

# HCFAL LEGISLATIVE SUMMARY

November 12, 1986

## OMNIBUS RECONCILIATION ACT OF 1986 P.L. 99-509

On October 21, 1986 the President signed into law H.R. 5300, the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509). Summaries of the Medicare and Medicaid provisions are attached.



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**OMNIBUS BUDGET RECONCILIATION ACT OF 1986**  
**(Public Law 99-509)**

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## PROVISIONS RELATING TO MEDICARE

### **Changes in Inpatient Hospital Deductible (Section 9301)**

#### Current Law

- o Medicare beneficiaries are required to pay the inpatient hospital deductible per spell of illness or "benefit period." The part A deductible is revised on a calendar-year basis through a formula that reflects the annual increase in the average cost of one day of inpatient hospital care. The deductible is \$492 in 1986.
- o The deductible is also used to compute the coinsurance amounts for inpatient days after the first 60 days in a spell of illness, as well as for post-hospital extended care services. The monthly part A premium is also derived from the deductible.

#### Provision

- o For calendar year 1987, the inpatient hospital deductible would be set at \$520.
- o In future years, the part A deductible would be indexed annually by the applicable percentage increase used for PPS rates, adjusted to reflect changes in real case mix.
- o The Secretary is required to issue regulations to update the inpatient hospital deductible and all coinsurance amounts between September 1 and September 15 in the year preceding the year they will apply.
- o The Secretary is required to issue, within 30 days following enactment, regulations to update the deductible and coinsurance amounts and part A premiums for 1987.

#### Effective date

- o For deductible, applies to spells of illness starting on or after January 1, 1987.
- o For coinsurance, applies to services provided on or after January 1, 1987.
- o For the part A premium, applies to months beginning with January 1987.

### **Applicable Percentage Increase in Payments for Inpatient Hospital Services (Section 9302)**

#### Current Law

- o Rates -- The Secretary determines the annual rate of increase in payment rates to PPS hospitals taking into account various factors affecting hospital costs, particularly the hospital market basket, as well as ProPAC's recommendations. PPS and PPS-exempt hospitals receive the same update.
  - Final rules issued September 3, 1986, provided for an increase for FY 1987 of 0.5 percent.

- o **Outliers --** The standardized payment amounts for urban and rural hospitals are reduced by an identical percentage in accordance with estimated payments for outlier cases. The thresholds defining cost and day outliers and the payment adjustment for such cases are set so that total payments for outliers will be equal to 5 percent of DRG payments.
- o **Calculation of Standardized Payments --** The standardized payment amounts, determined separately for urban and rural hospitals, are calculated on the basis of the average cost of an average case by hospital.
- o **Regional Referral Centers (RRCs) --** Other than for large rural hospitals (500 or more beds), the Secretary is given authority to set criteria for a rural hospital that has similar operating characteristics to a typical urban hospital in its region. A minimum threshold of 3,000 discharges is specified by law for rural osteopathic hospitals. RRC designation is awarded on a three-year basis
- o **Sole Community Hospitals --** Sole community hospitals are provided payment adjustments for uncontrollable volume declines of greater than 5 percent until October 1, 1986.

#### **Provision**

- o **Rates --** FY 1987 payment rates for PPS hospitals and the target rate-of-increase limits for PPS-exempt hospitals are increased by 1.15 percent. The increase in the PPS payment rates for FY 1988 will be equal to the market basket index minus 2 percentage points.
  - For FY 1988 and thereafter, the Secretary is required to inform Congress by April 1 of his initial estimate of the new fiscal year's update factor.
  - DRG classifications and weighting factors will be adjusted for FY 1988 and at least annually thereafter.
  - The update factor will be the same for all PPS hospitals including PPS hospitals in Puerto Rico, but may vary for other PPS-exempt hospitals and units.
- o **Outliers --** Provides for different offsets to the standardized amounts to pay for outliers in urban and rural hospitals. Requires that the 5 percent aggregate target for outliers and current thresholds be retained through FY 1987. This will result in higher offsets for urban hospitals than for rural hospitals.
- o **Calculation of Standardized Amounts --** The formula used to calculate the standardized payment amounts for urban and rural hospitals under PPS would be changed to be based on cost per discharge in the aggregate, rather than cost per discharge by hospital. Because the higher cost hospitals tend to have higher cost discharges, this change will increase the standardized payments (rural more than urban); the provision would be made budget neutral to prevent increased outlays.

- o **Regional Referral Centers --** The criteria are more explicitly defined in statute. In order to qualify, hospitals must have:
  - case mix at least equal to the median case mix for urban hospitals in the same census region (excluding hospitals with approved teaching programs);
  - 5,000 or more discharges per year or, if less, the median number of discharges in urban hospitals in the census region (rural osteopathic hospitals may qualify by meeting discharge criteria established by the Secretary); and
  - any other criteria established by the Secretary.
- + Any application for RRC status filed before January 1, 1987, and subsequently approved will be effective for discharges occurring on or after October 1, 1986. Otherwise, applications must be submitted in the quarter before the beginning of the hospital's cost reporting period.
- + Hospitals that are RRCs on the date of enactment will retain that status for cost reporting periods beginning on or after October 1, 1986, and before October 1, 1989.
- + Provisions pertaining to RRCs will be implemented to ensure that total payments remain budget neutral.
- o **Sole Community Hospitals --** The volume protection provision for sole community hospitals is extended through cost reporting periods beginning in FY 1988.
- o The Secretary will conduct a rural secondary specialty center demonstration project under Medicare in agreement with Lake Region Hospital and Nursing Home at Fergus Falls, Minnesota. For no more than 3 years, the hospital will be paid the regional urban standardized payment amount, adjusted by a rural wage index amount.
  - The Secretary will submit a report to Congress no later than 6 months after completion of the project.

**Effective Date**

- o The rate of increase for PPS-exempt hospitals and the hospital-specific portion of the PPS payments will apply to cost reporting periods beginning on or after October 1, 1986. For the Federal portion of the PPS rates, the rate of increase will be effective for discharges on or after October 1, 1986.
- o Separate outlier offsets for urban and rural hospitals will apply to discharges occurring on or after October 1, 1986.
- o Case-weighted urban and rural standardized amounts will be computed for discharges occurring on or after October 1, 1987.

- o Revised RRC criteria effective for cost reporting periods beginning on or after October 1, 1986.

### **Payments for Hospital Capital-Related Costs (Section 9303)**

#### **Current Law**

- o The prospective payment system (PPS) pays hospitals on a per discharge basis for the operating costs of inpatient services. Capital-related costs for inpatient services are currently excluded from the definition of operating costs for PPS and are reimbursed on a reasonable cost "pass-through" basis. This exclusion from the definition of operating costs was to expire on October 1, 1986, but was extended until October 1, 1987, by P.L. 99-349, the Urgent Supplemental Appropriations Act.

#### **Provision**

- o Requires aggregate reduction of capital-related payments to PPS hospitals. Payments will be reduced by:
  - + 3.5 percent for portions of cost reporting years occurring in FY 1987
  - + 7 percent for portions of cost reporting years occurring in FY 1988.
  - + 10 percent for portions of cost reporting years occurring in FY 1989.
- o Excludes sole community hospitals from reductions in payments for capital-related costs. If other capital-related costs are included in operating costs, sole community hospitals will continue to be paid for capital-related costs under the reasonable cost methodology until October 1, 1990.
- o Effective October 1, 1987, PPS hospitals in Puerto Rico are included in all provisions relating to capital for PPS hospitals.
- o The Secretary is granted the discretion to select FY 1988 or a later year for incorporation of capital-related costs under PPS. If capital is included in PPS for FY 1988 or FY 1989, aggregate payment amounts for capital under PPS must approximate those that would have been made under reasonable cost reimbursement.

#### **Effective Date**

- o Applies to cost reporting periods starting on or after October 1, 1986.

### **Coverage of Hospitals in Puerto Rico Under DRG Prospective Payment System (Section 9304)**

#### **Current Law**

- o Under current law, hospitals outside the 50 States and the District of Columbia

are excluded from the prospective payment system (PPS) and are paid on the basis of reasonable costs.

#### Provision

- o Effective October 1, 1987, hospitals located in Puerto Rico would be included in PPS. Hospitals that are excluded from PPS in other States would also be excluded in Puerto Rico.
- o Payment Rate - Prospective payment rates for Puerto Rican PPS hospitals would be the sum of 75 percent of a Puerto Rico-specific discharge-weighted standardized rate for urban or rural hospitals and 25 percent of discharge-weighted average of the national urban and rural standardized payment amounts.
- o Establishing the Base Year - The Puerto Rico-specific standardized payment amounts shall be calculated separately for urban and rural hospitals, based on Fiscal Year 1987 hospital cost reports, trended forward to the midpoint of Fiscal Year 1988 by the PPS update factor.
- o Standardization - The base amount would be standardized by excluding an estimate of indirect medical education costs, adjusting for variations among hospitals by area wage levels, adjusting for variations in case mix among hospitals and reduced by an appropriate percentage of disproportionate share payments to Puerto Rican hospitals.
- o Outlier Adjustments - The Puerto Rico average standardized amounts would be reduced by an appropriate percentage of outlier payments as estimated by the Secretary.
- o Area Wage Adjustment - Area wage adjustments would be made based on the relative hospital wage level in a hospital's geographic area compared to the Puerto Rican average hospital wage level.
- o Updates - For Fiscal Year 1989 and beyond, the Secretary would compute the the Puerto Rico adjusted DRG amount by increasing the urban or rural average standardized amounts for the previous fiscal year by the PPS update factor (adjusted to reflect most recent case mix data).
- o Additional Payments - Provisions that relate to hospitals under PPS generally would also apply, such as: outlier payments, payments for indirect medical education costs (paid only against the Puerto Rico-specific rate), payments for costs of certified registered nurse anesthetists, disproportionate share payments (paid only against the discharge-weighted average of the national urban and rural rates), and other exceptions and adjustments as determined by the Secretary. However, Puerto Rican hospitals would not be eligible for designations as regional referral centers or sole community hospitals.
- o For discharges occurring in Fiscal Year 1988, the Secretary must assure that the aggregate payment amounts for PPS do not exceed the aggregate amounts

that would have been paid if the Puerto Rico hospitals had continued to be paid on a cost reimbursement basis.

#### Effective Date

- o For discharges on or after October 1, 1987.

#### **Improving Quality of Care with Respect to Part A Services; Refinement of Prospective Payment System (Section 9305(a))**

##### Current Law

- o Under PPS, hospitals are paid a predetermined rate based on the DRG to which the patient is assigned. The DRGs are weighted to reflect the degree of resource utilization relative to the diagnosis. Payment rates for DRGs reflect the average cost of providing care to patients in each DRG category.

##### Provision

- o Requires the Secretary to submit a legislative proposal, within 2 years of enactment, to refine the PPS classification and payment system including payment for outliers, to assure that payments approximate the costs of medically necessary care. The refinements also must account for variations in severity of illness and case complexity not adequately addressed by the current system.

#### Effective Date

- o Upon Enactment.

#### **Improving Quality of Care with Respect to Part A Services; Requiring Notice of Hospital Discharge Rights (Section 9305(b))**

##### Current Law

- o Hospitals are required to provide Medicare inpatients with a notice explaining hospital discharge procedures and patients' rights to appeal discharge decisions. This notice also informs patients that notices of non-covered continued stay will be reviewed by their local peer review organization (PRO).

##### Provision

- o Requires hospitals to provide all inpatient beneficiaries with a written statement upon admission explaining their rights to benefits for inpatient hospital and post-hospital services, as well as their rights to appeal denials of benefits for continued inpatient services. The statement also must explain the circumstances under which individuals would be liable for

charges for continued hospital stay, including liability for payment for services if benefit denials are upheld under appeal.

**Effective Date**

- o Requires the Secretary to prescribe the language no later than six months after the date of enactment. Applies to hospital admissions not later than 60 days after language is prescribed.

**Improving Quality of Care with Respect to Part A Services; Requiring Hospitals to Provide Discharge Planning Process (Section 9305(c))**

**Current Law**

- o Under the conditions of participation set forth in the June 17, 1986 Federal Register, hospitals are required to have a discharge planning program to facilitate the provision of post-hospital care. Currently, this requirement is satisfied by hospitals which are accredited by the JCAH.

**Provision**

- o Requires hospitals, as a condition of participation in the Medicare program, to have a discharge planning process.
- o Requires the Secretary of HHS to develop guidelines and standards for hospital discharge planning to ensure a timely and smooth transition to the most appropriate post-hospital setting.
- o These requirements may not be satisfied by JCAH accreditation, unless the standards of the accrediting body are at least equal to the provision described above.

**Effective Date**

- o One year after enactment.

**Improving Quality of Care with Respect to Part A Services; Review of Standards for Medicare Conditions of Participation for Assuring Quality of Inpatient Hospital Services (Section 9305(d))**

**Current Law**

- o Under current conditions of participation for the Medicare program, hospitals are required to establish hospital-wide quality assurance programs aimed at identifying and correcting patient care problems.

**Provision**

- o Requires a study of the adequacy of the standards set forth in the Medicare

hospital conditions of participation to assure the quality of services furnished in hospitals.

- o Requires the Secretary of HHS to report to Congress no later than two years after the date of enactment.

**Effective Date**

- o Upon enactment.

**Improving Quality of Care with Respect to Part A Services; Study of Payment for Administratively Necessary Days (Section 9305(e))**

**Current Law**

- o Under PPS, payments to hospitals are based on the DRG category into which Medicare patients are classified. DRG payment rates reflect only the average cost of providing care to patients classified by diagnosis. These payment rates are not linked to length of stay. No special provision is made for additional payments for administratively-necessary days (i.e., days of continued inpatient stay necessitated by delays in obtaining placement of patients in skilled nursing facilities).

**Provision**

- o Requires a study to determine whether a separate payment should be made (in a budget-neutral manner) to hospitals for administratively-necessary days. The report should consider the following:
  - the need for payment to minimize the disproportionate financial impact of current law on certain hospitals (due to difficulties in arranging for appropriate post-hospital care), and the risk of discharges to inappropriate settings; and
  - administrative mechanisms to prevent inappropriate payment under this provision.
- o Requires the Secretary of HHS to report to Congress on the results of the study by January 1, 1989.

**Effective Date**

- o Upon Enactment.

**Improving Quality of Care with Respect to Part A Services; Extending Waiver of Liability Provisions to Hospice Programs (Section 9305(f))**

**Current Law**

- o The "favorable presumption" for waiver of liability is an administrative

mechanism which was established to avoid having to determine on a case-by-case basis whether the provider knew the services were not covered because they were not medically necessary, or because the patient needed custodial care.

- o In order to receive payment under the waiver, neither the provider nor the patient could have known, or have been expected to have known, that the care provided was not covered. Providers are presumed to meet this test if their denial rates are under a particular percentage.
- o This "favorable presumption" was eliminated by regulations published on February 21, 1986, although COBRA extended the protection for SNFs until October 7, 1988, and for HHAs until 12 months after the consolidation of claims processing. Favorable presumption was never established for hospices.

#### Provision

- o Establishes a favorable presumption for hospices which have 2.5 percent or fewer days of care denied on the basis of medical necessity.

#### Effective Date

- o The first day of the first month that begins at least six months after enactment, to November 1, 1988.

### **Improving Quality of Care with Respect to Part A Services; Extension of Waiver of Liability Provisions to Certain Coverage Denials for Home Health Services (Section 9305(g))**

#### Current Law

- o The current waiver protection does not apply to HHA services which are not covered because patients do not meet the homebound and intermittent care eligibility requirements. Program guidelines provide fiscal intermediaries and HHAs with guidance on how to make these coverage determinations.

#### Provision

- o Extends the waiver of liability to denials of home health services because beneficiaries did not meet the homebound requirement or did not have a need for intermittent skilled nursing care. Establishes in law the conditions which HHAs must meet to receive the favorable presumption.
- o Creates a new favorable presumption for claims denied because they do not meet homebound or intermittent guidelines that is in addition to the existing favorable presumption for claims that are not medically necessary or are for custodial care. Applies to HHAs which submit bills for payment and medical documentation on a timely basis, and which have denial rates of 2.5 percent or less for homebound and intermittent care requirements during the previous quarter.

- o Requires annual reports to Congress in March of 1987 and 1988 on the frequency and distribution of denials, by type of provider, for extended care, home health and hospice services. This report should include the following information: reasons for denials, percentage of denials paid under waiver, rate of reversals, and any other information necessary to determine the appropriateness of the percentage standard.

Effective Date

- o July 1, 1987 to October 1, 1989.

**Improving Quality of Care with Respect to Part A Services; Development of Uniform Needs Assessment Instrument (Section 9305(h))**

Current Law

- o There is no comparable requirement in current law.

Provision

- o Requires the Secretary of HHS to develop a uniform needs assessment instrument that can evaluate an individual's functional capacity and care requirements and the available resources to meet those needs, and that can be used by health care professionals and fiscal intermediaries in evaluating an individual's need for post-hospital services. The Secretary may develop more than one instrument for use in different situations.
- o Requires the Secretary to appoint an advisory panel composed of experts in post-hospital care, as well as representatives from fiscal intermediaries, HHAs, SNFs, physicians, hospitals, and Medicare beneficiaries. The instrument(s) should be developed in consultation with this panel.
- o Requires the Secretary to report to Congress by January 1, 1989. The report should include recommendations on the appropriate use of the instrument(s).

Effective Date

- o Upon enactment.

**Improving Quality of Care with Respect to Part A Services; Including in Annual Reports on Prospective Payment System Information on Quality of Post-Hospital Care (Section 9305(i))**

Current Law

- o The Secretary of HHS is required to submit an annual report to Congress on the impact of the prospective payment system for the years 1984-1987.

#### Provision

- o Extends the requirement for annual PPS impact reports to Congress through 1989.
- o Requires inclusion, in each annual PPS impact report, of information on the adequacy of quality assurance procedures for post-hospital services, including an assessment of problems preventing Medicare beneficiaries from receiving appropriate post-hospital services, and information on Medicare reconsiderations and appeals.

#### Effective Date

- o Enactment. Applies to reports for years beginning with 1986.

#### **Improving Quality of Care with Respect to Part A Services; Prior and Concurrent Authorization Demonstration Project (Section 9305(k))**

#### Current Law

- o Medicare fiscal intermediaries decide whether payment for post-hospital services provided to Medicare beneficiaries will be made. These payments are generally made on a retrospective basis.

#### Provision

- o Requires the Secretary of HHS to conduct a demonstration project on prior and concurrent authorization for post-hospital extended care services and home health services. The demonstration must include at least four projects and be implemented by January 1, 1987. Waivers of compliance with Medicare requirements must be made as necessary.
- o Demonstration projects must be developed in consultation with an advisory panel, which shall include experts in the areas of post-hospital services, as well as representatives from hospitals, fiscal intermediaries, physicians, and Medicare beneficiaries. The Secretary shall monitor acceptance of beneficiaries by providers, to prevent any delay in receipt of post-hospital services.
- o Requires an evaluation of the projects and a report to Congress by February 1, 1989. The evaluation should include comparisons between the current system and the demonstrations in the following areas: administrative and program costs (including costs of uncovered services paid under waiver, which would not be incurred under the demonstration), access to and availability of services (including costs to providers), timely patient discharges, accuracy and cost savings of payment determinations, and rate of claim reversals.
- o The demonstration projects will be funded by the Federal Hospital Insurance Trust fund.

### Effective Date

- o Upon enactment.

### Payments to Large Rural Hospitals Serving a Disproportionate Share of Low-Income Patients (Section 9306)

#### Current Law

- o Additional payments are made to PPS hospitals that serve a disproportionate share of low-income patients. This applies to discharges occurring on or after May 1, 1986, but before October 1, 1988.
- o For urban hospitals with 100 or more beds having a percentage of low-income patients of at least 15 percent, the Federal portion of the PPS payment is increased by 2.5 percent plus an additional 0.5 percent for each one percentage point that the percentage of low-income patients exceeds 15 percent. The maximum adjustment allowed is 15 percent.
- o For urban hospitals with less than 100 beds having a percentage of low-income patients of at least 40 percent, the adjustment is 5 percent.
- o For rural hospitals with a percentage of low-income patients of 45 percent, the disproportionate share adjustment would be 4 percent.
- o The percentage of low-income patients is defined as the hospital's total number of Medicare-covered inpatient days attributable to Medicare patients who are eligible for Federal Supplemental Security Income benefits, and the percentage of the hospital's total patient days attributable to Medicaid (non-dual eligible) recipients.
- o Payments are also made to urban hospitals with 100 or more beds which demonstrate that more than 30 percent of their inpatient revenues are derived from State and local government payments for indigent care (excluding payments under Medicare and Medicaid).

#### Provision

- o Gives the Secretary authority to establish a percentage criterion above which rural hospitals with 500 or more beds could qualify for a disproportionate share adjustment. The Federal portion of PPS payments for such hospitals would be increased by the same formula currently used for urban hospitals with 100 or more beds (i.e., 2.5 percent plus half the difference between 15 percent of the hospital's percentage of low-income patients, not to exceed 15 percent).
- o Adjustments for indirect costs of medical education and disproportionate share payments are extended through FY 1989.

### Effective Date

- o Applies to discharges occurring on or after October 1, 1986.

**Technical Amendments and Miscellaneous Provisions Relating to Part A (Section 9307)**

**Temporary Waiver of Inpatient Limitations For The Connecticut Hospice, Inc. (Section 9307(a))**

**Current Law**

- o Medicare-certified hospices are required to maintain no more than 20 percent of total days as inpatient days. Connecticut Hospice, Inc., currently has a waiver for a number of Medicare requirements, including the inpatient day limitation. These waivers expired on October 1, 1986.

**Provision**

- o Permits The Connecticut Hospice, Inc. to waive the inpatient care day limitation for a period of two years, provided Connecticut Hospice, Inc. does not exceed 50 percent of total days as inpatient days.

**Effective Date**

- o For hospice care provided before October 1, 1988.

**Massachusetts Medicare Repayment (Section 9307(b))**

**Current Law**

- o Massachusetts operated a Statewide hospital demonstration project from October 1, 1982, through June 30, 1986. The Secretary is required to judge the effectiveness of the demonstration to ensure that Medicare expenditures under the demonstration are not greater than they would have been under Medicare's regular reimbursement rules. The Secretary has determined that Medicare part A overpayments were made during the first two years of the Massachusetts waiver and has established a repayment schedule (overpayments from the third year will be assessed in January 1987).

**Provision**

- o Prohibits the Secretary from recouping or otherwise reducing payment to Massachusetts hospitals because of alleged overpayments under the statewide hospital reimbursement demonstration project. Recoupment of payments subject to recovery as overpayments cannot be made from the date of enactment of this section through January 1, 1988.

**Effective Date**

- o On or after date of enactment and before January 1, 1988.

## **Part A COBRA Technical Corrections (Section 9307(c))**

### **Current Law**

- o The Consolidated Omnibus Budget Reconciliation Act of 1985 contains a number of technical errors, several of which were not corrected by technical corrections in the Tax Reform Act of 1986.

### **Provision**

- o Eliminates modifications to COBRA sections 9104 (payments to hospitals for indirect costs of medical education) and 9105 (payments for hospitals which serve a disproportionate share of low-income patients). Makes clarifying changes in provisions impacting physician payments and continuation of employer-based health insurance coverage.

### **Effective Date**

- o October 22, 1986 (date of enactment of P.L. 99-514, the Tax Reform Act of 1986).

## **Miscellaneous Accounting Provision (Section(d))**

### **Current Law**

- o The Emergency Extension Act of 1985 (P.L. 99-107) provided that payments made for inpatient hospital services for discharges occurring (and cost report periods beginning) during the 45-day extension period shall be determined on the same basis as the amount of payment for these services for a discharge occurring on (or the cost reporting period beginning immediately on or before) September 30, 1985.

### **Provision**

- o The provision amends the Emergency Extension Act by specifying that a cost reporting period that begins on September 28, 29, or 30 is deemed to begin on October 1; and that any reference to September 30 should also be considered a reference to September 27.

### **Effective Date**

- o September 30, 1985 (date of enactment of P.L. 99-107).

## **Periodic Interim Payments (PIP) for DRG Hospitals and Prompt Payment for Medicare Providers (Section 9311)**

### **Current Law**

- o Current law does not specifically provide for periodic interim payments. However, to facilitate cash flows, regulations were developed allowing

hospitals, SNFs, and HHAs which meet certain requirements to receive PIP every 2 weeks, based on estimated annual costs subject to year end settlement.

- o In final regulations published August 15, 1986, the Department eliminated PIP for most PPS and PPS-exempt hospitals, effective July 1, 1987. The major exception is rural hospitals with fewer than 100 beds.
- o Although current law does not specify claims processing timeframes, HCFA issued guidelines in 1986 requiring part A intermediaries and part B carriers to process at least 95 percent of "clean" Medicare claims within 27 days of receipt.

#### Provision

- o Eliminates PIP for inpatient services in PPS hospitals. PIP will, however, be provided (or continue to be provided) for:
  - a hospital whose intermediary fails to demonstrate compliance with the prompt payment requirements for 3 consecutive calendar months (if the hospital meets the PIP requirements in effect on October 1, 1986). PIP will continue until the intermediary can demonstrate that ability;
  - a hospital that has a disproportionate share adjustment of at least 5.1 percent during FY 87 (any such hospital must have been paid on a PIP basis as of June 30, 1987, and continue to meet the criteria);
  - a rural hospital with fewer than 100 beds, paid on a PIP basis as of June 30, 1987, that continues to meet PIP requirements;
  - non-PPS hospitals,
  - hospitals reimbursed under a State hospital reimbursement system if PIP is an integral part of the system,
  - extended care services,
  - home health services, and
  - hospice care.
- o Accelerated payments may be available for PPS hospitals with significant cash flow problems.
- o Prompt payment provisions for part A require intermediaries to pay at least 95 percent of all "clean" non-PIP Medicare claims by a given number of calendar days after receipt. In FY 87 - 30 days; FY 88 - 26 days; FY 89 - 25 days; and FY 90 and thereafter - 24 days.
- o Prompt payment provisions for part B require carriers to pay at least 95 percent of all clean part B claims by a given number of calendar days after receipt. In FY 87 - 30 days; FY 88 - 26 days; FY 89 - 25 days; FY 89 and

thereafter - 24 days. Carriers must pay claims for participating physicians 7 days faster than for nonparticipating physicians in FY 38 and all fiscal years thereafter.

- o Failure to comply with prompt payment requirements for parts A and B would result in interest being paid beginning on the day after the date on which payment was due, and ending on the date payment is made. The interest rate for penalties will be the rate applicable for failure to make prompt payments (section 3902(a) of title 31 U.S.Code).
- o The Secretary should establish standards for timely payment of claims that do not meet the definition of a "clean" claim.

#### Effective Date

- o PIP provisions applies to claims received on or after July 1, 1987.
- o For providers currently receiving PIP, the elimination of PIP would be implemented only after demonstration by the intermediary of 3 consecutive months of compliance with the prompt payment provisions (beginning no earlier than April 1, 1987).
- o Prompt payment requirements will apply to claims received on or after November 1, 1986. Interest penalties will be applied as required only to claims received on or after April 1, 1987.
- o Carriers and intermediaries will be reimbursed for any necessary additional costs for claims received on or after April 1, 1987.

#### **Health Maintenance Organizations and Competitive Medical Plans; Repeal of "2 for 1" Conversion Requirement for Certain HMOs (Section 9312(a))**

##### Current Law

- o Under TEFRA, HMOs which have Medicare beneficiaries enrolled in old (pre-TEFRA) cost contracts can convert these beneficiaries to enrollment under their new risk contract, provided that the organization enrolls two new Medicare beneficiaries for every one beneficiary converted from the cost to the risk contracts. This is known as the "two for one" rule.

##### Provision

- o Repeals the two for one rule.

##### Effective Date

- o April 1987.

**Health Maintenance Organizations and Competitive Medical Plans; Requiring the Provision of an Explanation of Enrollee Rights (Section 9312(b))**

**Current Law**

- o HMOs and CMPs must provide for grievance procedures in order to contract with HCFA to provide services to Medicare beneficiaries. Services that an enrollee believes should have been provided but which were denied by the HMO/CMP are subject to the regular Medicare appeals procedure.
- o Medicare beneficiaries who enroll in an HMO or CMP must accept that only care provided through that organization will be covered, except for emergency and urgently needed out-of-area care.

**Provision**

- o Requires participating HMOs and CMPs to provide each enrollee, at the time of enrollment and annually thereafter, with an explanation of his or her rights, including rights to benefits, restrictions on services provided by outside providers or suppliers, out-of-area coverage, coverage of emergencies, and appeal rights.

**Effective Date**

- o January 1, 1987.

**Health Maintenance Organizations and Competitive Medical Plans; Restricting Waiver of Requirement of 50 Percent Non-Medicare Enrollment in HMOs and CMPS (Section 9312(c))**

**Current Law**

- o Participating HMOs and CMPs are required to have membership populations which are composed of at least 50 percent non-Medicare or Medicaid eligibles. The Secretary has the authority to waive this requirement if the circumstances so warrant, and if the organization makes an effort to increase its enrollment of non-eligibles.

**Provision**

- o Limits Secretary's ability to issue new waivers to plans with service areas where more than 50 percent of the population is entitled to Medicare and Medicaid benefits, and to government-operated HMOs for their first three years, provided they are trying to increase their private membership.
- o Allows the Secretary to suspend enrollment or payment for newly enrolled individuals or to terminate the contract of organizations which fail to comply with the 50 percent rule or the terms of the waiver.

- o Allows the Secretary to extend waivers of organizations currently under waiver which do not meet the new requirements, but which continue to make efforts to meet scheduled enrollment goals. Allows the Secretary to apply the new sanctions to these organizations.

#### Effective Date

- o New waiver restriction - enactment.
- o Sanctions - enactment.

### **Health Maintenance Organizations and Competitive Medical Plans; Prompt Payment of Claims (Section 9312(d))**

#### Current Law

- o Participating HMOs and CMPs are financially responsible for the cost of benefits provided to their Medicare enrollees, if those benefits are provided directly or under an alternate arrangement or were emergency services or urgently needed services.

#### Provision

- o Requires risk contracting organizations to pay claims for covered services submitted by providers and suppliers who do not have a contractual relationship with the organization, in accordance with the prompt payment provisions in Section 9311 of this Act.
- o If organizations fail to make prompt payments, the Secretary may provide for such payment and deduct the payment amounts and administrative costs from payments made to these organizations (after notice and opportunity for a hearing).

#### Effective Date

- o For services furnished on or after January 1, 1987.

### **Health Maintenance Organizations and Competitive Medical Plans; Requiring Access to Financial Records and Disclosure of Internal Loans (Section 9312(e))**

#### Current Law

- o Participating HMOs and CMPs are required to comply with the financial disclosure provisions of the Public Health Service Act, which require reporting of: 1) information necessary to demonstrate fiscal soundness; 2) information filed with HCFA identifying persons with ownership interests of more than five percent in the organization; and 3) descriptions of transactions between the organization and other parties, including property transactions and loans or other credit arrangements.

#### **Provision**

- o Requires HMOs and CMPs to provide information, upon request, on ownership of subcontractors with whom the contractor has done business in excess of \$25,000 during the previous year.
- o Requires HMOs and CMPs to release information on significant business transactions between the contractor and any subcontractor. Organizations also are required to notify the Secretary of loans and other special financial arrangements made between the contractor and subcontractors, affiliates, or related parties.

#### **Effective Date**

- o January 1, 1987.

#### **Health Maintenance Organizations and Competitive Medical Plans; Authority to Impose Civil Money Penalties (Section 9312(f))**

##### **Current Law**

- o Medicare contracts with HMOs and CMPs are automatically renewed unless contractors fail to meet their contractual obligations. The Secretary may terminate these contracts after notifying the contractor and allowing time for a hearing.

#### **Provision**

- o Imposes a \$10,000 penalty on risk-contracting HMOs and CMPs for each failure to provide medically necessary items and services required by law or by contract to Medicare beneficiaries if such failure has, or is likely to have, an adverse impact on the patients.

#### **Effective Date**

- o January 1, 1987.

#### **Health Maintenance Organizations and Competitive Medical Plans; Study of AAPCC and ACR (Section 9312(g))**

##### **Current Law**

- o Medicare payment to risk-contracting HMOs and CMPs is determined using estimates of the Adjusted Average Per Capita Cost (AAPCC) and the Adjusted Community Rate (ACR).

#### **Provision**

- o Requires the Secretary to contract for a study of methods that could be used to refine the AAPCC and ACR to reflect more accurately the costs of providing

care to different classes of patients.

- o The Secretary must submit specific legislative recommendations to Congress on how these methods can be refined by January 1, 1988.

**Effective Date**

- o Upon enactment.

**Health Maintenance Organizations and Competitive Medical Plans; Allowing Medicare Beneficiaries to Disenroll at a Local SSA Office (Section 9312(h))**

**Current Law**

- o Currently, beneficiaries who wish to disenroll from HMOs and CMPs must do so at the organization they are enrolled in.

**Provision**

- o Permits beneficiaries to disenroll from HMOs and CMPs at any local SSA office.

**Effective Date**

- o June 1, 1987.

**Health Maintenance Organizations and Competitive Medical Plans; Use of Reserve Funds (Section 9312(i))**

**Current Law**

- o Organizations having risk-sharing contracts are allowed to set-aside a portion of their Medicare payment in a reserve fund. These reserve funds are known as "benefit stabilization funds", and are established to prevent undue fluctuations in additional benefits offered in subsequent contract periods.

**Provision**

- o Allows HMOs and CMPs to use funds which were reserved in a benefit stabilization fund before the date of enactment to offset the one percent reduction in benefit payments for FY 1986 implemented under the Gramm-Rudman-Hollings Act.

**Effective Date**

- o Upon enactment.

**Provisions Relating to Improvement of Quality of Care; Permitting Provider Representation of Beneficiaries (Section 9313(a))**

**Current Law**

- o Beneficiaries who disagree with payment denials for Medicare part A services are entitled to appeal the coverage determination. Prior to April 1984, the providers who furnished the services in question were allowed to represent the beneficiary upon appeal. However, in April 1984, HCFA issued instructions to fiscal intermediaries to prohibit such representation, because of a potential conflict of interest.

**Provision**

- o Prevents the Secretary from prohibiting providers who have rendered the service in question from representing beneficiaries on appeals, if the providers waive the right to payments for the appealed services.
- o Prevents providers from imposing financial liability on beneficiaries in connection with such representation. Does not allow providers to claim the costs of unsuccessful appeals on the behalf of beneficiaries as reasonable costs.

**Effective Date**

- o Upon enactment.

**Provisions Relating to Improvement of Quality of Care; Permitting Review of Technical Denials (Section 9313(b))**

**Current Law**

- o "Technical" denials for HHA services, such as the homebound and intermittent care requirements are not subject to appeal.

**Provision**

- o Allows beneficiaries the right to appeal denials for home health services that do not meet the homebound and intermittent care requirements.

**Effective Date**

- o Upon enactment.

**Provisions Relating to Improvement of Quality of Care; Prohibition of Certain Physician Incentive Plans (Section 9313(c))**

**Current Law**

- o PPS hospitals are responsible for the costs of all medically necessary services provided to Medicare and Medicaid beneficiaries. TEFRA similarly requires

risk-contracting HMOs and CMPs to accept the financial responsibility for the cost of all covered benefits.

- o Because PPS hospitals and risk-contracting HMOs and CMPs are reimbursed a prospectively set amount for services provided to Medicare and Medicaid beneficiaries, providers stand to make a profit when the care provided to beneficiaries costs less than the amount of the payment received for the care. Similarly, providers lose money when they provide care in excess of payments received.

#### Provision

- o Prohibits hospitals and HMOs and CMPs under risk contracts from making incentive payments to physicians to encourage reduced or limited services to Medicare and Medicaid beneficiaries. A civil monetary penalty of not more than \$2,000 will be imposed on each hospital or HMO/CMP for each beneficiary for whom an incentive payment is made. This fine also will be applied to physicians accepting such payments for each beneficiary for whom the payments are accepted.
- o Requires the Secretary to study incentive arrangements offered to physicians by HMOs and CMPs and to report to Congress by January 1, 1988. The report should include a review of the incentive plans used by HMOs and CMPs, an evaluation of their potential to pressure physicians into decreasing or limiting their services to beneficiaries, and recommendations concerning an exception for incentive arrangements which encourage efficiency without jeopardizing quality of care.

#### Effective Date

- o Penalties against hospitals (and physicians accepting payment from hospitals) apply 6 months after enactment. Penalties against HMOs and CMPs (and physicians accepting payment from HMOs and CMPs) apply on or after April 1, 1989.

#### **Provisions Relating to Improvement of Quality of Care; Study to Develop a Strategy for Quality Review and Assurance (Section 9313(d))**

#### Current Law

- o HHS develops a coordinated research agenda, including studies which are mandated by law.

#### Provision

- o Requires the Secretary of HHS to conduct a study to design a strategy for reviewing and assuring quality of care under Medicare. The study will identify quality assurance concerns, develop prototype criteria and standards for defining and measuring quality of care, explore the feasibility of developing national quality review and assurance standards, and develop general criteria for allocating resources for quality assurance purposes.

- o Requires the Secretary to award the study to the National Academy of Sciences, provided it submits an acceptable application; otherwise, applications will be solicited from other non-profit organizations.
- o Requires consultation with experts in the areas of monitoring and quality of care, and others.
- o Requires the Secretary to establish an office within HHS to coordinate this study and other studies in the area of quality of care provided to Medicare beneficiaries.
- o Requires the Secretary to report to Congress on the study's findings and recommendations for increasing quality assurance and review activities in the Medicare program, not later than two years after enactment.

**Effective Date**

- o Upon enactment.

**Direct Costs of Graduate Medical Education (Section 9314)**

**Current Law**

- o Hospitals are reimbursed for graduate medical education expenses on the basis of a formula that takes into account each hospital's previous average cost per full-time equivalent (FTE) resident, the number of FTE residents during the period for which reimbursement is being made, and the hospital's proportion of total inpatient days used by Medicare patients during that period. Time spent by residents in outpatient settings is counted only if the setting is part of the hospital.

**Provision**

- o Permits counting only that time spent on patient care activities toward the determination of full-time equivalency. Permits payment for education expenses in any setting as long as the hospital incurs all or a significant portion of the cost of training in that setting.

**Effective Date**

- o July 1, 1987.

**Payments for Home Health Services; Limitations on Payment for Home Health (Section 9315)**

**Current Law**

- o On July 5, 1985, HCFA published limits for HHAs for fiscal years beginning July 1, 1985. These limits were set at 120 percent of mean costs, and were to be

established by type of service. The regulation also stipulated that the limits will drop to 115 percent of the mean for fiscal years beginning on or after July 1, 1986, and to 112 percent of the mean for fiscal years beginning on or after July 1, 1987.

#### Provision

- o Requires HHA cost limits to be applied on an aggregate basis rather than on a discipline-specific basis, with appropriate adjustments for administrative and general costs of hospital-based agencies.
- o Requires limits to be based on the most recent data available--using data for cost reporting periods no earlier than October 1, 1983--and to take into account costs to HHAs of changes in recent billing and verification procedures, as appropriate.
- o Requires a GAO impact study by February 1, 1988, on the appropriateness of applying by-discipline versus aggregate per visit cost limits. The report also must examine the appropriateness of the percentage limits established in regulations.

#### Effective Date

- o For cost reporting periods beginning on or after July 1, 1986.

### **Establishment of a Patient Outcome Assessment Research Program (Section 9316)**

#### Current Law

- o The Secretary is required to conduct studies relating to the health care of the aged and disabled and the administration of Medicare. In addition, specific studies are often mandated in conjunction with new provisions in the Medicare law.

#### Provision

- o Requires the Secretary to establish a research program on patient outcomes of selected medical treatments/surgical procedures for the purpose of assessing their appropriateness, necessity, and effectiveness.
- o The research program is authorized to be financed through the trust funds:
  - \$6 million for FY 1987,
  - \$7.5 million for FY 1988, and
  - \$7.5 million for FY 1989.
- o The research program is to be run by the National Center for Health Services Research and Health Care Technology (Public Health Service).

- o No less than 90 percent of each fiscal year's research appropriation will be used to fund grants and cooperative arrangements with non-Federal research entities. The remainder may be used by Federal entities and for administrative costs.
- o The Center is required to report findings to Congress and the public no later than 18 months after enactment, and annually thereafter.

#### Effective Date

- o October 1, 1986.

### **Improvements in Civil Monetary Penalty and Exclusion Provisions (Section 9317)**

#### Current Law

- o Practitioners and institutions which present false or improper claims for reimbursement to the Medicare and Medicaid programs are subject, in addition to criminal penalties, to civil monetary penalties of up to \$2,000 for each item or service, and in lieu of damages, an assessment of up to twice the amount claimed. These proceedings are prosecuted by the Office of the Inspector General, Department of Health and Human Services, before an administrative law judge; providers may appeal to the U. S. Circuit Court of Appeals. Individuals convicted of criminal offenses related to the Medicare or Medicaid programs may be excluded from participation in the programs; these individuals are entitled to an administrative hearing and, if the agency upholds the IG's decision to exclude, judicial review.

#### Provision

- o **Collateral Estoppel** - When an individual has a prior conviction of a Federal crime charging fraud or false statements, and current proceedings involve the same transactions, the individual is prevented from denying the elements affirmed in the previous trial.
- o **Misconduct Sanctions** - The official conducting a hearing may sanction a person, party, or attorney, for failing to comply with an order or procedure, failing to defend an action, or other misconduct that would interfere with the speedy, orderly, or fair conduct of a hearing. Sanctions include staying the proceedings and ordering the payment of attorneys' fees or other costs.
- o **Exclusion Clarification** - A physician or other individual is considered to have been convicted of a criminal offense, for the purpose of exclusion from the program, when (1) a court has entered a judgment of conviction, regardless of a pending appeal or an expunged judgment; (2) a court has made a finding of guilt; (3) a court accepts a plea of guilty or nolo contendere; and (4) when judgement of conviction is withheld in favor of the individual entering a "first offender" or similar program.

### **Effective Date**

- o Collateral estoppel - date of enactment without regard to when the criminal conviction was obtained; effective for pleas of nolo contendere tendered after the date of enactment.
- o Sanctions - applies to failures or misconduct occurring on or after the date of enactment.
- o Exclusion Clarification - applies to judgements entered, findings made, and pleas entered before, on, or after the date of enactment, and to first offender programs entered into on or after the date of enactment.

### **Hospital Protocols for Organ Procurement and Standards for Organ Procurement Agencies (Section 9318)**

#### **Current Law**

- o Hospitals are not required to have organ procurement protocols as a condition of participation.
- o An organ procurement agency (OPA) must provide four services to be certified as a Medicare provider and be eligible for reimbursement: (1) recovery of kidneys; (2) preservation of kidneys; (3) transportation of donated kidneys; and (4) the maintenance of a system to locate prospective recipients for recovered kidneys.

#### **Provision**

- o Hospital Protocols - To participate in Medicare and Medicaid, hospitals must establish protocols to encourage organ and tissue donation, and for hospitals performing transplants, be a member of and abide by the rules of the Organ Procurement and Transplantation Network.
- o Organ Procurement Agencies - To receive payment under Medicare or Medicaid for the cost of organ procurements, organ procurement agencies must:
  - be a qualified OPA operating under a grant under section 371(a) of the Public Health Service Act, or have been certified or recertified by the Secretary within the previous two years as meeting the standards to be a qualified OPA as described by section 371(b) of the PHS Act.
  - meet performance-related standards to be designated by the Secretary as an OPA so that payments may be treated as organ procurement costs for the purposes of reimbursement. The Secretary may designate only one OPA per service area.

#### **Effective Date**

- o October 1, 1987.

## **Medicare as Secondary Payer; Coverage Requirements for Certain Other Payers (Section 9319)**

### **Current Law**

- o TEFRA requires employers to offer their employees ages 65 through 69 the same group health plans offered to employees under age 65. When the employee or spouse age 65 to 69 elects such coverage, Medicare becomes the secondary payer. The beneficiary retains the right not to elect such coverage and to be covered only by Medicare. DEFRA extended this provision to include beneficiaries covered under a working spouse's employer-based group health insurance plan when the working spouse is under age 65. COBRA further extended the provision to apply to the working aged and spouses over age 69.

### **Provision**

- o Provides that Medicare is the secondary payer for disabled Medicare beneficiaries who elect to be covered by employment-based health insurance as a current employee (or family member of such employee) of a large employer (at least 100 employees).
- o Allows the government to take action, and creates a private cause of action for double damages when payers such as workmen's compensation, automobile or liability insurance plans or no fault insurance plans, or group health plans are primary, but fail to provide appropriate reimbursement.
- o Provides a special enrollment period for those disabled individuals who are no longer enrolled in a group health plan and want to enroll in Medicare part B.
- o A tax is imposed on employers and employee organizations that contribute to plans that do not conform to the Medicare secondary payer for the disabled provision. The tax would equal 25 percent of the employer's or employee organization's annual contributions to nonconforming group health plans.
- o Requires that the Comptroller General study and report to Congress by March 1, 1990, on the impact of access of disabled individuals and members of their families to employment and health insurance.

### **Effective Date**

- o Medicare secondary payer provision effective January 1, 1987 through December 31, 1992.
- o Private cause of action applies to items and services furnished on or after January 1, 1987.
- o Special enrollment periods occurring on or after January 1, 1987.
- o Tax on nonconforming plans provision applies to items and services furnished on or after January 1, 1987.

## **Payment For Services Of Certified Registered Nurse Anesthetists (Section 9320)**

### **Current Law**

- o Under "anti-unbundling" provisions of the prospective payment system, inpatient nonphysician services that are billed outside the DRG rates paid to hospitals are noncovered. However, the costs of anesthesia and related services furnished by certified registered nurse anesthetists (CRNAs) were temporarily excluded from the prospective rates and are reimbursed on a pass-through basis. This arrangement expires with hospitals' cost-reporting periods beginning on or after October 1, 1987.
- o Anesthesiologists can bill and are paid for services of CRNAs employed by them as though they performed the services themselves, and physicians who provide medical direction to CRNAs employed by or under contract with a hospital receive reduced reasonable charges.

### **Provision**

- o Extends the pass-through provision by 15 months so that it remains in effect through cost reporting periods beginning before January 1, 1989.
- o Effective for cost-reporting periods beginning on or after January 1, 1989, provides for direct reimbursement for anesthesia services and related care furnished by registered nurse anesthetists, subject to State licensure requirements.
- o Medicare would pay 80 percent of the lesser of the CRNA's actual charge or the fee schedule amount for anesthesia services and related care. Assignment is mandatory for these services and violations are subject to civil monetary penalties.
- o Directs the Secretary to establish a fee schedule for CRNA services, using a system of time units, base and time units, or any other appropriate methodology. The initial fee schedule will be based on audited data from cost reporting periods ending in FY 1985, and will be adjusted annually by the percentage increase in the Medicare Economic Index. The fee schedule can be national or adjusted for geographical areas.
- o The initial fee schedule would be set so that total direct payments for CRNA services, plus the applicable coinsurance in FY 1989, would equal estimated total amounts that would have been paid in 1989 under the payment rules in effect in FY 1987, adjusted for changes in prices and technology relating to the administration of anesthesia.
- o The Secretary is directed to adjust physician charges for medical direction, and/or the fee schedule amounts, to ensure that total payments plus coinsurance for all these services in 1989 and 1990 do not exceed the amounts that would have been paid absent this legislation. If this results in reductions in physician reasonable charges, a nonparticipating physician may not charge more than 125 percent of the reduced prevailing charge plus (in the first year) half

the difference between his/her actual charge in the previous year and 125 percent of the reduced prevailing charge. Violations are subject to sanctions.

#### **Effective Date**

- o Pass-through extension - Enactment
- o Direct reimbursement for CRNAs - Services furnished on or after January 1, 1989 and until the earlier of December 31, 1990 or one year after the report to Congress on the relative value scale.

#### **Technical Amendments and Miscellaneous Provisions Relating to Parts A and B (Section 9321)**

##### **Treatment of Group Purchasing Vendor Agreement (Section 9321(a))**

#### **Current Law**

- o Under the Medicare anti-fraud and abuse provisions, it is prohibited to receive, give, solicit, or offer any remuneration in return for referring or arranging for the furnishing of any item or service, or in return for purchasing, leasing, or ordering any good, facility, or service for which payment can be made under Medicare.
- o Some hospitals and other providers purchase medical supplies and equipment through their participation in group purchasing organizations (GPOs). GPOs purchase goods and services for participating institutions and charge them a service or transactional fee. In some situations, fees are also paid by the vendor or supplier in order to participate in the GPO agreement. This practice constitutes a technical violation of Medicare anti-fraud and abuse provisions.

#### **Provision**

- o The provision permits the payment of administrative fees to group purchasing organizations by a vendor if the purchasing agent has an appropriate written contract and full disclosure of the payment is made to the provider. The Secretary must be furnished similar payment information upon request.

#### **Effective Date**

- o Applies to payments made before, on, or after the date of enactment of this Act.

##### **Extension and Clarification of Competitive Contracting Authority (Section 9321(b))**

#### **Current Law**

- o The Secretary has the authority to enter into two competitively bid contracts

under part A and two such contracts under part B to replace poor performing intermediaries and carriers. This authority expired on September 30, 1986.

#### Provision

- o The provision extends the Secretary's existing demonstration authority through FY 1989 and allows for the use of other than cost-reimbursed contracts.

#### Effective Date

- o Upon enactment.

### **Treatment of Capital-Related Regulations (Section 9321(c))**

#### Current Law

- o The Secretary currently has authority to issue proposed and final regulations at any time. While the effective date for including capital in PPS cannot be earlier than FY 1988, it was expected that final regulations might have been issued at least before August 1987 in order to meet the Gramm-Rudman-Hollings budget deadlines.

#### Provision

- o The Secretary is prohibited from publishing in final form any regulation regarding changes in the methodology for computing the amount of payment for capital-related costs for inpatient hospital services under Medicare part A between September 1, 1986 and September 1, 1987, except for regulations required to implement this provision. The Secretary is also prohibited from including changes in capital payment policy in any regulation concerning PPS payments.

#### Effective Date

- o Prohibition effective September 1, 1986 through September 1, 1987.

### **Limitation On Authority To Issue Certain Final Regulations And Instructions Relating To Hospitals Or Physicians (Section 9321(d))**

#### Current Law

- o The Secretary may at any time issue regulations, instructions to Medicare carriers and fiscal intermediaries, and other instruments which change Medicare policy. Regulations must be issued in final form prior to August 15 or prior to October 6 to be included in the August or October Gramm-Rudman-Hollings baseline. An exception to this general rule, proposed regulations updating prospective payments for hospital operating costs are included in the August or October Gramm-Rudman-Hollings baseline if they are issued prior to the August 15 or October 6 deadline.

#### Provision

- o The Secretary is prohibited from issuing in final form any regulation, instruction or other policy about hospitals or physicians before September 1, 1987, which is estimated by the Secretary to achieve Medicare savings in FY 1988 of more than \$50 million.

#### Effective Date

- o Enactment through September 1, 1987.

#### **60-Day Notice For Proposed Regulations (Section 9321(e))**

##### Current Law

- o The Secretary currently has the authority to establish appropriate comment periods for Medicare regulations.

##### Provision

- o Requires that any notice of proposed rulemaking concerning Medicare must be published in the Federal Register with a public comment period of a least 60 days prior to issuance as a final regulation.
- o This restriction would not apply where there is a statutory provision which permits issuance in interim final form, permits a shorter period for public comment, or prescribes a deadline for implementation that is shorter than 150 days after enactment.
- o Changes due date for submission to Congress of ProPAC and Department recommendations concerning the PPS update factor from April 1 to March 1, beginning in 1987.

##### Effective Date

- o Upon enactment.

#### **Payments For Physicians' Services; Determination of Maximum Allowable Prevailing Charges for Physicians' Services (Section 9331(a))**

##### Current Law

- o Medicare pays physicians on a reasonable charge basis. The reasonable charge is the lowest of the physician's actual charge, the customary charge or the prevailing charge for the service, which is defined as the 75th percentile of customary charges in the area. Increases in prevailing charges are limited each year by the Medicare Economic Index (MEI).

#### Provision

- o Establishes two prevailing charge "tracks", one for participating physicians and one for non-participating physicians. Prevailing charges for services furnished on or after January 1, 1987 will be based on the prevailing charges in effect for participating physicians on December 31, 1986.
  - For services furnished by participating physicians on or after January 1, 1987, prevailing charges will be the prevailing charges in effect on December 31 of the previous year, increased by the percentage change in the MEI.
  - For services furnished by nonparticipating physicians on or after January 1, 1987, prevailing charges will be limited to 96 percent of the prevailing charges recognized for participating physicians during the same period.
  - Beginning with 1987, the same MEI increase will be applied to participating and nonparticipating physicians' prevailing charges. For 1987, the statute specifies that the MEI increase is 3.2 percent.

#### Effective Date

- o Applies to services furnished on or after January 1, 1987.

#### **Payments for Physicians' Services; General Limit on Actual Charges for Nonparticipating Physicians (Section 9331(b))**

#### Current Law

- o Since July 1, 1984, the actual charges for nonparticipating physicians have been frozen at the levels in effect during the April-June quarter of 1984.

#### Provision

- o Limits the actual charges of non-participating physicians to "maximum allowable actual charges" (MAAC), effective January 1, 1987. The maximum allowable actual charge for the current year is based on the maximum allowable actual charge for the previous year.
- o To determine the maximum allowable actual charge, compare the weighted average actual charge in the previous year to 115 percent of the current year's prevailing charge.
  - If the weighted average actual charge was equal to or greater than 115 percent of the current year's prevailing, the MAAC is increased by one percent.
  - If the weighted average actual charge was less than 115 percent of the current year's prevailing, the MAAC is increased by a specified fraction (1/4, 1/3, or 1/2 in FYs 87, 88 and 89, respectively) of the difference between it and the 115 percent threshold.

- o For purposes of determining a nonparticipating physician's 1987 maximum allowable actual charge, the 1986 maximum allowable actual charge is deemed to be the physician's median actual charge during the April-June quarter of 1984. For years following 1987, for services for which the physician had no charges during April-June 1984, the maximum allowable actual charge for the previous year will be the 50th percentile of nonparticipating physician's customary charges for the 12 month period ending June 30 of that year.
- o The Secretary will monitor nonparticipating physicians' actual charges, and may apply sanctions against physicians whose actual charges exceed maximum allowable actual charges.
- o The Secretary must provide nonparticipating physicians at the beginning of each year with a list of his/her maximum allowable actual charges for his/her most commonly furnished services.

#### Effective Date

- o Services furnished on or after January 1, 1987.

#### Payments For Physicians' Services; Medicare Economic Index (Section 9331(c))

##### Current Law

- o The Medicare Economic Index (MEI), which limits annual increases in physicians' charges for physicians' services, reflects changes in physician office practice costs and earning levels in general. A notice published in the August 11 Federal Register proposed a retroactive revision of the MEI, changing the proxy for office space costs.

##### Provision

- o Specifies that the MEI for 1987 is 3.2 percent.
- o Prohibits revision of the MEI for any period before January 1, 1985 to substitute rental equivalency for the housing component of the consumer price index.
- o Effective January 1, 1987, annualizes the MEI, making changes in the MEI on a year-to-year rather than cumulative basis and precluding retroactive revisions of the index.
- o Requires a study of the MEI's ability to accurately reflect economic changes in the provision of physicians services to Medicare beneficiaries.
- o Prohibits changes in the methodology used to calculate the MEI as of October 1, 1985, until completion of the study and then only after notice and comment in the Federal Register.

#### Effective Date

- o Upon enactment.

## **Payments For Physicians' Services; Development and Use of HCFA Common Procedure Coding System (HCPCS) (Section 9331(d))**

### **Current Law**

- o There is no current statutory provision.

### **Provision**

- o Requires the Secretary, after consultation with medical experts, to group procedure codes under HCPCS for payment purposes to minimize inappropriate increases in the intensity or volume of services resulting from code distinctions which do not reflect substantial differences in services rendered.
- o Requires carriers to make payments for part B services based on this grouping of procedure codes.

### **Effective Date**

- o No later than July 1, 1989 for grouping.
- o No later than January 1, 1990 for carrier payments.

## **Payments for Physicians' Services; Recommendations (Section 9331(e))**

### **Current Law**

- o The Secretary, taking into consideration the recommendations of the Physicians Payment Review Commission (PhysPRC), is required to develop a relative value scale (RVS) that establishes a numerical relationship among the various physicians' services for physician payment. The Secretary is required to complete the RVS and report to Congress on its development by July 1, 1987. The report is to include recommendations for application of the scale to payment for physician services after January 1, 1988.

### **Provision**

- o The date the Secretary is required to report on the RVS is deferred to July 1, 1989. The potential application date of the RVS is deferred until after December 31, 1989.
- o Requires the Secretary, in making recommendations for application of a RVS, to develop and assess an appropriate index to reflect justifiable geographic variations in practice costs without exacerbating the geographic maldistribution of physicians, and to assess the advisability and feasibility of developing an appropriate adjustment to serve as an incentive to physicians to practice in medically underserved areas.

- o Requires the Secretary to develop an interim geographic index prior to January 1, 1988 and to collect data based on the most accurate costs of practice in order to refine the index by December 31, 1989 and periodically thereafter.

#### **Effective Date**

- o Report to Congress by July 1, 1989
- o Development of an interim geographic index by January 1, 1988

#### **Incentives For Physician Participation; Recruiting Physicians (Section 9332(a))**

##### **Current Law**

- o Carriers are funded to operate the participating physician and supplier program and to develop professional relations staff to address billing and other problems.

##### **Provision**

- o Requires carriers to implement programs to recruit and retain physicians as participating physicians. An incentive pool equal to one percent of total payments to carriers for claims processing will be used to reward carriers for success in increasing the proportion of participating physicians.
- o Requires carriers to implement programs to familiarize beneficiaries with and assist them in locating participating physicians.
- o Requires the Secretary to develop a system to evaluate carrier performance in these responsibilities and other activities related to the participating physician program.

#### **Effective Date**

- o Applies to carrier contracts as of October 1, 1987; standards are to be established by October 1, 1987 to apply to contracts as of that date; carrier bonus payments to be first paid not later than April 1, 1988 to reflect performance of carriers during the enrollment period at the end of 1987.

#### **Incentives for Physician Participation; Directories of Participating Physicians (Section 9332(b))**

##### **Current Law**

- o A directory containing the name, address and specialty of all participating physicians and suppliers is to be published at the beginning of each year. Beneficiaries are informed of the existence of the directory and it is made available to each Social Security district and branch office, in each carrier's office and to Senior citizens' organizations. It is available for purchase by the public.

#### Provision

- o Requires carriers to mail appropriate area directories to beneficiaries, free of charge, upon request. Requires that an appropriate number of copies be sent to hospitals in the area.
- o Requires that directories contain alphabetical listings of all participating physicians and an alphabetical listing by the locality and specialty of the physicians.
- o Requires that a notice explaining the participating physician program and informing beneficiaries of the availability of the directory be included in the mailing of "appropriate" benefit checks.

#### Effective Date

- o Applies to directories for 1987.

#### **Incentives for Physician Participation; Prohibiting Billing of Services Determined to be Medically Unnecessary (Section 9332(c))**

#### Current Law

- o If a physician provides services on an assigned basis which are later determined not to be reasonable and necessary, the physician may not bill the patient.

#### Provision

- o If a physician provides services on a non-assigned basis which are later determined not to be reasonable and necessary, the physician is required to refund amounts collected from the beneficiary within:
  - 30 days of notification of noncoverage if the physician does not request reconsideration or seek appeal on a timely basis, or
  - 15 days if the initial determination of noncoverage is upheld on appeal.
- o Carriers and PROs are responsible for sending notices of denial to the physician.
- o Physician liability would be subject to the waiver of liability provisions.
- o Physicians not complying with repayment provisions would be subject to civil monetary penalties and/or exclusion from the Medicare program.

#### Effective Date

Applies to services furnished on or after October 1, 1987.

**Incentives for Physician Participation; Disclosure of Information of Unassigned Claims For Certain Physicians' Services (Section 9332(d))**

**Current Law**

- o No provision.

**Provision**

- o Requires a nonparticipating physician, who performs an elective surgical procedure on an unassigned basis for a beneficiary and charges at least \$500, to inform the individual in writing of the estimated actual charge for the procedure, the estimated approved charge under Medicare, the excess of the physician's actual charge over the approved amount and the coinsurance applicable to the procedure.
- o The written estimate may not be used in a civil suit.
- o A physician failing to comply is required to refund any amounts collected in excess of the Medicare approved charges, and may be subject to civil monetary penalties and/or exclusion.
- o The Secretary must establish a system to assure compliance.

**Effective Date**

- o Applies to surgical procedures performed on or after October 1, 1987.

**Incentives for Physician Participation; Maintenance and Use of Participating Physician Directories by Hospitals (Section 9332(e))**

**Current Law**

- o A directory containing the name, address and specialty of all participating physicians and suppliers is to be published at the beginning of each fiscal year. Beneficiaries are informed of the existence of the directory and it is made available to each Social Security district and branch office, in each carrier's office and to senior citizens' organizations. It is available for purchase by the public.

**Provision**

- o Requires hospitals to make directories of participating physicians available. When referral by hospital staff for outpatient care is made to a nonparticipating physician, the hospital staff must inform the beneficiary of the physician's participation status and where practical, identify at least one qualified participating physician.

### Effective Date

- o Applies to hospital agreements as of October 1, 1987.

### Limits on Reasonable Charges; Procedures for Establishment of Special Limits on Reasonable Charges for Part B Services (Section 9333)

#### Current Law

- o The Secretary must specify in regulations the factors that will be used to identify cases in which regular reasonable charge methodology results in charges that are not inherently reasonable, and the factors that will be considered in establishing realistic and equitable reasonable charges. A final rule implementing these requirements was published in the August 11, 1986 Federal Register.

#### Provision

- o Permits The Secretary to increase or decrease reasonable charges for specific physicians' services when:
  - Prevailing charges in a locality are significantly above or below prevailing charges in comparable localities;
  - Medicare and Medicaid are the primary sources of payment for the service;
  - The marketplace for the service is not competitive because of a limited number of physicians who perform the service;
  - Increases in charges cannot be explained by inflation or technology;
  - Charges do not reflect changing technology, increased facility with technology, or reductions in acquisition or production costs; or
  - The prevailing charges are substantially higher or lower than the payments made for the service by other purchasers in the same locality.
- o Requires that regional differences in fees be taken into account in establishing limits, unless there is substantial economic justification for a uniform fee or payment limit. That justification must be explained in the notice and final determination of the reasonable charge in the Federal Register.
- o Adjustments based on comparisons of the prevailing charges in different localities may be made only after taking into account differences in practice costs.
- o "Resource costs" include factors such as the time required to provide a procedure (including pre-procedure evaluation and post-procedure follow-up), the complexity of the procedure, the training required to perform the procedure and the risk involved in the procedure.

- o Requires the Secretary to consider the potential impact on quality, access and beneficiary liability, including the likely effects on participation and assignment rates, and reasonable charge reductions on unassigned claims in deciding whether to adjust payment rates.
- o If the Secretary determines, after consultation with potentially affected physicians, that a reasonable charge is grossly excessive or deficient and proposes to establish a realistic and equitable reasonable charge or a methodology for arriving at one, then he is required to publish notice of the proposal in the Federal Register. The notice must include an explanation of the factors and data taken into consideration, and the potential impact on access, quality and beneficiary liability. Requires a comment period of no fewer than 60 days. PhysPRC is required to provide comments to the Secretary within this period.
- o Limits the actual charges of nonparticipating physicians to 125 percent of the inherently reasonable charge limits ("termed the limiting charge"), plus (for a 12-month period beginning on the effective date of the reduced charge level) half the difference between the physician's actual charge in the previous year and the limiting charge. Physicians who violate these limits are subject to sanctions. The limits are in effect until the earlier of December 31, 1990 or one year after the Secretary reports to Congress on the relative value scale.
- o Requires the Secretary, not later than October 1, 1987, to review the inherent reasonableness of the reasonable charges for at least ten of the most costly Medicare procedures.

#### Effective Date

- o Upon enactment.

#### Payment for Cataract Surgical Procedures (Section 9334)

##### Current Law

- o Physicians are paid on a reasonable charge basis for cataract surgery. The Secretary is required, beginning April 1, 1986, to provide for separate reasonable charge screens for prosthetic lenses and for the related professional services of the physician and to apply inherent reasonableness guidelines in determining reasonable charges for prosthetic lenses. Carrier or PRO pre-procedure review of the necessity of assistants-at-surgery in cataract procedures is also required, based on the presence of a complicating medical condition.

##### Provision

- o Reduces the prevailing charges of participating and nonparticipating physicians for cataract surgical procedures by 10 percent in 1987 and by an additional 2 percent in 1988.
- o These reductions cannot result in a prevailing charge for a service that is below a floor of 75 percent of the weighted national average prevailing charge for that service in 1986.

- o Nonparticipating physicians' actual charges are limited to 125 percent of the reduced prevailing charges (called the "limiting charge") plus in the first year of the reduction, half the difference between the limiting charge and the physician's actual charge in the previous year.
- o Physicians who knowingly and willfully impose charges in excess of the limits on nonparticipating physicians' actual charges are subject to sanctions.
- o These provisions apply until the earlier of December 31, 1990 or 1 year after the Secretary reports to Congress on the relative value scale.
- o Ratifies the final regulation published October 7, 1986 in the Federal Register which establishes special reasonable charge payment limits for anesthesia services furnished by physicians during cataract surgery and iridectomies.

#### Effective Date

- o Services furnished on or after January 1, 1987.

#### **Payment Rates For Renal Services And Improvements In Administration Of ESRD Networks And Program (Section 9335)**

##### Current Law

- o Dialysis Treatment Rates - In the August 15, 1986, Federal Register, the Secretary published in final the base payment rates to facilities at \$115.62 for independent facilities and \$121.76 for hospital-based facilities.
- o Exceptions - The Secretary may provide exceptions to the prospective rates as warranted by unusual circumstances, including sole providers in isolated rural areas.
- o Immunosuppressive Drugs - Immunosuppressive drugs are covered by Medicare only when provided in an inpatient setting or administered by a physician incident to his services.
- o Network Reorganization - In the August 26, 1986, Federal Register the Secretary published the final rule granting the Secretary administrative authority to redesignate the network areas and a final notice specifying 14 new network areas.
- o Patient Representation - At least one patient representative must be on the network coordinating council and executive committee.
- o Network Functions - Responsibilities include: encouraging use of appropriate treatment settings; developing criteria, standards, and network goals; evaluating procedures by which facilities assess appropriateness of treatment; identifying facilities not cooperating in achieving networks goals; and submitting an annual report to the Secretary.

- o Facility Cooperation - The Secretary may terminate or withhold certification of facilities that consistently fail to cooperate with network plans and goals.
- o Vocational Rehabilitation - The maximum number of patients suitable for home dialysis or transplant should receive these treatments.
- o ESRD Registry - The Secretary annually submits a report to Congress on the ESRD program.

**Provision**

- o Dialysis Treatment Rates - The Secretary will reduce the base rates in effect May 13, 1986 by \$2.00 to facilities for dialysis treatments furnished on or after October 1, 1986, and before October 1, 1988.
- o Exception Requests - Exception requests, to include those from pediatric facilities, will be deemed approved unless disapproved by the Secretary not later than 60 working days after the request is received.
- o Dialysis Payment Rate Study - The Secretary will request a proposal for a study to evaluate the effect of reductions in payment rates for facility and physician dialysis services on access to and quality of care, from the National Academy Sciences (NAS), or other private non-profit organization(s) if NAS is unable.
- o Immunosuppressive Drugs - Part B will cover outpatient immunosuppressive drugs furnished to transplant patients for 1 year after a transplant.
- o Network Reorganization - The Secretary will establish at least 17 ESRD network areas not later than May 1, 1987. Each area will have a network organization by July 1, 1987, which will establish a network council and a medical review board.
  - The Secretary will develop and publish standards, criteria, and procedures to evaluate actual performance of area organizations and to evaluate an applicant organization's capability to perform. Only 20 percent of the weight of the evaluation may be attributed to the element of price. A network organization may not be terminated for one of the designated 17 areas unless it has failed to perform according to the above mentioned criteria. If an agreement is terminated, a successor will be selected by competitive bid.
  - If the Secretary designates a network organization not previously designated for an area, the Secretary will offer to continue to fund the previously designated organization for 30 days after the newly designated organization assumes the network duties.
- o Patient Representation - At least one patient representative is required on each network council and each medical review board.
- o Network Functions - The following functions for network organizations are added: encouragement of patient, provider, and facility participation in vocational rehabilitation programs, as well as establishment of the necessary standards and criteria; reports to the Secretary on facilities and providers not

providing appropriate care; implementation of a patient grievance process; conduct of onsite reviews of facilities and providers; collection and analysis of data for the Secretary and the National ESRD Registry.

- o **Facility Cooperation** - The Secretary may terminate or withhold certification of facilities for failing to follow the recommendations of the network medical review boards.
- o **Vocational Rehabilitation Services** - Vocational rehabilitation services must be available and encouraged for the maximum number of suitable patients to facilitate their return to gainful employment.
- o **ESRD Registry** - The Secretary will establish a national ESRD registry which will utilize data reported by network organizations, transplant centers, and other sources to support: preparation of an annual report to Congress; analysis of alternative treatment modes; evaluation of allocation of resources; an analysis of mortality and morbidity trends and other quality of care indices; and other studies that will assist Congress in evaluating the ESRD program. A professional advisory group will be appointed to assist in policy and procedure formulation. A report to Congress on the establishment of the registry must be presented by April 1, 1987, and the registry must be established by January 1, 1988.
- o **Network Funding** - The Secretary will reduce the composite rates paid to facilities by \$0.50 per treatment and provide this money to the network organizations in the area where the treatments were provided.
- o **Reuse Protocols** - The Secretary will establish protocols on standards and conditions for the reuse of dialyzer filters by October 1, 1987. For service provided on or after January 1, 1988, facilities may not reuse other dialysis supplies unless the Secretary has established protocols for their reuse. Failure to follow protocol requirements subjects the facility to denial of program participation and denial of payment for treatments furnished in violation of the requirements.

#### **Effective Date**

- o **Payment provision applies to services rendered on or after October 1, 1986, and before October 1, 1988.**
- o **Exception requests provision applies to requests received on or after enactment.**
- o **Payment for immunosuppressive drugs is effective for those furnished on or after January 1, 1987.**
- o **Patient representation, network organization responsibilities, and facility cooperation provisions are to be implemented by July 1, 1987.**
- o **Rate reductions for network funding applies to treatments rendered on or after January 1, 1987.**

## **Vision Care (Section 9336)**

### **Current Law:**

- o Medicare pays for eye examinations furnished by a physician to a patient with a complaint or symptom of eye disease or injury. Optometrists are included in the Medicare definition of "physician", but only with respect to services related to the treatment of aphakia.

### **Provision**

- o Provides for payment under Medicare for vision care services furnished by optometrists, if the services are among those already covered by Medicare and if the optometrist is legally authorized to perform the service in the State in which it is furnished.

### **Effective date**

- o Services furnished on or after April 1, 1987.

## **Occupational Therapy Services (Section 9337)**

### **Current Law**

- o Medically necessary occupational therapy services are covered under part A when provided as part of covered inpatient hospital services, skilled nursing facility services, home health services or hospice care. Part B coverage is limited to treatment in a hospital outpatient department, comprehensive outpatient rehabilitation facility, home health agency, or when provided incident to physician's services.

### **Provision**

- o Extends part B coverage of services for occupational therapy services to those furnished in a skilled nursing facility (when part A coverage has been exhausted), in a clinic, rehabilitation agency, or public health agency or by others under arrangements with such entities. Reimbursement is based on reasonable costs except that services furnished under arrangements cannot exceed the amount that would have been paid on a salary-related basis.
- o Extends part B coverage to occupational therapy services furnished by an independently practicing therapist in the therapist's office or beneficiary's home. Reimbursement will be made on the basis of 80 percent of reasonable charges, with no more than \$500 in incurred expenses eligible for coverage in a calendar year. Physicians must certify need for such services and treatment plan must be established by a physician or by qualified occupational therapist.

### **Effective Date**

- o Applies to expenses incurred for outpatient occupational therapy services furnished on or after July 1, 1987.

## **Services of a Physician Assistant (Section 9338)**

### **Current Law:**

- o Payments are made to physicians for services and supplies furnished incident to a physician's professional services. The services of nonphysicians are covered as incident to physicians' services and such services must be rendered under the physician's direct supervision.

### **Provision**

- o Provides for coverage of and separate payment for services performed by a physician assistant in a hospital, skilled nursing facility, intermediate care facility or as an assistant-at-surgery, if the service would be covered when performed by a physician. Physician assistants must meet State licensure requirements and be supervised by a physician. Services and supplies furnished incident to these services are covered if they would be covered when furnished incident to physicians' service.
- o The prevailing charges for the services of physician assistants are limited to a percentage of nonspecialist physicians' prevailings for the same services (65 percent for assistant-at-surgery services, 75 percent for other services provided in hospitals and 85 percent for skilled nursing facility and intermediate care facility services).
- o Assignment for these services is mandatory and payment can only be made to the employer of the physician assistant.
- o The Secretary may reduce the amount Medicare pays to hospitals and skilled nursing facilities to prevent duplicate payments for physician assistants services.
- o Sanctions will be imposed on physician assistants or physicians who knowingly and willfully charge beneficiaries extra billing amounts.
- o Requires the Secretary to study the payment rates of physician assistants to ensure that the amount of part B payments reflect the approximate cost of furnishing the services, taking into account compensation costs and overhead and supervision costs attributable to physician assistants.

### **Effective date**

- o Services furnished on or after January 1, 1987.
- o Report due to Congress by April 1, 1988.

## **Payment for Clinical Diagnostic Laboratory Tests (Section 9339)**

### **Current Law**

- o Payment for clinical laboratory services is made on the basis of fee schedules

established on a regional, statewide or carrier service basis. The fee schedule for physician office laboratories and independent clinical laboratories (including hospital laboratories furnishing services to persons who are not patients of the hospital) is set at 60 percent of the prevailing charge levels in effect for the fee screen year beginning July 1, 1984. The fee schedule for hospital outpatient laboratories is set at 62 percent. Assignment is mandatory for independent clinical laboratories. Mandatory assignment for physician office laboratories takes effect January 1, 1987.

- o The fee schedules are adjusted annually in January to reflect changes in the consumer price index for all urban consumers. Effective July 1, 1986, the Secretary is required to establish nationwide payment ceilings for each test. Effective January 1, 1988, a national fee schedule is required for tests performed in physician office laboratories and independent laboratories. At the same time, payment for hospital outpatient laboratory services is slated to revert to cost-based reimbursement.

#### Provision

- o Delays requirement for a national fee schedule for two years and eliminates the methodology for national fee schedules.
- o Eliminates the 2 percent differential for hospital outpatient laboratories except where the laboratory serves an emergency room on a 24-hour a day basis. Eliminates the January 1, 1988, sunset provision on the fee schedule for hospital outpatient laboratory services.
- o Specifies that State laws regarding medical direction of clinical laboratories prevail over the medical direction requirements in Medicare's conditions of participation.
- o Requires the Secretary to provide for and establish trip fees for the collection of samples from beneficiaries who are homebound or inpatients in nonhospital facilities.
- o Extends the moratorium on laboratory competitive bid demonstrations for one year.
- o Requires a report to Congress, on the advisability and feasibility of, and methodology for, establishing national fee schedules for payment for clinical diagnostic laboratory tests.

#### Effective date

- o Delay of national fee schedule requirement is effective upon enactment.
- o Elimination of 2 percent differential for hospital outpatient laboratories applies to services furnished on or after January 1, 1987.
- o State standards for medical direction is effective January 1, 1987.

- o Trip fee provision applies for samples collected on or after January 1, 1987.
- o Report to Congress is due April 1, 1988.

### **Payment of Parenteral and Enteral Nutrition Supplies and Equipment (Section 9340)**

#### **Current Law**

- o Parenteral and enteral nutrition (PEN) supplies (nutrients and equipment) currently are reimbursed on the basis of reasonable charges, under Medicare part B.
- o For services that are widely and consistently available, and that are determined to be comparable in quality from supplier to supplier, the Secretary may decide to reimburse these services at the "lowest charge level", or at the 25th percentile of the charges submitted for the items and services in question.

#### **Provision**

- o Requires the Secretary of HHS to apply the lowest charge level provision to enteral and parenteral nutrition nutrient supplies and equipment.

#### **Effective Date**

- o January 1, 1987, for enteral nutrition nutrients, supplies and equipment and for parenteral nutrition supplies and equipment. October 1, 1987, for parenteral nutrients.

### **Changing Medicare Appeal Rights (Section 9341)**

#### **Current Law**

- o Beneficiaries dissatisfied with a carrier's disposition of a part B claim are entitled to a review by the carrier. If the beneficiary is still not satisfied with the decision, he can request a fair hearing by the carrier if the amount in controversy is \$100 or more. The law does not provide for any further administrative appeal or judicial review for a part B claim.

#### **Provision**

- o Provides that under part B a beneficiary may obtain an administrative law judge hearing if the amount in controversy is \$500 or more, and judicial review if the amount in controversy is \$1,000 or more. Carrier hearings are retained for amounts in controversy between \$100 and \$500.
- o In determining the amount in controversy, the Secretary must allow two or more claims to be aggregated if the claims involve the delivery of similar or related services to the same individual, or involve common issues of law and fact arising from services furnished to two or more individuals.

- o Specifies that national coverage determinations are not subject to review by an administrative law judge and limits judicial review.
- o The provision precludes judicial review of regulations or instructions issued before January 1, 1981, which relate to the part B payment methodology.

**Effective Date**

- o Applies to items and services furnished on or after January 1, 1987.

**Alzheimer's Disease Demonstration Projects (Section 9342)**

**Current Law**

- o Medicare covers the acute care needs of beneficiaries with Alzheimer's disease, but does not cover maintenance-type services to assist them in remaining at home.

**Provision**

- o The Secretary must conduct at least 5, but not more than 10, demonstration projects to determine the effectiveness, cost, and impact of providing comprehensive services to Medicare beneficiaries with Alzheimer's disease or related disorders.
- o Services such as case management, home and community-based services, mental health, outpatient drugs, respite care, family counseling, adult day care and other in-home services must be specifically geared to meeting the needs of Alzheimer's patients.
- o Projects must be three years in length, and be conducted at sites which are geographically diverse and easily accessible to a high proportion of Medicare beneficiaries.
- o Each beneficiary in the project must be provided, at entrance to and exit from the project, with a complete medical and mental status exam.
- o The projects must be conducted by entities who are able to provide all necessary services directly or by contract.
- o The Secretary will waive Medicare requirements where necessary.
- o The Secretary will provide for the projects to be evaluated and submit two reports to Congress: a preliminary report during the project's third year and a final report upon completion that includes recommendations for legislative changes.
- o Expenditures may not exceed \$40 million for the demonstration and \$2 million for the evaluation, and will be provided from the Federal Supplementary Medical Insurance Trust Fund.

## Effective Date

- o Upon enactment.

## Ambulatory Surgery (Section 9343)

### Current Law

- o Medicare is authorized to pay for ambulatory surgical procedures performed in ambulatory surgical centers (ASCs), hospital outpatient departments (OPDs), and physician offices. Medicare pays ASCs on the basis of prospective rates for four groups of surgical procedures established in regulations August 5, 1982. Medicare pays 100 percent of these ASC rates waiving the usual part B 20 percent coinsurance and deductible requirement. The rates do not include payment for physicians' services, prosthetic devices, or laboratory services. Hospitals are reimbursed for procedures on the ASC list on a reasonable cost basis, and beneficiaries pay 20 percent coinsurance.
- o In all these settings, except physician offices, physicians' services are reimbursed at 100 percent of reasonable charges if the physician accepts assignment. Otherwise, the beneficiary is responsible for the 20 percent coinsurance and the deductible. Payment for services performed in a physician's office has not been implemented because adequate utilization and quality control peer review is not available for office based surgery.

### Provision

- o When hospital outpatient departments perform procedures approved for ambulatory surgical centers, payment for hospital outpatient department services will be the lesser of the OPD's costs or charges (in the aggregate) net of cost sharing; or a blend of hospital costs and ASC rates, at 75/25 in FY 87 and 50/50 thereafter.
- o By July 1, 1987, and annually thereafter, the Secretary must review and update ASC payment rates; the list of procedures must be reviewed and updated within six months after enactment, and every two years thereafter.
- o Payment may not be made for any expenses incurred for non-physician items or services which are furnished to an individual who is a patient of a hospital by an entity other than the hospital. Individuals violating this provision by submitting bills for nonphysician outpatient services are subject to civil monetary penalties of not more than \$2,000. Services billed by suppliers for hospitals' outpatients will be noncovered and denied.
- o PRO contracts must include a review of all ambulatory surgery procedures performed in the area, or a sample review of such procedures at the Secretary's discretion.
- o Coinsurance and deductible requirements are required for ambulatory surgical procedures without regard to the setting of the ambulatory surgery.

- o The Secretary must develop a prospective payment system for ambulatory surgical procedures performed in hospitals on an outpatient basis. The rates must encompass payment for facility services commonly furnished in connection with such procedures. Rates must take into account the costs of hospitals providing ambulatory surgical procedures; the costs of payments to ASCs; and the extent to which any differences in these costs are justified. An interim report is due to Congress by April 1, 1988, and a final report due April 1, 1989, must include implementation recommendations for services provided on or after October 1, 1989. The Secretary is required to develop a model prospective payment system for the payment of hospital outpatient services other than ambulatory surgical procedures, and to report on the model system by January 1, 1991.
- o By July 1, 1987, hospitals will be required, as a condition for payment for part B outpatient hospital services, to report claims for payment for such services using the HCFA Common Procedure Coding System.

#### **Effective Date**

- o Payment rate provisions apply on a cost-reporting period basis, beginning on or after October 1, 1987.
- o The ASC rate update and PRO review of ambulatory surgical procedures will apply to services furnished after June 30, 1987.
- o The ASC procedure list must be updated within 6 months of enactment.
- o The prohibition on unbundling of hospital outpatient services applies to hospital agreements entered into or renewed after January 1, 1987.

#### **Technical Amendments and Miscellaneous Provisions Relating to Part B (Section 9344)**

##### **Current Law**

- o The Physician Payment Review Commission (PhysPRC) consists of 11 commissioners. PhysPRC's duty is to provide recommendations on physician reimbursement under part B. Members are appointed by the Director of the Office of Technology Assessment.
- o A beneficiary's coverage period under part B can be terminated by filing a notice cancelling enrollment, or because of nonpayment of the premium. If a beneficiary files a notice cancelling enrollment, the effective date of the termination is the close of the calendar quarter following the calendar quarter in which the notice is filed.
- o HCFA is currently conducting research on DRG-based payment for radiology, anesthesia, and pathology inpatient services.
- o A preventive health demonstration must be performed in at least five sites.

## Provision

- o Expands the membership of PhysPRC by 2 for a total of 13 members. The Director may modify initial three-year terms to assure that no more than five members' terms expire in the same year.
- o Modifies the effective date of disenrollment when a Medicare beneficiary files a notice to the month following the month the notice was filed.
- o Requires the Secretary to study and report to Congress on the design and implementation of a part B prospective payment system for radiology, anesthesia, and pathology services provided to hospital inpatients.
- o The prevention demonstration must include one site in a rural area and funding not to exceed \$5 million over the duration of the program.

## Effective Date

- o New Commission members are to be appointed no later than 60 days after enactment.
- o The disenrollment provision applies to notices filed on or after July 1, 1987.
- o Part B payment report due to Congress by July 1, 1987.
- o The amendment to the prevention demonstration is effective as if it were included in COBRA.

## **PRO Review Of Hospital Denial Notices (Section 9351)**

### Current Law

- o Hospitals are authorized to make determinations that further inpatient care is no longer necessary. By regulations, hospitals may issue a denial notice if:
  - The attending physician agrees to the discharge in writing (in which case the hospital may begin to charge for continued stay beginning with the third day after the patient receives the notice), or
  - The PRO reviews the case and concurs with the decision of the hospital.
- o A beneficiary who receives a denial notice may appeal the denial of continued stay to the peer review organization (PRO). The PRO must review the case and provide a determination within 3 working days after receipt of the request for appeal or, where medical records are required, after receipt of the records.
- o If the PRO reverses the hospital's determination, the hospital may not bill for continued stay. If the PRO upholds the hospital's determination, a beneficiary may incur financial liability for several days before receiving notice of the PRO's decision.

#### Provision

- o Provides that a hospital may provide a patient with a coverage denial notice if the hospital determines continued stay is no longer necessary and the attending physician agrees with the hospital's determination.
- o If the attending physician disagrees with a hospital's determination, the hospital may request the PRO to review their determination.
- o If a patient receives a hospital notice of noncoverage and requests PRO review, the PRO must review the determination and provide notice to the patient, attending physician and hospital, regardless of the patient's financial liability for continued stay.
- o If a patient requests PRO review of the hospital's determination no later than noon on the first working day after receipt of the notice, the hospital must furnish the PRO, by close of business that day, with the records necessary to make a determination. In this case, the PRO must provide notice of its review no later than one full working day after it has received the request and the records.
- o If a patient has made a timely request and did not know or could not reasonably be expected to know that continued stay was unnecessary, the hospital may not charge the patient for hospital services before noon of the day after receipt of the PRO's decision.
- o PROs must solicit the views of the patient in conducting the review.

#### Effective Date

- o The provision describing when the hospital may begin to charge for services provided a patient who has requested an appeal is effective on enactment.
- o All other provisions are effective on or after the first day of the first month that begins more than 30 days after enactment.

#### **PRO Review Of Inpatient Hospital Services and Early Readmission Cases (Section 9352)**

##### Current Law

- o Under PRO contracts for 1986-88, PROs are required to review readmissions occurring within 15 days of a previous discharge.

##### Provision

- o Requires the fiscal intermediaries to provide to PROs, on a monthly basis, data

necessary to enable the PROs to initiate a timely review process. If the fiscal intermediary cannot furnish the data on a timely basis, the hospital is required to do so.

- o PROs must perform reviews of early readmissions to determine if inpatient hospital and post-hospital services met professionally recognized standards of care. Reviews may be done on a sample basis if appropriate. An early readmission case is defined as a readmission occurring within 31 days of discharge.

#### Effective Date

- o Timely provision of hospital information is effective not later than 6 months after enactment.
- o Review of readmissions within 31 days is effective with contracts entered into or renewed on or after January 1, 1987, except that "post-hospital services" furnished by physicians will only include those services furnished in a hospital, other inpatient facility, ambulatory surgical center or rural health clinic until January 1, 1989.

#### **PRO Review of Quality of Care; Allocation of Funds for Review of Quality of Care (Section 9353 (a))**

##### Current Law

- o PROs are authorized to review the professional activities of health care practitioners and providers to determine if services are medically necessary, meet professionally recognized standards of quality, and are provided in the most appropriate setting. Under current contracts, PROs review hospital inpatient services only. COBRA requires PROs to review services provided by health maintenance organizations (HMOs) and competitive medical plans (CMPs), and assistants at cataract surgery, and to do pre-procedure review of 10 procedures, and authorizes PROs to deny payment for poor quality of care.

##### Provision

- o Requires PROs to allocate a reasonable portion of their activities to review of quality of services among different cases and settings including inpatient hospital, post-acute, ambulatory, and HMO/CMP care.
- o In allocating their activities, PROs are to consider the need for review based on previous problems, the cost and potential yield of the reviews, and the availability and adequacy of alternate quality review and assurance mechanisms.
- o Requires each PRO contract to include review of inpatient and outpatient services provided by HMOs and CMPs to determine the quality and appropriateness of services provided. The level of review activity is to equal

the level of review activity, per beneficiary, in other settings. The Secretary may contract for HMO review with organizations other than PROs in half of the States by April 1987, provided that these States collectively have 50 percent or less of the total number of HMO or CMP enrollees.

- o The Secretary is required to identify methods available to assist PROs in identifying potential cases of substandard care.
- o Requires the Secretary to provide at least 12 PROs with assistance in review and analysis of small area variations in utilization of hospital and other services for which Medicare reimbursement is made.

#### Effective Date

- o Allocation of review activities will be effective with contracts as of January 1, 1987, except review of physicians' services, other than those provided in hospitals, other inpatient facilities, ambulatory surgical centers and rural health clinics, is delayed until January 1, 1989.
- o Review of HMOs and CMPs applies on or after April 1, 1987. The level of effort requirements do not take effect until on or after January 1, 1988.
- o Identification of methods to identify substandard care is effective on enactment.

#### **PRO Review of Quality of Care; Requiring Consumer Representative on Peer Review Boards (Section 9353(b))**

##### Current Law

- o Composition of the PRO governing body is not specified by law.

##### Provision

- o Requires at least one consumer representative on PRO governing body.

##### Effective Date

- o With contracts entered into or renewed on or after January 1, 1987.

#### **PRO Review of Quality of Care; Improving Peer Review Responsiveness to Beneficiary Complaints (Section 9353 (c))**

##### Current Law

- o Current law does not address PROs' responsiveness to beneficiary complaints. The 1986-88 PRO contracts do require responsiveness to beneficiary complaints.

#### **Provision**

- o PROs are required to conduct appropriate review of all written complaints by beneficiaries about the quality of services provided. The PRO must inform the individual of the final disposition of the complaint.
- o The PRO must provide the practitioner with an opportunity to discuss the complaint only where there is a finding that care does not meet professionally recognized standards of health care.

#### **Effective Date**

- o Applies to complaints made on or after the first day of the first month that begins more than 9 months after the date of enactment.

#### **PRO Review of Quality of Care; Sharing of Information by Peer Review Organizations (Section 9353(d))**

#### **Current Law**

- o PROs are exempt from the provisions of the Freedom of Information Act. PROs are required to hold confidential information acquired in performing review except:
  - Information necessary to permit persons to carry out PRO functions,
  - As provided by regulation to assure protection of the rights and interests of patients, practitioners or providers of health care,
  - To assist Federal and State agencies in investigating fraud, abuse or risks to public health, and
  - Information relating to specific cases as requested by State licensing and certification agencies necessary to perform their duties.

#### **Provision**

- o Requires PROs to share confidential information related to a specific case or possible pattern of substandard care upon request of the State licensing, State certification agency or national accreditation body, to the extent that such information is necessary for that agency to carry out its official functions.

#### **Effective Date**

- o Applies to requests for data and information made on and after the end of the sixth month period beginning on the date of enactment.

## **PRO Review of Quality of Care; Funding of Additional Duties (Section 9353(e))**

### **Current Law**

- o The costs of PRO review are funded by transfer of funds from the Federal Hospital Insurance Trust Fund. The aggregate amount to be paid to all PROs during a year must be no less than the aggregate amount expended during FY 1986 on PRO reviews, adjusted for inflation.

### **Provision**

- o Requires hospitals, skilled nursing facilities and home health agencies to maintain an agreement with the PRO regarding review of services (other than inpatient hospital services) and review of beneficiary complaints regarding quality.
- o The review activities are to be considered a cost of providing services and are to be paid directly to the PRO, on behalf of the provider, by the Secretary. Payments are to be transferred in appropriate amounts from the part A and part B trust funds and are to be not less in the aggregate than the amount determined by the Secretary to be sufficient to cover the costs of specified review activities.
- o Similar provisions apply with respect to HMOs and CMPs.

### **Effective Date**

- o Applies to provider agreements as of October 1, 1987 and risk-sharing contracts with HMOs and CMPs as of April 1, 1987.

## PROVISIONS RELATING TO MEDICAID

### **Optional Coverage for Poor Pregnant Women and Children (Section 9401)**

#### **Current Law**

- o States are required to provide Medicaid coverage to all children receiving assistance under AFDC and may provide coverage for children who would be eligible for AFDC except that their income does not meet AFDC requirements.
- o States are required to cover all children born after October 1, 1983 up to age 5 who meet the AFDC income and resource requirements and may extend coverage to all such children under age 5 immediately.
- o States are required to cover pregnant women meeting AFDC income and resource standards.

#### **Provision**

- o Creates a new optional categorically needy group composed of pregnant women (through 60 days following pregnancy) and infants up to 1 year of age with family incomes up to the Federal poverty level. Beginning in FY 88 States could increase the age level by one in each fiscal year until all children up to age 5 were included. A State cannot elect to cover only pregnant women or only children. A State could not elect to cover one age group unless children in all younger age groups were covered.
- o Provides that States could choose an income eligibility level up to 100 percent of the Federal poverty line. The State is required to use the same methodology used in determining eligibility for AFDC benefits.
- o Specifies that application of a resource standard is a State option. The resource requirement for pregnant women can be no more restrictive than the SSI requirement and for children the requirement can be no more restrictive than the AFDC requirement. Alternatively, the State may choose to have no resource requirements.
- o Specifies that any different treatment of income and resources provided for newly eligible persons shall not require or permit such treatment for other persons.
- o Provides that if a State chooses to cover this new optional categorically needy group, it may not lower its AFDC payment levels below those in effect on April 17, 1986.
- o Specifies that newly covered pregnant women are only entitled to services related to pregnancy and to other conditions that may complicate pregnancy.

- o Permits a State to treat a pregnant woman eligible under this provision as eligible for Medicaid throughout her pregnancy without regard to any change in family income.
- o Requires States to extend eligibility for an infant or newly eligible child receiving inpatient services on the date the infant or child attains the maximum age, with respect to which coverage is provided, until the end of the inpatient episode.

#### **Effective Date**

- o Except for the phased-in coverage of children, applies to medical assistance furnished in calendar quarters beginning on or after April 1, 1987 without regard to whether or not final regulations have been promulgated by that date. The phased-in coverage of children begins October 1, 1987 and is extended in one-year intervals until October 1, 1990. The same provision applying to regulations applies.

#### **Optional Coverage of Elderly and Disabled Poor for All Medicaid Benefits (Section 9402)**

##### **Current Law**

- o Eligibility of the elderly and the disabled for Medicaid is linked to actual or potential receipt of cash assistance under the SSI program.
- o The elderly and the disabled covered under Medicaid generally are persons receiving Federal and/or State SSI payments, residing in a skilled nursing facility or intermediate care facility, or incurring substantial medical expenses.
- o The income and resource eligibility criteria differ substantially among the States.

##### **Provision**

- o Creates a new optional categorically needy group composed of the elderly and disabled who would receive the same benefit package as other categorically needy recipients.
- o Provides that States could choose an income eligibility level up to 100 percent of the Federal poverty line.
- o Requires States to use SSI resource standards, except that if a State has a medically needy program that has higher standards, it may utilize those higher standards for this new group.
- o Specifies that a State may not implement this option unless it has also agreed to cover some newly eligible pregnant women and infants.

##### **Effective Date**

- o Applies to payments to States for calendar quarters beginning on or after

July 1, 1987, without regard to whether or not final regulations have been promulgated by that date.

### **Optional Coverage of Poor Medicare Beneficiaries for Medicare Cost-Sharing Expenses (Section 9403)**

#### **Current Law**

- o Coverage under part B of Medicare requires payment of a monthly premium. Most States make this payment for their Medicaid eligibles under a 'buy-in' agreement. Federal matching for premium payments is only available for dual eligibles who also receive cash assistance.
- o States may receive Federal matching payments for Medicare cost-sharing charges, including deductibles and coinsurance, for services provided to their dual eligibles.

#### **Provision**

- o Creates a new optional coverage group composed of Medicare part A beneficiaries with family incomes not in excess of State-set thresholds of up to 100 percent of the Federal poverty level. A State choosing this option would also have to cover some newly eligible pregnant women and children.
- o Requires a State to use the SSI resource standards unless it has a medically needy program, in which case it may use the higher standards applicable to the medically needy.
- o Specifies that benefits are limited to Medicare cost-sharing which is defined as part A premiums (if applicable), part B premiums, part A deductibles and coinsurance, and part B deductibles and coinsurance. At State option, premiums for enrollment with a Medicare-qualified risk-sharing HMO may also be included.
- o Provides that the total of Medicaid payments for Medicare cost-sharing charges may exceed the amounts otherwise payable under the State plan for such services.

#### **Effective Date**

- o Applies to payment for calendar quarters beginning on or after July 1, 1987, without regard to whether or not final regulations have been promulgated.

### **Medicaid Eligibility for Qualified Severely Impaired Individuals (Section 9404)**

#### **Current Law**

- o Low-income individuals who qualify for Medicaid on the basis of disability must, in most States, meet the disability standards of the Supplemental Security Income (SSI) program. (Some States have opted to impose more restrictive

disability criteria than those in SSI. These are commonly referred to as the "209(b) States" in reference to the statutory provision which gives them the option to use their 1972 eligibility standards for the elderly and disabled.)

- o For purposes of SSI, an individual is not covered to be disabled if, after a 9-month trial work period, he or she is able to engage in "substantial gainful activity" (SGA), which the Secretary has defined as average countable earnings of over \$300 per month. Loss of disabled status of SSI purposes means loss of categorical eligibility for Medicaid.
- o The Disability Amendments of 1980 (P.L. 96-265) added a new section 1619 to the SSI law. Section 1619(a) provides that an individual who loses eligibility for SSI because he or she has worked and demonstrated the ability to engage in SGA, but who continues to have a disabling impairment, may become eligible for special SSI benefits until his or her countable income reaches the SSI income disregard "break-even point" (\$756 per month in 1986 in a State with no supplementation). Those who qualify for these special SSI benefits usually continue to be eligible for Medicaid as long as they need medical assistance to continue working.
- o Section 1619(b) provides Medicaid coverage for individuals whose earnings exceed the SSI income disregard "break-even point." This special Medicaid eligibility status applies so long as the individual: (1) continues to be blind or have a disabling impairment; (2) except for earnings, continues to meet all the other requirements for SSI eligibility; (3) would be seriously inhibited from continuing to work by the loss of Medicaid coverage; and (4) has earnings that are not sufficient to provide a reasonable equivalent of the Medicaid and SSI benefits that would have been available if he or she did not work. The Social Security Administration has established a "threshold" in each State's average per capita Medicaid expenditures; individuals with gross earnings in excess of this threshold no longer meet requirement (4) and therefore lose Medicaid coverage, unless their individual medical expenses exceed the State's average Medicaid expenditures.

#### Provision

- o Amends title XIX of the Act to establish a new mandatory, categorically needy coverage group: "qualified severely impaired individuals." This group includes any individual under 65 who received, in the month preceding the first month in which this provision applies to the individual, either SSI, State supplementation, or special 1619(a) benefits and was eligible for Medicaid. Such an individual must:
  - continue to be blind or have a disabling physical or mental impairment;
  - except for earnings, continue to meet all other requirements for SSI eligibility (including having unearned income below the SSI benefit standard);
  - be seriously inhibited by the lack of Medicaid coverage from continuing to work or from obtaining employment; and

- have earnings that are not sufficient to provide a reasonable equivalent of the Medicaid, SSI and title XX attendant care benefits that would be available if he or she did not work.

#### **Effective Date**

- o Applies to payments for calendar quarters beginning on or after July 1, 1987, without regard to whether regulations to implement these amendments have been promulgated by that date. Delay would be permitted where State legislation is required to amend the State's Medicaid plan.

#### **Clarification of Eligibility of Homeless Individuals (Section 9405)**

##### **Current Law**

- o There is no Federal requirement that an individual have a fixed or permanent residence in order to qualify for Medicaid.
- o Nor may a State impose, as a condition of eligibility for Medicaid, any residence requirement which excludes any person who resides in the State.
- o Some States and localities, however, apparently require applicants for Medicaid to supply a fixed address in order to qualify.

##### **Provision**

- o Clarifies that States and localities may not impose any residence requirement that excludes from Medicaid eligibility any otherwise qualified individual who resides in the State regardless of whether or not the individual's residence is maintained permanently or at a fixed address.

#### **Effective Date**

- o Upon enactment.

#### **Payments for Aliens Under Medicaid (Section 9406)**

##### **Current Law**

- o The Medicaid statute does not explicitly identify whether otherwise qualified aliens are entitled to benefits.
- o Until recently, the Secretary had limited Medicaid payments for aliens, by regulation, to otherwise eligible aliens who were lawfully admitted for permanent residence or who were permanently residing under color of law (PRUCOL) in the U.S., including aliens who were lawfully present under certain sections of the Immigration and Nationality Act.
- o On July 14, 1986, a U.S. District Court struck down this regulation as outside

the scope of the authority delegated under the Medicaid statute because that statute contains no exclusion of aliens.

- o The result of this decision is that otherwise qualified aliens are now entitled to Medicaid coverage (in the State of New York).

#### Provision

- o Prohibits Federal payments for States for medical assistance furnished to aliens who are not lawfully admitted for permanent residence or permanently residing in the U.S. under color of law and further provides that States are not required to offer coverage to such aliens.
- o Makes an exception for aliens who are otherwise qualified for Medicaid and have emergency medical conditions. States are required to cover these individuals.
- o To be covered under this exception, provides that an alien need not actually receive a cash payment under AFDC or SSI; however, the alien must meet the income, resource, and categorical requirements of the applicable cash assistance program.
- o Defines an emergency medical condition as a medical condition (including emergency labor and delivery) of sufficient severity (including severe pain) that the absence of immediate medical attention could result in placing the patient's health in serious jeopardy, serious impairments to bodily functions, or serious dysfunction of any organ or part.

#### Effective Date

- o Applies to medical assistance furnished to aliens on or after January 1, 1987, whether or not final regulations have been promulgated by that date.

#### **Optional Presumptive Eligibility Period for Pregnant Women (Section 9407)**

##### Current Law

- o Medicaid allows for a 3-month retroactive eligibility period prior to the date on which application for medical assistance is made. Regulations further require State agencies to determine eligibility within 45 days from the day of the application for benefits.
- o If the application is approved, Medicaid-covered medical expenses incurred during the 3-month retroactive eligibility period and services incurred after the date of application are reimbursed under the normal Medicaid rules. If the application is denied, medical expenses incurred during the 3-month retroactive eligibility period and services incurred after the date of application remain the responsibility of the individual.

### **Provision**

- o Permits States to make available ambulatory prenatal care during a presumptive eligibility period that begins when a qualified provider determines that the family income of the woman meets eligibility standards and ends when a final determination is made.
- o Allows States to grant this presumptive eligibility for a period not to exceed 45 days if:
  - the woman has begun maternity care with a qualified Medicaid provider,
  - a qualified provider determines the woman's family income is below the Medicaid standard,
  - the provider notifies the State agency within 5 working days of the woman's eligibility, and
  - the individual applies for Medicaid within 14 calendar days of the presumed eligibility. If the individual does not apply, the presumptive eligibility ends in 14 days.
- o Defines a qualified provider as one who provides outpatient, rural health or clinic services under the State Medicaid plan and receives funding from certain other Federal programs or is a State-approved perinatal clinic.
- o Requires States to provide guidelines to clinics on determining eligibility. Clinics that do not perform to the State's satisfaction may be barred from the presumptive eligibility program.
- o Provides that Federal payments will be the same as for other beneficiaries.
- o Provides that in determining excess erroneous payments, there shall not be included any erroneous payments for ambulatory prenatal care provided during a presumptive eligibility period.

### **Effective Date**

- o Applies to ambulatory prenatal care furnished in calendar quarters beginning on or after April 1, 1987, without regard to whether or not final regulations have been promulgated by such date.

### **Respiratory Care Services for Ventilator-Dependent Individuals (Section 9408)**

#### **Current Law**

- o The Medicaid statute makes no direct provision for home respiratory services as a distinct service category. At its discretion, a State may pay for home

respiratory services either as a medically necessary component of home health care services; as services provided to disabled children under age 18, but only if the services cost no more than institutional care and only if all disabled children meeting certain criteria are covered under this optional service; or as part of home and community-based services covered under a section 1915(c) waiver.

#### Provision

- o Amends section 1902(e) of the Social Security Act to permit States to provide optional coverage of respiratory care services at home to ventilator-dependent individuals without regard to comparability of amount, duration, and scope. Covered individuals must be medically dependent on a ventilator for life support at least six hours per day; must have been dependent as inpatients in hospitals, SNFs or ICFs for at least 30 consecutive days, or the maximum number of days authorized under the State plan, whichever is less; must require respiratory care on an inpatient basis and be eligible for Medicaid for the inpatient care; must have adequate social support services to be cared for at home; and must wish to be cared for at home.
- o Defines respiratory care services as those provided on a part-time basis in the home of the individual by a respiratory therapist or other health care professional trained in respiratory therapy, as determined by the State, payment for which is not otherwise included within other items and services covered for such persons under the State's Medicaid Plan.
- o Does not require States to offer respiratory services of the same amount, duration, and scope to any persons except those who meet the specific requirements outlined above.

#### Effective Date

- o Upon Enactment.

#### **Permitting States to Offer Home and Community-Based Services to Certain Low-Income Individuals (Section 9411)**

#### Current Law

- o Section 1915(c) of the Social Security Act authorizes the Secretary to waive certain sections of the Act to enable States to provide home and community-based long-term care services, not available under the regular Medicaid program, to individuals who would otherwise require institutionalization in a SNF or ICF, the cost of which would be borne by Medicaid, or who, but for the provision of these services, would receive inpatient hospital, SNF or ICF services because they are dependent on ventilator support.

- o In order to receive approval for a waiver, States must assure that the estimated average per capita expenditure for Medicaid under the waiver in a given fiscal year would not exceed that as estimated by the State, if the waiver had not been granted.
- o Under section 1915(g) of the Act, States are permitted to target optional case management benefits to certain regions of a State and to recipients without regard to amount, duration, and scope requirements.

**Provision**

- o Extends eligibility for home and community-based services under the section 1915(c) waiver authority to all individuals who, but for the provision of such services, would require the level of care provided in a hospital, SNF or ICF.
- o Provides that States may estimate the average per capita expenditures for waivers applying only to persons with a particular illness or condition who are inpatients in hospitals, SNFs, or ICFs, by using only the expenditures associated with this group of persons and not the expenditures associated with other individuals in these facilities.
- o Allows States to limit the provision of case management services to AIDS and ARC patients as well as to individuals with chronic mental illnesses.
- o Adds certain additional services under the section 1915(c) waiver authority for the chronically mentally ill population. These services include: day treatment or other partial hospitalization services; psychosocial rehabilitation services; and clinic services (whether or not furnished in a facility).

**Effective Date**

- o Applies to applications for waivers or renewals approved on or after date of enactment.

**Waiver Authority for Chronically Mentally Ill and Frail Elderly (Section 9412)**

**Current Law**

- o Section 1115 of the Social Security Act contains provisions that allow the Secretary to waive compliance with certain requirements for certain periods to carry out experimental, pilot or demonstration projects.

**Provision**

**Chronically Mentally Ill Demonstration Waiver**

- o Authorizes the Secretary to waive certain Medicaid requirements to allow

States to implement demonstration programs to improve the continuity, quality and cost-effectiveness of mental health services available to the Medicaid-eligible chronically mentally ill. Medicaid requirements which may be waived include Statewideness, comparability, freedom of choice, and review and screening of care. The requirements applying to entities providing care on a prepaid capitation basis that they be HMOs for Medicaid purposes and the 75 percent ceiling on Medicaid/Medicare enrollment are waived.

- o In order to grant such a waiver, provides that the Secretary must determine:
  - that the program is receiving funding under the Robert Wood Johnson Foundation and HUD program for the Chronically Mentally Ill.
  - that the State has provided satisfactory assurances that with respect to Medicaid-funded mental health services, the demonstration will be budget neutral; i.e., the estimated average per capita expenditure for medical assistance for mental health provided in any fiscal year to persons covered under the program does not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been incurred in that year for such persons if the waiver had not been granted.
  - that the State provides assurances that there will be no reduction or limitation in benefits to a Medicaid-eligible chronically mentally ill individual.
  - that States may offer the following services under this demonstration: case management services for the chronically mentally ill, habilitation services, day treatment or other partial hospitalization services, residential services (other than room and board), psychosocial rehabilitation services, clinic services (whether or not furnished in a facility); and other services as the Secretary may approve.

#### **Frail Elderly Demonstration Waiver**

- o Provides for the Secretary to grant waivers of certain requirements of titles XVIII and XIX of the Social Security Act to not more than 10 public or nonprofit private community-based organizations to provide health care on a capitated basis to the frail elderly.
- o Provides that the terms and conditions will be substantially the same as those of the On Lok waiver.
- o Provides that to receive a waiver, an organization must have been awarded a grant by the Robert Wood Johnson Foundation.
- o Provides that any waiver granted will be for an initial period of 3 years and can be extended beyond that period.

#### **General**

- o Requires a waiver be granted for an initial term of 3 years which may be extended for an additional 2-year term. The request will be deemed granted

unless the Secretary denies the request in writing within 90 days after submission. The authority for the Secretary to approve a waiver under this section would extend only during the 5-year period beginning October 1, 1986.

- o Prohibits the Secretary from requiring as a condition for approving a waiver, that the actual total expenditures for services provided under the waiver (and associated with Federal matching payments) not exceed approved estimates for services. Nor can the Secretary deny Federal matching payments for services on the ground that a State has failed to limit actual total expenditures for services under the waiver to approved estimates for these expenditures. However, the Secretary shall monitor the waivers and after notice for a hearing, terminate any waiver where non-compliance has occurred.
- o Requires the Secretary to report to Congress no later than January 1, 1993, on the cost, accessibility, utilization and quality of services provided under these waivers.

**Effective Date**

- o Upon enactment.

**Continuation of "Case-Managed Medical Care for Nursing Home Patients" Demonstration Project (Section 9413)**

**Current Law**

- o Under his waiver authority granted to conduct demonstrations regarding Medicare and Medicaid alternative payment systems, the Secretary of Health and Human Services approved applications for waivers for the Massachusetts Department of Public Welfare's demonstration project to reduce inappropriate and costly hospitalizations. The original waivers permitted fee-for-service reimbursement for the provision of medical services by physician-supervised nurse practitioners/physician assistants for 6,500 residents of nursing homes for the period July 1, 1983, through June 30, 1986; an additional waiver extended the project through June 30, 1987.

**Provision**

- o Requires the Secretary to approve applications for waivers necessary for continuation of this demonstration project from July 1, 1987, through June 30, 1989, until an evaluation focusing on the impact of the project on the use of nursing home services and hospital emergency room and outpatient services is completed.
- o Provides that approval or renewal of an application shall be on the same terms and conditions as applied to the demonstration project on July 1, 1986.

**Effective Date**

- o Upon enactment.

## **New Jersey Respite Care Pilot Project (Section 9414)**

### **Current Law**

- o Medicaid does not currently cover respite care services except where provided under a home and community-based services waiver approved by the Secretary under section 1915(c) of the Social Security Act.

### **Provision**

- o Requires the Secretary to enter into an agreement with the State of New Jersey to conduct a pilot project under Medicaid which would provide respite care services to elderly and disabled persons in order to determine the extent to which:
  - the provision of necessary respite care services to individuals at risk of institutionalization will delay or avert that need; and
  - respite care services enhance and sustain the role of the family in providing long term care services for the elderly and disabled at risk of institutionalization.
- o Conditions - stipulates that the agreement with the Secretary will provide:
  - that the project be administered by a State health services agency, which may be the same State agency that administers medical assistance under title XIX of the Social Security Act;
  - that if the project imposes any cost sharing requirements on participants who are eligible for benefits under title XIX of the Social Security Act, these requirements will be imposed in accordance with the provisions of section 1916 of the Act, which lays out the conditions for use of enrollment fees, premiums, deductions, cost sharing, and similar charges; and
  - for a system of review to assure that respite care services are provided only to individuals reasonably determined to be in need of such services.
- o Defines respite care services as short-term and intermittent companion or sitter services, homemaker and personal care services, adult day care, inpatient care, and emergency respite as well as peer support and training for family caregivers.
- o Requires New Jersey to arrange for an independent evaluation of the project to be transmitted by the State to the Secretary within 6 months of the termination of the project.

### **Effective Date**

- o Upon Enactment.

## **Inapplicability of Paperwork Reduction Act (Section 9415)**

### **Current Law**

- o The provisions of the Paperwork Reduction Act (44 USC 35) outline the rules agencies must comply with when collecting and disseminating Federal information. Section 3507 of the Act specifically states that public information activities conducted by the agency must receive prior clearance through the OMB. This entails the submission to the Director of OMB of the proposed information collection request and all other appropriate materials and then OMB approval of the agency's request. In addition, the Director may not approve an information collection request for a period in excess of three years.
- o Waiver requests for Medicare and Medicaid demonstration projects must follow these guidelines.

### **Provision**

- o Provides that provisions of the Paperwork Reduction Act will not apply to the information required in Part 2 of this Act ("Provision of Services under Waiver Authority") or amendments made by this Act.

### **Effective Date**

- o Upon enactment.

## **Holding States Harmless in Fiscal Year 1987 Against a Decrease in the Federal Medical Assistance Percentage (Section 9421)**

### **Current Law**

- o The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provided that beginning in Fiscal Year 1987, the Federal Medical Assistance Percentage (FMAP) be calculated on an annual rather than a biennial basis.

### **Provision**

- o Provides a "hold-harmless" provision for States adversely affected by a COBRA change to annual calculations of the (FMAP).

### **Effective Date**

- o October 1, 1986.

## **Waiver of Certain Requirements (Section 9422)**

### **Current Law**

- o Medicaid law authorizes coverage, for up to three months prior to application,

for an individual who has received Medicaid-covered services during the time period and who would have been eligible for Medicaid at the time the services were received if he or she had applied for Medicaid.

#### Provision

- o Extends the normal 3-month retroactive coverage period for services provided by the Medical University of South Carolina. Medicaid would be allowed to pay for claims for services provided during the period October 1, 1984, to July 1, 1985, to persons who are determined no later than 6 months after the date of enactment to have been eligible when the services were rendered.
- o Provides that individuals covered by this provision are, upon application, under the age of 18 or pregnant women.

#### Effective Date

- o Upon enactment.

#### **Independent Quality Review of HMO Services (Section 9431)**

##### Current Law

- o Regulations require that entities which serve Medicaid beneficiaries on a prepayment basis must have internal quality assurance systems meeting certain specifications. Under Medicare, services provided by risk contracting HMOs and CMPs are subject to review by utilization and quality control peer review organizations (PROs) effective January 1, 1987.

##### Provision

- o Requires States to provide for an annual, independent review of Medicaid services provided or arranged by each HMO, HIO or other prepaid plan with which the State has entered into a risk-based contract.
- o Allows a State to select a PRO or private accreditation organization. It may not use State agencies to fulfill this requirement.
- o Results of review must be available, on request, to the Secretary, the OIG, and the GAO.

##### Effective Date

- o Applies to payments under title XIX for calendar quarters beginning on or after July 1, 1987.

## **State Utilization Review Systems (Section 9432)**

### **Current Law**

- o States may at their option implement second surgical opinion programs (SSOPs) or hospital preadmission review programs.
- o On June 17, 1986, the Secretary published a proposed rule that would require every State to have in place by January 1, 1987, a mandatory SSOP or, as an alternate, an existing utilization review plan that prevents unnecessary surgery, is cost effective, and meets with the Department approval.

### **Provision**

- o Temporarily prohibits the Secretary from issuing final regulations that require States to implement SSOPs or inpatient hospital preadmission review programs.
- o Ends the prohibition 180 days after delivery to Congress of a report, based on a representative sample of States, on high cost or high volume procedures, payment rates and aggregate payments for such procedures; utilization rate of those procedures among Medicaid and non-Medicaid populations; number of physicians performing those procedures and number providing second opinions; and steps States with mandatory SSOPs take to avoid access problems especially in rural areas. The report must also include a list of surgical procedures which the Secretary believes should be included in a mandatory SSOP under Medicaid. The report is due no later than October 1, 1988.
- o Provides that the Secretary must also submit to Congress, by January 1, 1990, a study that examines the utilization of selected medical treatments and surgical procedures by Medicaid beneficiaries to assess the appropriateness, necessity and effectiveness of such treatments and procedures.

### **Effective Date**

- o Upon enactment.

## **Clarification of Flexibility for State Medicaid Payment Systems for Inpatient Services (Section 9433)**

### **Current Law**

- o States are required to provide assurances to the Secretary that their Medicaid payments for hospitals, SNF, and ICF services are "reasonable and adequate" to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with State and Federal laws, regulations and quality and safety standards.
- o States must also make assurances that individuals eligible for medical assistance have reasonable access to inpatient hospital services of adequate

quality. States must also take into account hospitals that serve a disproportionate number of low-income patients with special needs.

- o Under HCFA regulations implementing these provisions, States have to make assurances that their payment methodology will not result in payments for hospitals, SNFs, ICFs, or ICFs/MR that exceed in the aggregate the estimated amounts that would be paid if Medicare reimbursement principles were applied.

#### Provision

- o Provides that the Secretary shall not limit the amount of payment adjustments that may be made under a State Medicaid plan with respect to hospitals that serve a disproportionate number of low-income patients with special needs.

#### Effective Date

- o Retroactive to August 13, 1981 (enactment date of OBRA, P.L. 97-35).

### **Financial Disclosure Requirements for HMOs; Civil Money Penalties (Section 9434)**

#### Current Law

- o All entities furnishing services under Medicaid must disclose, upon request by the State or the Secretary, full and complete information as to the ownership of a subcontractor with whom the entity has had business transactions in excess of \$25,000 per year, and any significant business transactions with such subcontractor.
- o Entities must disclose to the State the identity of each person with control interest or ownership interest of 5 percent or more.
- o Federally qualified HMOs must report to the Secretary a description of transactions between the HMO and a party in interest, and make such information available to its members upon request.

#### Provision

- o Requires that any HMO that is not a Federally qualified HMO and is contracting with a State to provide services to Medicaid beneficiaries on a capitated or risk basis must report to the State a description of transactions between the organization and party in interest.
- o Provides that transactions that must be reported include: any sale, exchange, or leasing of property; any furnishing for consideration of goods, services or facilities (but not employee salaries); and any loans or extensions of credit.
- o Requires each organization to make the information reported available upon request to the Secretary, the OIG/DHHS, the Comptroller General and to its enrollees. The State or Secretary may request that the information be in the form of a consolidated financial statement for the organization and entity.

- o Requires that the Secretary must provide prior approval of contracts in excess of \$100,000 between States and entities contracting to provide services to Medicaid beneficiaries on a capitated or risk contracting basis.
- o Provides for civil money penalties for entities providing services to Medicaid patients on a risk basis if an entity has failed to provide required medically necessary items and services, and if that failure has adversely affected the patients. Civil money penalties of up to \$10,000 can be imposed for each failure.

#### Effective Date

- o Financial disclosure provision is effective six months after enactment.
- o Approval of contractual expenditure provision is effective upon enactment and applies to contracts entered into, renewed, or extended after the end of the 30-day period on enactment.
- o Civil money penalty provision is effective on enactment.

#### **COBRA Technical Corrections and Clarifications Relating to the Medicaid Program (Section 9435)**

##### Current Law

- o The Consolidated Omnibus Budget Reconciliation Act of 1985 contains a number of technical errors.

##### Provision

- o Maintenance Income Standards-Makes income standards for home and community-based waivers effective before, as well as on or after the effective date of COBRA.
- o Hospice Care for Dual Eligibles-Clarifies the rules for payment with respect to an individual who is eligible for both Medicare and Medicaid, who resides in a skilled nursing facility or intermediate care facility, who is having Medicaid payments made on his or her behalf for such institutional services, who has elected Medicare hospice coverage, and who is in a State that has not elected to cover hospice services. The State is directed to pay the hospice program an amount equal to the amounts allocated under the State Medicaid plan for room and board in the SNF or ICF, plus applicable coinsurance amounts. Defines the term room and board broadly to include various activities that would normally be performed by family members for non-institutionalized hospice patients.
- o Trust-Clarifies that section 9506 of COBRA, regarding the treatment of income tax from certain trusts, does not apply to certain trusts established before April 7, 1986, solely for the benefit of residents in an intermediate care facility for the mentally retarded.

- o **Effective Dates**-Amends sections 9505(e), optional hospice benefits; 9508(b), optional targeted case management; 9510(b), optional coverage for individuals in a medical institution; and 9511(b), optional coverage of children, to state that the provisions are effective on the date stated in COBRA "without regard to whether or not regulations to carry out the amendments have been promulgated by that date".
- o **Health Insuring Organizations**-Clarifies that, for purposes of meeting the requirement in section 1903(m)(2)(A)(i) of the Social Security Act, a health insuring organization (HIO) is only required to be organized under the laws of the State in which it is doing business, including a State's corporation law, and does not need to be organized under the HMO laws of the State. It need only make services accessible and have adequate protection against the risk of insolvency in order to participate in Medicaid.

**Effective Date**

- o Applies as if included in the enactment of COBRA (April 7, 1986).

**Payment for Certain Long-Term Care Patients in Hospitals (Section 9436)**

**Current Law**

- o The Medicaid rate of payment for patients awaiting long-term care placement in an acute care hospital because there is a shortage of SNF and ICF beds in the community is the estimated State-wide average rate per patient day for SNF or ICF services rather than the hospital's inpatient acute care rate, with one exception. The State may choose to pay the higher inpatient rate if there are no excess beds in the hospital nor in the area where the hospital is located. Historically, a hospital or area has been considered to have excess beds if its occupancy rate is under 80 percent.

**Provision**

- o Allows States which obtained a waiver of payment methodology for the period January 1, 1983 to December 31, 1985, to pay for services rendered to patients awaiting long-term care placement at the higher, acute-care rate if the Secretary determines that a sufficient number of hospital beds has been decertified in the State to offset the costs of a higher rate.

**Effective Date**

- o Applies to payments for services furnished during the 3-year period beginning January 1, 1986, after the date the Secretary makes the determination described above.

## **Elimination of 3-Percent Trigger for Cost-of-Living Increases (Section 9001)**

### **Current Law**

- o The Social Security Act provides for a cost-of-living adjustment (COLA) for benefits under the Old-Age, Survivors, and Disability Insurance program if the consumer price index (CPI) increases by 3.0 percent or more during a specified base period. If the CPI rises by less than 3.0 percent, there is no COLA provided. In the following year, however, the COLA is based on the accumulated increase in the CPI over two years.
- o Several other programs have automatic payment increase provisions which are linked to the social security COLA and are increased only if the social security COLA is provided. This includes Supplemental Security Income (SSI) cash benefits.
- o Persons receiving social security retirement benefits may not have their payment amounts reduced due to increases in the premium for Medicare's Supplementary Medical Insurance (SMI) program. Thus, if there is no social security COLA, there can be no increase in the SMI premium.

### **Provision**

- o Eliminates the 3-percent trigger for the provision of the social security COLA effective with increases effective in December 1986. A COLA would be provided in any year in which there has been a measurable increase in the CPI during the specified base period.

### **Effective Date**

- o For months after September 1986.

## **Targeting under Income and Eligibility Verification System (Section 9101)**

### **Current Law**

- o The Social Security Act requires that States establish an income and eligibility verification system (IEVS) for AFDC, Medicaid, unemployment compensation, Food Stamps, and SSI programs. The programs must request and make use of IRS unearned income information and quarterly wage information. It further requires that the use of such information be targeted to those uses which are most likely to be productive in identifying and preventing ineligibility and incorrect payments.
- o Currently, regulations require that information be requested and verified for all applicants and recipients within a 30-day time period. Action can be delayed on up to 20 percent of the information items when collateral verification sources must be contacted.

**Provision**

- o Clarifies that in targeting the IEVS program to those uses which are likely to be most productive, no State shall be required to use information obtained through the system to verify the eligibility of all recipients. The conference committee report also contains language which extends the time period for verification of information received to 45 days.

**Effective Date**

- o Upon Enactment.