for future use of updated life safety code editions or more stringent standards if necessary to protect the safety of residents. (An NPRM was published by the Department in the Federal Register on November 5, 1985 specifying the 1985 edition of the Life Safety Code of the NFPA.)

Effective Date: Upon enactment.

Correction and Reduction Plans for Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) (Section 9516)

Current Law: The Secretary has the authority to conduct validation, or "look behind", surveys to determine the validity of Medicaid certification actions taken by the designated State survey agency for ICFs/MR. Where the Secretary finds that a facility substantially fails to meet the standards of participation for ICFs/MR under the Medicaid program, he may terminate the facility's participation under the program in which case the Medicaid patients would be transferred to a certified facility.

Modification: The provision specifies the conditions under which a State may submit a plan of correction for a facility found to have non-life-threatening deficiencies. States may submit written plans to the Secretary to either 1) make all necessary staff and physical plant corrections within 6 months of the approval date of such a plan, or 2) complete a phased reduction in the facility's population within 36 months on the condition that the State agrees to achieve interim objectives established at six-month intervals. States will have the same period allowed under current law within which to file correction plans (30 days), and 65 days to file reduction plans in order to accommodate the public hearing requirement discussed below.

Under the correction plan option, if a State substantially fails to make the necessary corrections within the six-month period, the Secretary may terminate the facility's provider agreement.

To submit a reduction plan proposal, a State will have to provide for a hearing at the affected facility at least 35 days prior to submission of a reduction plan to the Secretary, and demonstrate that it has successfully provided home and community-based services similar to the services proposed to be provided under the reduction plan. The Secretary is not to approve any reduction plan in less than 31 days after its submission to allow interested residents, family, staff, and members of the public to comment.

A State's reduction plan must:

- o Identify and describe the number and service needs of existing facility residents to be provided home and community-based services and the timetable for providing these services in six-month intervals within the required 36-month period;

- o Describe the methods to be used to select residents for home and community-based services and to develop the alternative home and community-based services to meet their needs effectively;
- o Describe the necessary safeguards to be applied to protect the health and welfare of the former residents who are to receive home and community-based services;
- o Provide that residents of the the affected facility who are eligible for Medicaid will be placed in another setting (or another part of the affected facility) so as to retain their eligibility;
- o Specify the actions to be taken to protect the health and safety of the residents who remain in the affected facility while the reduction plan is in effect;
- o Provide that the ratio of qualified staff to residents at the facility will be the higher of the ratio the Secretary determines necessary to assure the health and safety of the residents or the ratio which was in effect at the time the finding of substantial deficiencies was made; and
- o Provide for the protection of the interests of employees affected by actions under the reduction plan.

The Secretary must provide for at least 30 days after the submission of a reduction plan by a State, during which he may receive comments, before approving or disapproving the plan.

The Secretary is to carefully monitor the State's progress in fulfilling its obligation under a reduction plan. If a State fails to meet its interim reduction goals during any given six-month period, the Secretary must either take prompt action to terminate the facility's provider agreement or disallow five percent of the Federal matching payments the State would otherwise receive for the cost of care for all Medicaid-eligible residents in the facility for each month the State remains out of compliance.

If the Secretary approves more than 15 reduction plans in any fiscal year, any plans beyond the 15 must be to correct deficiencies of at least \$2 million for a facility or a part thereof.

The Secretary will be required to publish, within 60 days of enactment, proposed regulations with a 30-day comment period implementing the correction and reduction plans. The Secretary must submit a report to Congress on the implementation of this section at least 6 months prior to the expiration of the Secretary's approval authority.

Effective Date: Upon enactment.

Modifying Application of Medicaid HMO Provisions for Certain Health Centers (Section 9517)

Current Law: 1) **Contracting with Certain Health Centers:** States can contract with certain organizations to provide health care services to Medicaid beneficiaries on a prepaid capitated risk or other risk basis. Among these organizations are: Community Health Centers and Migrant Health Centers, primarily funded by the Public Health Service (PHS), and certain rural health care centers known as Appalachian Health Centers, funded under the Appalachian Regional Development (ARD) Act, that had existed prior to June 30, 1976.

2) **Recipient "Lock-in":** States can restrict Medicaid beneficiaries from disenrolling without cause from certain organizations offering services on a prepaid, capitated basis for periods of up to six months. This restriction is known as "lock-in". Organizations eligible to participate in the lock-in provisions include Federally qualified HMOs, and Community, Migrant, and Appalachian Health Centers that are receiving, and had received in each of the two preceding years, at least \$100,000 under the appropriate sections of the PHS or ARD Acts. In either case, regulations specify that the organizations must also meet the requirement that less than 75 percent of their enrollment is composed of Medicaid or Medicare beneficiaries.

3) **Guaranteed Enrollment Period:** In the case of Medicaid recipients who are enrolled in a Federally qualified HMO contracting with a State Medicaid program and who would otherwise lose their Medicaid eligibility, States may deem these individuals eligible for Medicaid with respect to the services provided by the HMO for a period of up to six months.

4) **Health Insuring Organizations (HIOs):** HIOs are generally entities that contract with States on a risk basis to arrange for the provision of services to Medicaid eligibles for a capitated fee. HIOs do not provide services to Medicaid recipients like an HMO but rather subcontract with health care providers to deliver services. HIOs do not have to meet the contracting requirements of HMOs as found at 1903(m)(2) of the Social Security Act.

Modification: 1) **Contracting with Certain Health Centers:** Allows States to contract on a risk basis with Community and Migrant Health Centers and Appalachian Health Centers that are receiving, and for the past two years have received, at least \$100,000 in grants under the appropriate sections of the PHS and ARD Acts.

2) **Recipient "Lock-in":** Permits Community and Migrant Health Centers and Appalachian Health Centers that are contracting with the Medicaid program on a risk basis, and are receiving, and had received during the two preceding years, at least \$100,000 in grants under the appropriate sections of the PHS and ARD Acts, to participate in the lock-in provision without regard to the 75 percent rule.

3) **Guaranteed Enrollment Period:** Allows States to provide for continuation of benefits to individuals enrolled in certain Community, Migrant, and Appalachian

Health Centers on the same basis as individuals enrolled in Federally qualified HMOs. The eligible Community, Migrant, and Appalachian Health Centers are those that are contracting as HMOs with the Medicaid program and are receiving, and received in each of the two preceding years, at least \$100,000 under the appropriate sections of the PHS and ARD Acts.

4) HIOs: Where an HIO does more than simply act as a fiscal agent to review and process claims for payment, but actually provides or arranges with other providers (through subcontract or otherwise) for the delivery of services to Medicaid eligibles (even though the HIO does not itself deliver services), it is subject to all the regulatory requirements to which any HMO or similar prepaid entity is subject under current law. This applies to all HIOs which become newly operational after January 1, 1986 except for HIOs which had approved freedom of choice waivers with the Secretary prior to that date but had not yet become operational.

Effective Date: Upon enactment.

Extension of MMIS Deadline (Section 9518)

Current Law: Current law calls for all States to have a certified MMIS by the earlier of September 30, 1982 or the last day of the sixth month following the date specified for the operation of such systems in the State's most recently approved advance planning document submitted before enactment of P.L. 96-398 (enacted October 7, 1980).

Modification: The provision extends the deadline for a certified MMIS to September 30, 1985.

Effective Date: Applies to all payments made to States for calendar quarters beginning on or after October 1, 1982.

Report on Adjustment in Medicaid Payments for Hospitals Serving Disproportionate Numbers of Low Income Patients (Section 9519)

Current Law: States are required, in developing their Medicaid payment rates for inpatient hospital services, to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs.

Modification: The provision requires the Secretary to submit to Congress, by October 1, 1986, a report (1) describing the methodology used by States in paying hospitals that serve a disproportionate number of low income patients with special needs, (2) identifying hospitals that have received a disproportionate share adjustment, and (3) specifying the proportion of low income and Medicaid inpatient days at these hospitals.

Effective Date: Upon enactment

Task Force on Technology-Dependent Children (Section 9520)

Current Law: No provision.

Modification: The provision requires the Secretary to establish, within 6 months following enactment, a task force concerning alternatives to institutional care for technology-dependent children. A "technology-dependent child" is defined as a child who has a chronic illness which makes the child dependent upon the continuing use of medical care technology (such as a ventilator).

The provision specifies the composition of the task force. It must include representatives of Federal and State agencies with child health-related responsibilities, health insurers, large employers, providers, and parents of technology-dependent children.

The task force is required to submit, not later than two years after enactment, a final report to the Secretary and the Congress on (1) barriers that prevent the provision of care in a home or community setting to technology-dependent children, and (2) recommended changes in the provision and financing of health care in private and public health care programs so as to provide home and community-based alternatives to these children.

Effective Date: Upon enactment.

Expansion of Services Under Demonstration Waivers (Section 9522)

Current Law: For the provision of Medicaid services, States can contract on an at-risk basis with an entity which provides (a) inpatient hospital services and any other mandatory Medicaid service, or (b) any three or more mandatory services, only if the entity meets the specified HMO contracting requirements found in section 1903(m)(2) of the Social Security Act. The Secretary may not waive these requirements when approving a freedom-of-choice waiver under section 1915(b).

Modification: Authorizes the Secretary to waive, for the State of Oregon only, the specified HMO contracting requirements for entities providing services under freedom of choice waivers granted or applied for in 1986. Such organizations cannot provide more than five of the mandatory services nor inpatient hospital services.

Effective Date: Upon enactment.

Extension of Texas Waiver Project (Section 9523)

Current Law: Section 1115 of the Social Security Act gives the Secretary general authority to conduct experiments and demonstrations under various Social Security Act titles, including Medicaid, and to waive compliance with certain program requirements in carrying out these demonstrations. Under this demonstration authority, the Secretary approved a Medicaid waiver for the project, "Modifications of the Texas System of Care of the Elderly: Alternatives to the Institutionalized Aged," for the period January 1980 through December 1985.

Modification: The provision requires the Secretary to renew, upon application from the State, approval for this demonstration project until January 1, 1989. The provision further requires that approval be renewed on the same terms and conditions as applied to the project as of December 31, 1985 and specifies that this approval remain in effect until the Secretary finds that the applicant no longer complies with these terms and conditions.

Effective Date: Upon enactment.

Wisconsin Health Maintenance Organization Waiver (Section 9524)

Current Law: Only HMOs that are Federally qualified or organizations that receive funding under the Migrant Health Center, Community Health Center, or Appalachian Regional Commission programs (as amended by section 9517 of this Act) are permitted to utilize the recipient "lock-in" provision under Medicaid. This provision allows States to restrict Medicaid recipients from disenrolling without cause from these organizations for periods of up to six months. Other prepaid plans must allow Medicaid enrollees to disenroll from the plan for any reason at the beginning of the first full calendar month after a full calendar month that the recipient is in the plan.

The Secretary may not waive the one-month disenrollment requirements for certain HMOs participating in a Medicaid freedom-of-choice waiver. Wisconsin has a freedom-of-choice waiver which, when initially approved in 1982, included a waiver of the one-month disenrollment requirement. A one-year renewal of the Wisconsin freedom-of-choice waiver approved in 1985 could not include a waiver of the disenrollment requirement.

Modification: The Secretary is required to renew the freedom-of-choice waiver granted to Wisconsin, upon request of the State, including HMO participation in the lock-in provision, for renewable terms of two years, subject to the showings required generally of such freedom-of-choice waivers.

Effective Date: Upon enactment.

New Jersey Demonstration Project Relating to Training of AFDC Recipients as Home Health Aides (Section 9525)

Current Law: The Omnibus Reconciliation Act of 1980 (P.L. 96-499) authorized 90 percent Federal matching for the reasonable costs of demonstration projects to train AFDC recipients as homemaker-home health aides. The Secretary was authorized to enter into agreements with States for the purpose of conducting these demonstrations. Project duration was limited to a maximum of 4-years plus an additional period of up to 6 months for planning and development and a similar period for final evaluation and reporting. Seven States, including New Jersey, conducted homemaker-home health aide demonstration projects.

Modification: The provision requires the Secretary to continue for one additional year the demonstration project conducted by the State of New Jersey. Federal matching for the project is reduced from 90 to 50 percent.

Effective Date: Upon enactment.

Reference to Provisions of Law Providing Coverage Under, or Directly Affecting, the Medicaid Program (Section 9526)

Current Law: No Provision

Modification: There is a new section 1920 at the end of title XIX which lists existing non-title XIX statutory provisions that determine or affect Medicaid eligibility and establish additional State plan requirements so that they can be easily located elsewhere in the Social Security Act and in other statutes.

Effective Date: Upon enactment.

Children With Special Health Care Needs (Section 9527)

Current Law: Title V of the Social Security Act, the Maternal and Child Health (MCH) Services Block Grant, authorizes funds to States to provide services and care for children who are crippled or who are suffering from conditions leading to crippling.

Modification: The provision changes the term "crippled children" to "children with special health care needs" wherever the term "crippled children" appears in title V. It also makes another technical change of striking "crippled childrens' services" and substituting instead "services for children with special health needs."

Effective Date: Upon enactment.

Annual Calculation of Federal Percentage (Section 9528)

Current Law: Under current law, the Federal medical assistance percentage (FMAP) and Federal public assistance percentage (FPAP) are recalculated between October 1 and November 30, every even-numbered year. They are in effect for two-year periods beginning the following October.

Modification: This provision provides for annual rather than biennial calculations of the FMAP and FPAP.

Effective Date: For Fiscal Years 1987 and thereafter. Such amendments shall apply without regard to the current requirement that the rates be promulgated prior to November 30 of the year prior to the year in which the new percentages become applicable. The Secretary shall promulgate the new percentages for Fiscal Year 1987 as soon as practicable after the date of enactment.

Medicaid Coverage Relating to Adoption Assistance and Foster Care (Section 9529)

Current Law: Under title IV-E of the Social Security Act, SSI- or AFDC-eligible children with special needs and for whom payments are being made under an adoption assistance agreement are eligible for Medicaid. Regardless of where the child resides, the State which entered into the adoption assistance agreement is responsible for providing Medicaid coverage for the child even if the child and the adoptive parents live in a different state. Similarly, children in foster care for which Federal funding is provided under title IV-E are eligible for Medicaid coverage, Medicaid is provided by the State responsible for the foster care placement.

Modification: Specifies that all children receiving adoption assistance or foster care payments are to be considered residents of the State in which they are placed even if this is not the State making the IV-E payment or the State wherein the adoption assistance agreement was entered.

Clarifies that children with special medical or rehabilitative needs who are adopted under a publicly funded adoption program other than title IV-E are eligible for Medicaid regardless of the income and resource levels of the adoptive parents. States could, at their option, extend Medicaid coverage if:

- o an adoption assistance agreement (other than one under title IV-E) is in effect;
- o the child was eligible for Medicaid before the adoption assistance agreement was entered into; and
- o the State determines that the child because of special medical or rehabilitated care would be difficult to place without Medicaid coverage.

Effective date: Upon enactment, and for adoption assistance agreements entered into before, on, or after the date of the enactment.

Recommendations for Long-Term Health Care Policies (Section 9601)

Current Law: There is no current provision.

Modification: The Secretary, in consultation with the National Association of Insurance Commissioners, shall establish not later than 60 days after enactment a task force of 18 members on long-term care health insurance policies. The task force shall be composed of members representing the National Association of Insurance Commissioners, Federal and State agencies with responsibilities relating to health or the elderly, private insurers, consumers, and long-term health care providers. The task force shall develop recommendations for long-term health care policies, including those designed to limit marketing and agent abuse, to assure the dissemination of information that will permit informed choice and a reduction in the purchase of unnecessary or duplicative coverage, and to assure that policy benefits are reasonable in relationship to premiums charged. Within eighteen

months, the task force is to report to the Secretary, the House Committee on Energy and Commerce, and the Senate Committee on Labor and Human Resources on both the recommendations it has developed and on recommendations for any additional activities it finds appropriate. The report is to be distributed to the States through a cooperative effort between the Secretary and the National Association of Insurance Commissioners. Within 90 days the Task Force shall terminate. The Secretary shall send to the two Committees two reports on 1) actions taken by the States to implement the Task Force's recommendations and to recommend additional action and 2) recommendations for legislative and administrative action to respond to issues raised by the task force, if needed, or to improve consumer protection. The first of these reports is due 18 months after the aforementioned report, and the second, 18 months later.

Recommendations are not to be construed as preempting State law.

Effective Date: Upon Enactment.

