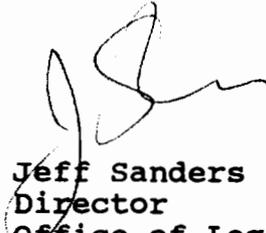


HCFA LEGISLATIVE SUMMARY

OMNIBUS BUDGET RECONCILIATION ACT OF 1989 P.L. 101-239

On December 19, 1989, the President signed into law H.R. 3299, the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239). Summaries of the Medicare, Medicaid, and other relevant provisions are attached.



Jeff Sanders
Director
Office of Legislation and Policy

Attachment

**OMNIBUS RECONCILIATION ACT OF 1989
PUBLIC LAW 101-239**

TABLE OF CONTENTS

Title IV - MEDICARE, MEDICAID, AND OTHER HEALTH PROVISIONS

Subtitle A - Medicare

Part 1 - Provisions Relating to Part A

Subpart A - General Provisions		<u>Page</u>
Sec. 6001	Extension of Reductions under Original Sequester Order and Applicability of New Sequester Order....	1
Sec. 6002	Reductions in Payments for Capital-Related Costs of Inpatient Hospitals Services for Fiscal Year 1990.....	1
Sec. 6003	Prospective Payment Hospitals	
	(a) Changes in Hospital Update Factors.....	2
	(b) Reduction in DRG Weighting Factors for Fiscal Year 1990; Future Annual Recalibration of DRG Weights on Budget Basis.....	3
	(c) Disproportionate Share Adjustment.....	4
	(d) Extension of Regional Referral Center Classification	5
	(e) Criteria and Payment for Sole Community Hospitals.....	6
	(f) Criteria and Payment for Medicare Dependent, Small Rural Hospitals.....	7
	(g) Essential Access Community Hospital Program...	8
	(h) Geographic Classification of Hospitals.....	13
	(i) Legislative Proposal Eliminating Separate Average Standardized Amounts.....	16
	(j) ProPAC Study of Payments to Rural Sole Community Hospitals and Small Rural Hospitals.	17
Sec. 6004	PPS-Exempt Hospitals.....	17
Sec. 6005	Payments for Hospice Care.....	19
Subpart B - Technical and Miscellaneous Provisions		
Sec. 6011	Pass Through Payment for Hemophilia Inpatients....	19
Sec. 6012	Medicare Buy-In for Continued Benefits for Disabled Individuals.....	20
Sec. 6013	Buy-In Under Part A for Qualified Medicare Beneficiaries.....	22
Sec. 6014	ProPAC Study on Medicare Dependent Hospitals.....	22
Sec. 6015	Provisions Relating to Target Amount Adjustments..	23
Sec. 6016	Study of Methods to Compensate Hospices for High-Cost Care.....	24
Sec. 6017	Prohibition on Nursing Home Balance Billing.....	24
Sec. 6018	Hospital Anti-Dumping Provisions.....	25
Sec. 6019	Release and Use of Hospital Accreditation Surveys.	26
Sec. 6020	Intermediated Sanctions for Psychiatric Hospitals.	27

	<u>Page</u>
Sec. 6021 Eligibility of Merged or Consolidated Hospitals for Periodic Interim Payments.....	27
Sec. 6022 Extension of Waiver for Finger Lakes Area Hospital Corporation.....	28
Sec. 6023 Clarification of Continuation of August 1987 Hospital Bad Debt Recognition Policy.....	29
Sec. 6024 Use of More Recent Data Regarding Routine Service Costs of Skilled Nursing Facilities.....	29
Sec. 6025 Permitting Dentist to Serve as Hospital Medical Director.....	30
Sec. 6026 GAO Study of Hospital-Based and Freestanding Skilled Nursing Facilities.....	30
Sec. 6027 Massachusetts Medicare Repayment.....	31
Sec. 6028 Allowing Certifications and Recertifications by Nurse Practitioners and Clinical Nurse Specialists for Certain Services.....	31

Part 2 - Provisions Relating to Part B

Subpart A - General Provisions

Sec. 6101 Extension of Reductions Under Sequester Order.....	32
Sec. 6102 Physician Payment Reform.....	32
Sec. 6103 Establishment of Agency for Health Care Policy and Research.....	41
Sec. 6104 Reduction in Payments for Certain Procedures.....	49
Sec. 6105 Reduction in Payments for Radiology Services.....	50
Sec. 6106 Anesthesia Services.....	50
Sec. 6107 Delay in Update and Reduction in Percentage Increase in the Medicare Economic Index.....	51
Sec. 6108 Miscellaneous Provisions Relating to Payment for Physician's Services.....	52
Sec. 6109 Waiver of Liability Limiting Recoupment in Certain Cases.....	53
Sec. 6110 Reduction in Capital Payments for Outpatient Hospital Services.....	53
Sec. 6111 Clinical Diagnostic Laboratory Tests.....	54
Sec. 6112 Durable Medical Equipment.....	55
Sec. 6113 Mental Health Services.....	56
Sec. 6114 Coverage of Nurse Practitioner Services in Nursing Facilities.....	58
Sec. 6115 Coverage of Screening Pap Smears.....	59
Sec. 6116 Coverage Under, and Payment for, Outpatient Rural Primary Care Hospital Services Under Part B.....	60

Part 2 - Provisions Relating to Part B

Subpart B - Technical and Miscellaneous Provisions

Sec. 6131 Modification of Payment for Therapeutic Shoes for Individuals with Severe Diabetic Foot Disease.....	61
Sec. 6132 Payments to Certified Register Anesthetists.....	62

Sec. 6133	Increase in Payment Limit for Physical and Occupational Therapy Services.....	62
Sec. 6134	Study of Payment for Portable X-Ray Services.....	63
Sec. 6135	Extension of Municipal Health Service Demonstration Projects.....	63
Sec. 6136	Study of Reimbursement for Ambulance Services.....	64
Sec. 6137	ProPAC Study of Payments for Services in Hospital Outpatient Departments.....	64
Sec. 6138	PhysPRC Study of Payments for Assistants at Surgery.....	65
Sec. 6139	GAO Study of Standards for Use of and Payment for Items of Durable Medical Equipment.....	66
Sec. 6140	Narrowing of Range of Amounts Recognized for Items of Durable Medical Equipment.....	67
Sec. 6141	Physician Office Labs.....	67
Sec. 6142	Study of Reimbursement for Blood Clotting Factor for Hemophilia Patients.....	68

Part 3 - Provisions Relating to Parts A and B

Subpart A - General Provisions

Sec. 6201	Reductions Under Original Sequester Order and Applicability of New Sequester Order for Health Maintenance Organizations.....	68
Sec. 6202	Medicare as Secondary Payer.....	69
Sec. 6203	Payment for End Stage Renal Disease Services.....	78
Sec. 6204	Physician Ownership of, and Referral to, Health Care Entities.....	80
Sec. 6205	Costs of Nursing and Allied Health Education.....	86
Sec. 6206	Disclosure of Assumptions in Establishing AAPCC; Elimination of Coordinated Open Enrollment Requirement.....	88
Sec. 6207	Extension of Expiring Authorities.....	89

Subpart B - Technical and Miscellaneous Provisions

Sec. 6211	Medicare Hospital Patient Protection Amendments...	90
Sec. 6212	Health Maintenance Organizations and Competitive Medical Plans.....	93
Sec. 6213	Rural Health Clinic Services.....	95
	(a) Staffing Requirements; Inclusion of Nurse Midwife Services.....	95
	(b) Coverage of Social Workers.....	95
	(c) Expansion of Eligible Areas.....	95
	(d) Effective Date.....	95
	(e) Dissemination of Rural Health Clinic Information.....	96
	(f) Treatment of Certain Facilities as Rural Health Clinics.....	96
	(g) Expansion of Functions of Office of Rural Health Policy.....	97

	<u>Page</u>
Sec. 6214 Determining Eligibility of Home Health Agencies for Waiver of Liability for Denied Claims.....	98
Sec. 6215 Extension of Authority to Contract with Fiscal Intermediaries and Carriers on Other than a Cost Basis.....	98
Sec. 6216 Expansion of Rural Health Medical Education Demonstration Project.....	99
Sec. 6217 Inner-City Hospital Triage Demonstration Project..	100
Sec. 6218 GAO Study of Administrative Costs of Medicare Program.....	101
Sec. 6219 Provisions Relating to End Stage Renal Disease Services.....	101
Sec. 6220 Amendments Relating to the United States Bipartisan Commission on Comprehensive Health Care.....	102
Sec. 6221 National Commission on Children.....	103
Sec. 6222 Continued Use of Home Health Wage Index in Effect Prior to July 1, 1989, Until After July 1, 1991...	104
Sec. 6223 HCFA Personnel Study.....	105
Sec. 6224 Peer Review Organizations.....	106

Part 4 - Part B Premium

Sec. 6301 Part B Premium.....	107
-------------------------------	-----

Subtitle B - Medicaid

Part 1 - General Provisions

Sec. 6401 Mandatory Coverage of Certain Low-Income Pregnant Women and Children.....	108
Sec. 6402 Payment for Obstetrical and Pediatric Services....	109
Sec. 6403 Early and Periodic Screening, Diagnostic, and Treatment Services Defined.....	110
Sec. 6404 Payment for Federally Qualified Health Center Services.....	111
Sec. 6405 Required Coverage of Nurse Practitioner Services..	112
Sec. 6406 Required Medicaid Notice and Coordination with Special Supplemental Food Program for Women, Infants and Children (WIC).....	112
Sec. 6407 Demonstration Projects to Study the Effect of Allowing States to Extend Medicaid to Pregnant Women and Children Not Otherwise Qualified to Receive Medicaid Benefits.....	113
Sec. 6408 Other Medicaid Provisions	
(a) Institutions for Mental Disease.....	114
(b) Extension of Texas Personal Care Services Waiver.....	115
(c) Hospice Payment for Room and Board.....	115
(d) Medicare Buy-In for Premiums of Certain Working Disabled.....	116

Part 2 - Technical and Miscellaneous Provisions

Sec. 6411 Miscellaneous Technical Amendments

- (a) Technical Correction to Medicare Buy-In for the Elderly..... 117
- (b) Extension of Delay in Issuance of Certain Final Regulations..... 117
- (c) Disproportionate Share Hospitals..... 118
- (d) Fraud and Abuse Technical Amendment..... 119
- (e) Spousal Impoverishment..... 119
- (f) Health Insuring Organizations..... 120
- (g) Day Habilitation and Related Services..... 121
- (h) Medically Needy Income Levels..... 121
- (i) Technical Correction Concerning Transitional Coverage..... 122
- (j) Minnesota Prepaid Medicaid Demonstration Project Extension..... 123

Subtitle C - Maternal and Child Health Block Grant Program

Sec. 6501 Increase in Authorization of Appropriations..... 123

Sec. 6503 Use of Allotment Funds and Application for Block Grant Funds..... 124

Sec. 6504 Reports..... 124

Sec. 6506 Development of Model Applications..... 124

Sec. 6507 Research on Infant Mortality and Medicaid Services 125

Sec. 6508 Demonstration Project on Health Insurance for Medically Uninsurable Children..... 125

Subtitle D - Vaccine Compensation Technicals

Sec. 6601 Vaccine Injury Compensation Technicals..... 125

Subtitle E - COBRA Continuation Coverage

Sec. 6701 Extension, Under Internal Revenue Code, Under 6702 Public Health Service Act, and Under ERISA, of 6703 Coverage from 18 to 29 Months for Those with a Disability at Time of Termination of Employment... 126

Sec. 6801 Amendments to the Public Health Service Act, 7862 Internal Revenue Code, and ERISA..... 127

Subtitle F - Technical and Miscellaneous Provisions Relating to Nursing Home Reform

Sec. 6901 Medicare and Medicaid Technical Corrections Relating to Nursing Home Reform

- (a) Moratorium on Implementation of February 2, 1989 Regulations..... 128
- (b) Nurse Aide Training..... 128
- (c) Publication of Proposed Regulations Respecting Preadmission Screening and Annual Resident

Review.....	131
(d) Other Amendments	
(1) Clarification of Applicability of Enforcement Rules to Dually-Certified Facilities.....	131
(2) Clarification of Federal Matching Rate for Survey and Certification Activities.....	132
(3) Medicare Waiver Authority for Certain Demonstration Projects.....	132

TITLE VIII - HUMAN RESOURCES AND INCOME SECURITY PROVISIONS

Sec. 8003 Permanent Extension of Medicaid Eligibility Extension Due to Collection of Child or Spousal Support.....	133
Sec. 8007 Case Plans to Include Health and Education Records and to be Reviewed and Updated at the Time of Each Placement.....	133
Sec. 8008 Establishment and Conduct of SSI Outreach Programs for Children.....	134
Sec. 8010 SSI Rules for Deeming to Children the Income and Resources of their Parents Waived for Certain Disabled Children.....	134
Sec. 8011 SSI Exclusion from Income of a Domestic Commercial Transportation Ticket Received as a Gift.....	135
Sec. 8012 Reduction in Time During which Income and Resources of Separated Couple Must be Treated as Jointly Available for SSI Purposes.....	135
Sec. 8013 SSI Exclusion of Accrued Income with Respect to Certain Burial Spaces.....	136
Sec. 8014 SSI Exclusion from Resource of All Income-Producing Property.....	136
Sec. 8015 Demonstration of Effectiveness of Minnesota Family Investment Plan.....	137

TITLE X - MISCELLANEOUS AND TECHNICAL SSA AMENDMENTS

Subtitle D - Human Resource and Income Security Provisions

Sec. 10404 Demonstration Project.....	138
Sec. 10405 Agent Orange Settlement Payments.....	138



OMNIBUS BUDGET RECONCILIATION ACT OF 1989

TITLE VI -- MEDICARE, MEDICAID, AND OTHER HEALTH PROVISIONS

Subtitle A -- Medicare

Part 1 -- Provisions Relating to Part A

Subpart A -- General Provisions

Extension of Reductions Under Original Sequester Order and Applicability of New Sequester Order (Section 6001)

Current Law

- o On October 16, 1989, the President issued a final sequester order pursuant to the requirements of the Balanced Budget and Emergency Deficit Control Act of 1985 (amended by the Balanced Budget and Emergency Deficit Control Act of 1987). Under the terms of the sequester order, Medicare benefit payment for part A services rendered on or after October 17, 1989, are reduced by 2.092 percent. The 1990 sequester reduced all part A payments (to hospitals, skilled nursing facilities, home health agencies, and health maintenance organizations) by 2.092 percent from October 17, 1989 through December 31, 1989.
- o Part A payments are reduced by 1.40 percent beginning on January 1, 1990 and ending September 30, 1990 due to a revised sequester order.

Provision

- o Increases payment for part A services by 1.42 percent to offset the effects of the new sequester order.

Effective Date

- o Effective for services provided on or after January 1, 1990 through the remainder of the fiscal year.

Reduction in Payments for Capital Related Costs of Inpatient Hospital Services for Fiscal Year 1990 (Section 6002)

Current Law

- o Capital-related costs (including depreciation, leases, rentals interest and a return on equity for proprietary hospitals) are excluded from the PPS payment for inpatient hospital services for hospital cost reporting periods beginning before October 1, 1991, and are reimbursed on a reasonable cost basis.

- o OBRA 87 reduced payment amounts for capital-related costs by 12 percent in FY 88, beginning January 1, 1989, and by 15 percent in FY 89.
- o Sole community hospitals (SCHs) are exempt from capital payment reductions.

Provision

- o Extends the 15 percent reduction in capital-related payments for portions of cost reporting periods or discharges occurring on January 1, 1990 through the remainder of FY 90.
- o Continues to exempt SCHs from capital payment reductions.

Effective Date

- o Effective for cost reporting periods or discharges beginning on or after January 1, 1990.

Changes in Update Factors (Section 6003 (a))

Current Law

- o The PPS rates are increased each year by an "update factor." For FY 88 and 89, separate update factors have been applied to hospitals based on their location (large urban, other urban and rural). This distinction would end in FY 89.
- o The FY 88 updates are set at 1.5 for large urban hospitals, 3.0 for rural hospitals, and 1.0 for other urban hospitals. The FY 89 updates are set at the hospital market basket minus 2.0, 1.5, and 2.5 for large urban, rural, and other urban hospitals, respectively.
- o Thereafter, the Secretary is required to increase the PPS payment rate by the projected increase in the market basket index.

Provision

- o Establishes update factors for discharges occurring on or after January 1, 1990 and before October 1, 1990 as:

Large Urban Hospitals:	Market Basket + 0.12 percent
Rural Hospitals:	Market Basket + 4.22 percent
Other Urban Hospitals:	Market Basket - 0.53 percent

- o Provides that update factors for FY 91 and subsequent years will be equal to the market basket index.
- o Provides that for the purpose of computing future update

factors, the update factors for FY 90 are deemed to be those in effect beginning January 1, 1990.

Effective Date

- o Effective for discharges on or after January 1, 1990.

Reduction in DRG Weighting Factors for Fiscal Year 1990; Future Annual Recalibration of DRG Weights on Budget Neutral Basis (Section 6003(b))

Current Law

- o The Secretary is required to adjust DRG classifications and weighting factors each year beginning in FY 88 to reflect changes in treatment patterns, technology, and other factors.
- o The payment rate for each DRG consists of a base payment amount for all DRGs and a relative weighting factor for the particular DRG. The base payment represents the cost of an average Medicare inpatient case. The relative weighting factor represents the relative costliness of an average case in the particular DRG compared to cost of the overall average Medicare case.

Provision

- o Requires the Secretary to reduce the weighting factor for each DRG by 1.22 percent for discharges in FY 1990. Therefore, the net updates in the FY 90 PPS rates beginning January 1, 1990 are:

Large Urban Hospitals:	Market Basket - 1.10 percent
Rural Hospitals:	Market Basket + 3.00 percent
Other Urban Hospitals:	Market Basket - 1.75 percent

- o Prohibits the Secretary from adjusting the DRG weighting factors on other than a budget neutral basis effective FY 1991.
- o Requires the Secretary to include the recommended DRG weighting factor adjustments in the annual report to Congress on the initial estimates for PPS changes which is due no later than March 1 before the beginning of each fiscal year.

Effective Date

- o Reduction in weighting factor is effective for discharges on or after October 1, 1989.
- o Future budget neutral adjustments is effective for discharges on or after October 1, 1990.

Disproportionate Share Adjustments (Section 6003(c))

Current Law

- o PPS hospitals that serve a significantly disproportionate number of low-income patients receive increased payments.
- o The disproportionate patient percentage for individual hospitals is defined as the sum of the total number of inpatient days attributable to Medicare beneficiaries who receive Supplemental Security Income (SSI) benefits divided by the total number of Medicare patient days and the number of Medicaid patient days divided by the total patient days, multiplied by 100.
- o Hospitals that serve a disproportionate share of low income patients will receive increased payments until September 30, 1995. The rates are as follows:
 - Urban hospitals with 100 or more beds and over 30 percent of their revenues derived from State and local government payments for indigent care, excluding Medicare and Medicaid payments, receive a disproportionate share adjustment of 25 percent.
 - Urban hospitals with 100 or more beds or rural hospitals with 500 or more beds and a disproportionate patient percentage of at least 15 percent receive a payment adjustment of 2.5 percent, plus 50 percent of each 1.0 percent by which the hospital's disproportionate patient percentage exceeds 15 percent.
 - Urban hospitals with fewer than 100 beds and a disproportionate patient percentage of at least 40 percent receive a payment adjustment of 5 percent.
 - Rural hospitals with fewer than 500 beds and a disproportionate patient percentage of at least 45 percent receive a payment adjustment of 4 percent.

Provision

- o Revises the disproportionate share payment adjustments:
 - Urban hospitals with 100 or more beds and over 30 percent of their revenues derived from State and local government payments for indigent care, excluding Medicare and Medicaid payments, receive an adjustment of 30 percent.
 - Urban hospitals with 100 or more beds or rural hospitals with 500 or more beds and a disproportionate patient percentage greater than 20.2 receive an adjustment of 5.62

percent plus 65 percent of each 1.0 percent by which the hospital's disproportionate patient percentage exceeds 20.2 percent.

- Urban hospitals with 100 or more beds or rural hospitals with 500 or more beds and a disproportionate patient percentage less than 20.2 but at least 15 percent receive an adjustment of 2.5 percent plus 60 percent of each 1.0 percent by which the hospitals' disproportionate patient percentage exceeds 15 percent.
- Urban hospitals with fewer than 100 beds and a disproportionate patient percentage of at least 40 percent continue to receive an adjustment of 5 percent.
- Rural referral centers (RRCs) and sole community hospitals (SCHs) with a disproportionate patient percentage of at least 30 percent receive an adjustment of 10 percent, or 4 percent plus 60 percent of each 1.0 percent by which the hospital's disproportionate patient percentage exceeds 30 percent, whichever is greater.
- RRCs which are not SCHs with a disproportionate patient percentage of at least 30 percent, receive an adjustment 4 percent plus 60 percent of each 1.0 percent by which the hospital's disproportionate patient percentage exceeds 30 percent.
- Rural SCHs with a disproportionate patient percentage of at least 30 percent receive an adjustment of 10 percent.
- Rural hospitals with 100 or more beds which are not a RRCs or SCHs, and which have a disproportionate patient percentage of at least 30 percent receives an adjustment of 10 percent.
- Rural hospitals with fewer than 500 beds which are not RRCs or SCHs, and which have a disproportionate patient percentage of at least 45 percent continue to receive an adjustment of 4 percent.

Effective Date

- o Effective for discharges occurring on or after April 1, 1990.

Extension of Regional Referral Center Classification (Section 6003(d))

Current Law

- o The status of each hospital classified as a regional referral

center (RRC) must be reviewed every three years to determine if the hospital continues to meet the qualifying criteria.

- o A hospital must meet the RRC criteria in at least 2 of the last 3 years or for the current year to retain its RRC status.
- o OBRA 1986 allowed hospitals classified as RRCs on or after its October 21, 1986 enactment to retain that status for cost reporting periods beginning on or after October 1, 1986 and before October 1, 1989.

Provision

- o Extends RRC classification for all hospitals so designated as of September 30, 1989 for 3 years, from cost reporting periods October 1, 1989 through the October 1, 1992.

Effective Date

- o Effective for cost reporting periods beginning on or after October 1, 1989.

Criteria and Payment for Sole Community Hospitals (Section 6003(e))

Current Law

- o Hospitals can qualify sole community hospitals (SCHs) if they are the sole source of inpatient services reasonably available in a geographic area due to factors such as isolated location, weather conditions, travel conditions, or the absence of other hospitals, as determined by the Secretary.
- o SCH payments are a blended rate based on 75 percent of the hospital-specific rate and 25 percent of the Federal regional DRG rate.
- o A hospital that meets the SCH criteria, whether or not it elects to be paid as a SCH, may receive a payment adjustment to cover fixed costs if it experiences a decline in volume of 5 percent or more due to circumstances beyond its control for cost reporting periods beginning before October 1, 1990.
- o SCHs are eligible for a payment adjustment if operating costs increase significantly due to the addition of new inpatient facilities or services.

Provision

- o Requires the Secretary to develop new SCH criteria to determine if a hospital is the sole source of services reasonably

available in a geographic area based on the travel time required to reach the nearest alternative source of appropriate inpatient care.

- o Ratifies current regulation which designates a hospital to be a SCH if the hospital is located more than 35 road miles from another hospital.
- o Continues SCH classification for those SCHs that would not meet the new SCH criteria.
- o Allows SCHs to receive payment, for cost reporting periods beginning on or after April 1, 1990, based on the greater of the following:
 - 100 percent of the hospital-specific rate, based on FY 82 base year costs, with annual updates;
 - 100 percent of the hospital-specific rate, based on FY 87 base year costs, with annual updates; or
 - the Federal national PPS rate.
- o Makes permanent the payment adjustment for volume decreases.
- o Eliminates the compensation adjustment for experiencing a significant increase in operating costs due to the addition of new inpatient facilities or services.

Effective Date

- o Enactment, except those provisions which apply to cost reporting periods beginning on or after April 1, 1990.

Criteria and Payment for Medicare-Dependent, Small Rural Hospitals (Section 6003(f))

Current Law

- o No provision.

Provision

- o Defines "medicare-dependent, small rural hospital" as a hospital:
 - Located in a rural area;
 - With no more than 100 beds;
 - Not classified as a sole community hospital (SCH); and

- With at least 60 percent Medicare inpatient days or Medicare discharges during the cost reporting period beginning in FY 1987.
- o Establishes payment provisions for Medicare-dependent, small rural hospital similar to the new SCH payment provisions for cost reporting periods ending on or before March 31, 1993.
- o Provides Medicare-dependent, small rural hospitals with a payment adjustment to cover fixed costs if it experiences a decline in volume of 5 percent or more due to circumstances beyond its control.

Effective Date

- o Applies only to the cost reporting periods beginning April 1, 1990 and ending on or before March 31, 1993.

Essential Access Community Hospital Program (Section 6003(g))

Current Law

- o No provision.

Provision

- o Waiver Authority - Permits the Secretary to waive Medicare Part A provisions necessary to conduct the EACH program.
- o Grants - Requires the Secretary to:
 - Provide grants to not more than 7 States and to eligible hospitals and facilities or consortia of hospitals and facilities; and
 - Designate hospitals and facilities located in States receiving grants as essential access community hospitals (EACHs) or rural primary care hospitals (RPCCHs).
 - Requires that grants made to a hospital or facility may not exceed \$200,000.
- o State Eligibility - Provides that a State is eligible to receive a grant if it has:
 - Developed, or is in the process of developing, a State rural health care plan that:
 - + creates at least one State rural health network;
 - + promotes regionalization of rural health services;
 - + improves access to hospital and other health services for

- rural residents; and
 - + enhances the provision of emergency and other transportation services related to rural health care.
- Developed, or will develop, a health plan in consultation with the State's hospital association and rural hospitals.
- Designated, or is in the process of designating, rural non-profit or public hospitals or facilities as EACHs or RPCHs within the State rural health network.
- o Hospital/Facility Eligibility - Provides that a hospital or facility is eligible to receive a grant if it:
 - Is located in a State receiving a grant;
 - Is designated by the State as an EACH or RPCH, or is a member of the State rural health network;
 - Is designated as a RPCH by the Secretary even though it is not located in a State receiving a grant or designated as a RPCH by the State; and
 - Submits the proper application and supporting information to enable the Secretary and the State to certify that receipt of the grant is consistent with the State's rural health care plan.
- o Consortium Eligibility - Provides that a consortium is eligible to receive a grant if each of the hospitals or facilities is a member of the State rural health network and individually eligible to receive such a grant.
- o Grant Activities - Requires States to use the grants for demonstrations to plan and implement a rural health care plan and rural health networks, designate hospitals or facilities as EACHs and RPCHs, and develop and support communication and emergency transportation systems.

Hospitals, facilities, and consortia must use the grants to cover the costs (including capital and the costs of developing necessary communications systems and/or emergency transportation system) of converting to a RPCH or EACH, or participating in the State rural health network.

- o EACH Designation - Requires that a hospital designated as an EACH by the State must:
 - Be located in a rural area;
 - Be located more than 35 miles from any other EACH, rural referral center, or urban regional referral center, or meet

other geographic criteria imposed by the State with Secretarial approval.

- Have at least 75 inpatient beds or be located more than 35 miles from any other hospital;
 - Have an agreement to provide emergency and medical backup services to RPCHs participating in its rural health care network;
 - Have an agreement with each RPCH in its rural health network to accept transferred patients, to receive and transmit data, and to provide staff privileges to RPCHs physicians; and
 - Meet any other requirements imposed by the State with the approval of the Secretary.
- o RPCH Designation - Requires that a facility designated as a RPCH by the State must:
- Be located in a rural area;
 - Be actively participating in the Medicare program and not in violation of any Medicare requirements;
 - Cease providing inpatient care except as defined by this provision;
 - Agree, as a member of a rural health network, to participate in the network's communications and data sharing systems;
 - Provide 24-hour emergency care;
 - Have no more than 6 inpatient beds for care not to exceed 72 hours in order to stabilize the patient before discharge or transfer;
 - Meet rural hospital staffing requirements except:
 - + Does not need to meet standards regarding number of hours per day or days per week the facility must be open, except to the 24 emergency care requirement;
 - + May provide dietician, pharmacist, laboratory technician, medical technologist, and radiological technologist services on a part-time, off-site basis; and
 - + 72-hour observation inpatient care may be provided by a physician's assistant or nurse practitioner with the oversight of a physician.

- Meet the following requirements of a rural health clinic:
 - + Maintains clinical records on all patients;
 - + Establishes agreements with other hospitals for referral and admission of patients requiring inpatient services, diagnostic services, or specialized services not provided by the RPCH;
 - + Has written policies to govern the furnishing of services;
 - + Has a physician, physician assistant, or nurse practitioner responsible for execution of policies;
 - + Provides routine diagnostic services and clinical laboratory services and has prompt access to additional diagnostic services;
 - + Is capable of storing, administering, and dispensing drugs and biologicals determined necessary by the Secretary;
 - + Establishes procedures for utilization review of services;
 - + Agrees not to charge any individual eligible for Medicare for items or services, except for the required deductible or coinsurance amount; and
 - + Is not a rehabilitation agency or a mental disease treatment facility.

In designating RPCHs, States must give preference to hospitals participating in a rural health network. States are not prohibited from designating hospitals or facilities as RPCHs because they operate swing beds.

- o Secretarial Designation of EACHs and RPCHs -- Requires the Secretary to designate hospitals as EACHs and RPCHs if they are located in a State receiving an EACH grant and are designated as EACH and RPCHs by the State.
 - Permits the Secretary to designate a hospital as an EACH if it would have been so designated by the State except that the hospital has fewer than 75 beds or is within 35 miles of another hospital.
 - Permits the Secretary to designate a hospital as an RPCH if it would have been so designated except that it has not stopped providing inpatient care, has more than 6 inpatient beds, or does not meet rural staffing requirements.

- Permits the Secretary to designate up to 15 facilities as RPCHs in States which do not participate in the EACH program or are not designated as RPCH by the State, as long as they are located in rural areas, are not in violation of any Medicare requirements, and provide 24-hour emergency care.

o Rural Health Network - Defines a "rural health network" as consisting of:

- At least one hospital designated as an EACH which is a rural referral center or an urban regional referral center; and
- At least one facility designated as a RPCH.

The members of the network must have agreements regarding patient referral and transfer, the development and use of communication systems for sharing patient data, and the provision of emergency and non-emergency transportation.

o EACH Payment - EACHs are treated as a sole community hospital for payment purposes. If an EACH's reasonable costs during a cost reporting period increases as a result of becoming part of the State rural health network and, as a result, increases costs for subsequent cost reporting periods, the Secretary can increase the hospital-specific amount.

o RPCH Payment - Provides inpatient RPCH services are covered only when certified by a physician as immediately required on a temporary, inpatient basis. RPCHs are paid the per diem reasonable costs, updated after the first 12-month cost reporting period of operation by the annual PPS update factor for rural hospitals.

Requires the Secretary to develop a prospective payment system for inpatient RPCH services furnished on or after January 1, 1993.

o Duplication of Payment - The Secretary must reduce payment amounts to hospitals and RPCHs participating in the EACH demonstration program to the extent necessary to avoid duplication of any payment made under demonstration grants or the transition grant program.

o Funding Authorization - Authorizes appropriations from the Federal Hospital Insurance Trust Fund for FYs 90, 91, and 92, of \$10 million each year for grants to States and \$15 million each year for grants to hospitals, facilities, and consortia.

o Rural Health Transition Grants - Amends the Rural Health care Transition Grant Program as follows:

- Grants may be used to provide instruction and consultation

via telecommunications to physicians in class 1 or class 2 health manpower shortage areas;

- Applications are to be made to the Administrator versus the Governor;
- Extends grants to three years at \$50,000 a year.
- Grants can be used to develop a plan for converting to an RPCH or to develop a rural health network.
- Revises fund amounts authorized to be appropriated from the Federal Hospital Trust Fund for FYs 90, 91, and 92 to \$25 million.

Effective Date

- o Enactment.

Geographic Classification of Hospitals (Section 6003(h))

Current Law

- o Hospital located outside a Metropolitan Statistical Area (MSA) are classified as rural hospitals.
- o The Secretary must treat a hospital located in a rural county adjacent to one or more urban areas as being located in the urban MSA in which the greatest number of workers in the community commute if the:
 - Rural county would otherwise be considered part of an urban area except that the rural county does not meet the standard relating to commuting rates, and
 - Rural residents who commute to the central country or counties of all adjacent MSAs constitute 15 percent of the number of employed rural residents, or
 - The sum of rural residents who commute to the central country or counties of adjacent urban areas plus the residents of those adjacent urban areas who commute to the rural county must be at least 20 percent of the number of employed rural residents.
- o The Secretary must apply a separate wage index to hospitals located in urban areas, excluding the reclassified hospital, if inclusion of the reclassified hospital reduces the wage index for that urban area.
- o The Secretary must maintain a rural area's wage index, if reclassifying hospitals located in rural counties reduces the

wage index for that rural area.

- o Adjustments apply only for discharges in FY 1990 and 1991.
- o The Secretary must make proportional adjustments in urban hospital payment rates to assure that these provisions do not result in either higher or lower aggregate PPS payments.
- o The Secretary must adjust payment rates for rural hospitals to ensure that aggregate payments to rural hospitals are not changed by the provisions.

Provision

- o Board - Establishes the Medicare Geographic Classification Board to review hospital applications requesting geographic reclassification for determining the hospital's average standardized rate, or requesting a change in the applicable wage index.
 - The Board must be appointed within 180 of enactment and will consist of five members appointed by the Secretary: 2 rural hospital representatives, 1 ProPAC member, and at least 1 member knowledgeable in analyzing the costs of inpatient hospital services.
 - Provides the Board with full power and authority to make rules and establish procedures as needed.
 - Authorizes the Board to engage technical assistance and receive necessary information; requires that the Secretary provide the Board with the needed secretarial, clerical, and other assistance.
 - Provides that the Board members be compensated for each day of duty as a GS-18 and be reimbursed for travel expenses.
- o Reclassification - Requires that reclassification applications for a fiscal year must be submitted by the hospital no later than the first day of its preceding fiscal year, and the Board must render its decisions no later than 180 days thereafter.

The decision of the Board is final unless the unsuccessful applicant appeals to the Secretary within 15 days. The Secretary will receive no new evidence, and must issue a decision, which is not subject to judicial review, within 90 days.

- o Guidelines - Requires the Secretary to publish by July 1, 1990 Board guidelines for:
 - Comparing wages taking into account occupational mix;

- Determining whether a county should be treated as part of a specific MSA;
 - Considering information provided by an applicant about the effects of the hospital's geographic classification on access to inpatient hospital services by Medicare beneficiaries; and
 - Considering the appropriateness of the New England County Metropolitan Areas criteria.
- o Effect of Reclassification on the Wage Index - If reclassifying a hospital located in a rural county as being located in an urban area reduces the urban wage index:
- By one percentage point or less, the reclassified hospital would be excluded from the wage index calculation; or
 - By more than one percentage point, separate wage indices would apply to the urban hospitals (excluding the reclassified hospital) and to the rural hospitals (as if they were located in a separate urban county).

If reclassifying a rural county to an urban area or an urban county from one urban area to another urban area reduces the urban wage index:

- By one percent or less, the reclassified county would be excluded from the wage index calculation; or
- By more than one percent, separate wage indices would apply to the hospitals in the urban county (excluding the reclassified hospitals) and to the hospitals in the reclassified county.

If reclassifying hospitals located in a rural county reduces the rural wage index, the rural wage index would be calculated as if the hospitals had not been excluded from the rural area.

Reclassification decisions of the Board or Secretary cannot result in the reduction of any county's wage index to a level below the State wage index for rural areas.

- o Additional Payments - Requires the Secretary to make additional payments to hospitals affected by errors in the determination, adjustment, or computation of the area wage index, but only for discharges occurring before October 1, 1990. Hospitals are eligible for such payments if the:
- Error resulted from the submission of erroneous data (except if the hospital submitted erroneous data);

- Error was due to the 1984 survey of hospital wages and wage-related costs; and
- Correction of the error resulted in an adjustment to the area wage index of not less than three percent.
- o Wage Index Updates - Requires the Secretary to update the wage index survey by October 1, 1990 and October 1, 1993 and at least every 12 months thereafter. Any adjustments or updates made, beginning in FY 91, must be budget neutral.

Effective Date

- o Enactment, except the revision of rules for treatment of reclassified hospitals and the floor for area wage indices are effective for discharges occurring after April 1, 1990.

Legislative Proposal Eliminating Separate Average Standardized Amounts (Section 6003 (i))

Current Law

- o The Secretary is required to compute an average standardized amount for the U.S. and for each region.
- o Urban hospitals are defined as being located within a Metropolitan Statistical Area (MSA) or within a similar area as recognized by the Secretary. "Large urban" areas have populations of more than 1 million (based on Census Bureau estimates), "other urban" refer to all other urban areas.
- o Rural hospitals are defined as being located in an area outside an MSA or similar area.

Provision

- o Requires the Secretary to submit a legislative proposal and an impact analysis to Congress and ProPAC by October 1, 1990 regarding:
 - Elimination of the separate standardized amounts under PPS for large urban, other urban, and rural areas;
 - Phasing-in of a single rate in all areas beginning in FY 92 and completed in FY 95;
 - Modification, maintenance, or creation of additional payments or adjustments for teaching hospital, rural referral centers, sole community hospitals, disproportionate share hospitals, and outlier cases;

- Recalculation of standardized amounts to reflect more recent cost reporting periods;
 - Modification of reimbursement, where appropriate, to PPS-exempt hospitals; and
 - Methodology which reflects severity of illness of patients within the same DRG.
- o Requires ProPAC and the Congressional Budget Office to submit a report to Congress by February 1, 1991, evaluating the legislative proposal and potential impact.

Effective Date

- o Enactment.

ProPAC Study of Payments to Rural Sole Community Hospitals and Small Rural Hospitals (Section 6003 (j))

Current Law

- o No provision.

Provision

- o Requires ProPAC to study and report to by Congress May 1, 1990 on:
 - Using a cost-based system to pay small, rural hospitals and sole community hospitals for inpatient operating costs;
 - Developing and applying alternative definitions of market share for determining sole community hospitals status; and
 - Developing and applying a payment method to account for decreases in admissions and its impact on payment and operating costs for small, rural hospitals.

Effective Date

- o Enactment.

PPS-Exempt Hospitals (Section 6004)

Current Law

- o Exceptions or adjustments in PPS are provided for hospitals extensively involved in cancer treatment and research, as defined by regulation.

- o Cancer hospitals can elect to be reimbursed either on a reasonable cost basis or as a PPS hospital.
- o Cancer hospitals electing to be reimbursed on a reasonable cost basis must be treated similarly to PPS hospitals in terms of periodic interim payments (PIP) and capital-related payments.
- o PPS-exempt hospitals are reimbursed using target amounts defined as the hospital's base-year costs inflated by a rate of increase limit. Hospitals below the target amount receive a bonus. Current base year for determining target amounts is cost reporting periods beginning in FY 1982.
- o Exceptions and adjustments to hospital target rate can be made if events beyond the hospital's control distort the base year costs or annual cost increases.

Provision

- o Exempts from PPS those hospitals classified on or before December 31, 1990 as extensively involved in cancer treatment and research (extended deadline date was written specifically for the Ohio State University Hospital).
- o Exempts from PPS any hospital classified as a cancer hospital on or before December 31, 1991 in a PPS waiver state (written specifically for Johns Hopkins Hospital)
- o Applies to cost reporting periods beginning on or after October 1, 1989, except for hospitals classified as cancer hospitals after the date of enactment, in which case the effective cost reporting periods are those beginning on or after the date of classification.
- o Provides that PIP eligibility determinations take effect 30 days after enactment.
- o Eliminates the reduction in capital-related costs for inpatient services for hospitals classified as cancer hospital before or on enactment for portions of cost reporting periods during or after October 1, 1986.
- o Amends the base year for determining target rates for cancer hospitals, in cost reporting periods beginning on or after April 1, 1989, to whichever target amount is higher, cost reporting period beginning in FY 87 or FY 82 with updates.

Effective Date

- o Applies to cost reporting periods beginning on or after October 1, 1989 for hospitals classified before enactment. Applies to cost reporting periods beginning on or after classification for

hospitals classified after enactment. For hospitals classified before enactment, capital reductions are eliminated as of FY 87. Determinations for PIP eligibility are effective 30 days after enactment.

Payments for Hospice Care (Section 6005)

Current Law

- o Payment rates for the four levels of hospice care are:

Routine home care	\$ 63.17
Continuous home care	368.67
Inpatient respite care	65.33
General inpatient care	281.00

- o The attending physician and hospice medical director must certify a beneficiary as terminally ill within two days of initiation of hospice care.

Provision

- o Increases rates in FY 1990 by 20 percent and, in subsequent fiscal years, by the hospital market basket rate of increase.
- o Extends period by which physician certification must be provided to no later than eight days after hospice care is initiated, if verbal certification is provided within two days.

Effective Date

- o Applies to services furnished on or after January 1, 1990.

Subpart B -- Technical and Miscellaneous Provisions

Pass Through Payment for Hemophilia Inpatients (Section 6011)

Current Law

- o The costs of approved educational activities and capital are excluded from PPS and are "passed-through" PPS and paid on a cost basis.

Provision

- o Establishes a PPS pass-through payment to hospitals for the cost of administering blood clotting factors to individuals with hemophilia.

- o The Secretary will determine a payment amount by multiplying a predetermined price per unit of blood clotting factor (in consultation with ProPAC) by the number of units provided to an individual.
- o ProPAC and HCFA are required to develop recommendations for the clotting factor payment amount, to be submitted to the Congress not later than 18 months after enactment.

Effective Date

- o Effective for services provided 6 months after enactment, expiring 2 years after enactment.

Medicare Buy-In for Continued Benefits for Disabled Individuals (Section 6012)

Current Law

- o No provision for buy-in. Social Security Disability Insurance (SSDI) beneficiaries who return to work, but remain medically disabled, lose cash benefits after a 12 month period. Medicare benefits cease after an additional 36 month period of extended benefits expires.

Provision

- o Gives disabled beneficiaries under the age of 65 the option of purchasing Medicare coverage after they have worked a full 48 months and exhausted their extended periods of Medicare eligibility if they:
 - continue to be disabled or impaired under conditions which established eligibility, or are blind, and
 - lose their eligibility for benefits due to earnings in excess of the amount permitted, and
 - are not otherwise entitled to benefits,
- o Requires that each individual be provided an initial 7 month enrollment period, which begins following notification that entitlement to current benefits will terminate. After January 1, 1990, an individual may also enroll annually during a general enrollment period, from January 1 to March 31.
- o Makes the Medicare "coverage period" effective when the individual becomes eligible or when enrollment takes place, whichever option is the latest. Options include:
 - if the individual enrolls before the month in which the

individual first becomes eligible, coverage begins the first month the individual is eligible.

- if the individual enrolls during the month he becomes eligible, coverage begins the first day of the next month after the individual enrolls.
 - if the individual enrolls in the month after eligibility, coverage begins the first day of the second month after enrollment.
 - if the individual enrolls more than one month after eligibility, coverage begins the first day of the third month following enrollment.
 - if the individual enrolls during the general enrollment period, coverage begins the July 1 following enrollment.
- o The coverage period continues until enrollment is terminated under the following conditions:
- one month after the Secretary informs the individual that eligibility conditions are not being met.
 - one month after the individual elects to terminate enrollment.
 - as of the month before eligibility for hospital insurance benefits under Medicare.
 - when individual ceases to pay premiums.
- o The 90-day grace period provided before termination of benefits for non-payment may be extended to 180 days for those cases where the Secretary determines there was good cause for failure to pay the overdue premiums within the 90-day grace period. Termination of coverage under this section will result in the simultaneous termination of any coverage affected under any other part of this title.
- o The Secretary will develop regulations governing payment of the premium, which shall be deposited in the Treasury to the credit of the Federal Hospital Insurance Trust Fund.
- The premium will be payable beginning with the first month of an individual's coverage period, and ending with the month in which the individual dies, or in which coverage is terminated.
- o Section 1837 (h) of the Social Security Act which applies to fraud or misrepresentation regarding enrollment eligibility and section 1837 (i) which describes alternative enrollment periods

for individuals who delay enrollment due to current enrollment in private insurance coverage apply to the above stated eligibility and termination requirements.

Effective Date

- o Enactment, except that no coverage shall be provided for any month prior to July, 1990.

Buy-in Under Part A for Qualified Medicare Beneficiaries (Section 6013)

Current Law

- o Under a buy-in agreement States could pay Medicare Part B premiums for Medicaid eligibles also eligible for Medicare. Prior to OBRA 86, federal matching funds for buy-in of Part B premiums were available only for cash-assistance recipients.
- o OBRA 86 permitted States to cover the cost of Part B premiums for Medicare Part B beneficiaries not otherwise eligible for Medicaid (at States option).
- o The Medicare Catastrophic Care Act of 1988 (MCCA) provisions expanded the buy-in option to a requirement for Qualified Medicare Beneficiaries (QMBs), which are those elderly and disabled individuals with income at or below a specified percentage of the poverty line. States can phase-in their coverage of QMB's between January 1, 1989 and January 1, 1993 until all individuals at or below 100 percent of the poverty line are covered.

Provision

- o Expands coverage for QMBs by permitting States to pay the costs of premiums, cost sharing and coinsurance for option to Medicare Part A in the same manner as they do for Part B.

Effective Date

- o January 1, 1990.

PropAC Study on Medicare Dependent Hospitals (Section 6014)

Current Law

- o No provision.

Provision

- o As part of its report to Congress, the Prospective Payment Assessment Commission is required to include a study of the appropriateness of an adjustment to the methodology for determining the PPS payments to hospitals with a high proportion of Medicare discharges.
- o Provides that the report to Congress is due no later than June 1, 1990.

Effective Date

- o Enactment

Provisions Relating to Target Amount Adjustments (Section 6015)

Current Law

- o TEFRA 1982 established a ceiling on the allowable rate of increase for hospital inpatient operating costs. This ceiling still applies to PPS-exempt hospitals which include: psychiatric, rehabilitation, children's long term care hospitals and psychiatric and rehabilitation distinct part units of acute care hospitals.
- o The PPS-exempt hospitals and units receive payment for the inpatient hospital services they furnish on the basis of reasonable cost up to a ceiling.
- o Under the rate of increase limits, an annual target amount (inpatient operating cost per discharge) is set for each hospital, based on the hospital's own cost experience in its base year. This target amount is applied as a ceiling on the allowable costs per discharge for the hospital's next cost reporting period.
- o Currently, a hospital that has inpatient operating costs per discharge in excess of its target amount would be paid no more than that amount. However, if the operating costs are less than its target amount, the costs would be paid on top of an additional percentage amount.
- o Each hospital's target amount is adjusted annually before the beginning of its cost reporting period.

Provision

- o Requires that the Secretary determine a hospital's target amount using a new base year that is determined to be more representative of inpatient service costs.

- o Requires the Secretary to publish instructions within 180 days after enactment specifying the application process to be used in providing exceptions and adjustments in target amounts for hospitals.

Effective Date

- o For cost reporting periods beginning on or after April 1, 1990.

Study of Methods to Compensate Hospices for High-Cost Care (Section 6016)

Current Law

- o No Provision.

Provisions

- o Requires the Secretary to conduct a study of high-cost hospice care provided to Medicare beneficiaries and evaluate the ability of hospice programs to provide such care.
- o Based on the study, the Secretary must develop methods to compensate hospices for high-cost care provided to Medicare beneficiaries, and report on the study and any recommendations to Congress by April 1, 1991.

Effective Date

- o Enactment.

Prohibition on Nursing Home Balance Billing (Section 6017)

Current Law

- o A provider of services who has furnished items or services at the request of an individual can charge the individual for the balance of the payment due if such services or items are in excess of the amount of the set reimbursement rate.
- o A provider of services who customarily furnishes an individual items or services which are more expensive than the items or services determined to be necessary and which have not been requested by the individual, may also charge the individual or other person for costs in excess of the necessary payment for the efficient delivery of needed health services if:
 - the Secretary has provided notice to the public of any charges being imposed on individuals entitled to benefits under this title on account of costs in excess to the

necessary costs in the efficient delivery of needed health services by particular providers.

- the provider of services has identified such charges to the individual or other person, as charges to meet costs in excess of the cost determined to be necessary in the efficient delivery of needed health services.

Provision

- o Prohibits balance billing by nursing homes to Medicare patients except when the beneficiary requests extra items or services.

Effective Date

- o Enactment.

Hospital Anti-Dumping Provisions (Section 6018)

Current Law

- o Hospitals with emergency departments must comply with patient "anti-dumping" regulations, which requires them to examine and treat patients with emergency medical conditions and women in active labor who present themselves for treatment. A hospital is not allowed to transfer a patient until stabilized.
- o Hospitals must provide the appropriate medical records of examination and treatment to the receiving facility upon transferring a patient to another facility.
- o A Medicare hospital is not required to participate in Medicaid, nor is it required to inform its patients of non-participation.

Provision

- o Requires hospitals and rural primary care hospitals with emergency departments to:
 - implement a policy to ensure compliance with Medicare "anti-dumping" requirements,
 - maintain records of patients transferred to or from the hospital for five years from date of the transfer, and
 - maintain a list of physicians who are on call for duty after the initial examination to provide any treatment necessary to stabilize a patient with an emergency medical condition.
- o Requires Medicare participating hospitals to post conspicuously

a sign in their emergency department specifying the rights of individuals, including women in labor, to receive emergency medical treatment.

- o Requires hospitals to also post conspicuously a sign in their emergency department stating whether or not it participates in Medicaid.

Effective Date

- o July 1, 1990, whether or not regulations have been promulgated by this date.

Release and Use of Hospital Accreditation Surveys (Section 6019)

Current Law

- o A hospital is deemed to meet requirements for participation in Medicare if it is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). HCFA performs validation surveys of JCAHO approved hospitals on a sample basis or if allegations of quality problems are made at a specific hospital.
- o Only if a hospital is the subject of a validation survey by HCFA, must it agree to authorize JCAHO to release a copy of the most current accreditation survey in order to meet deeming requirements.
- o The Secretary may not disclose any accreditation survey released by JCAHO.
- o A hospital may lose its deemed status and be removed from the Medicare program if the Secretary finds that a hospital has serious deficiencies in quality or safety following a validation survey.

Provision

- o A hospital is deemed to meet requirements for participation in Medicare on the basis of JCAHO accreditation and only if it authorizes the JCAHO to release the most current accreditation survey and other relevant material to the Secretary.
- o Requires JCAHO to release such information to the Secretary regardless of whether the hospital is the subject of a validation survey.
- o Authorizes the Secretary to disclose surveys and related information that involves an enforcement action taken by the Secretary.

- o Permits the Secretary to determine, on the basis of information other than that derived from a validation survey, that a hospital does not meet participation requirements.

Effective Date

- o All provisions are effective upon enactment, except the provision relating to JCAHO release of information applies six months after enactment (i.e. June 19, 1990).

Intermediate Sanctions for Psychiatric Hospitals (Section 6020)

Current Law

- o No Provision.

Provision

- o Requires the Secretary to terminate a psychiatric hospital's Medicare agreement if the hospital fails to meet the requirements for Medicare participation and the deficiencies immediately jeopardize the health and safety of its patients.
- o Permits the Secretary to terminate the hospital's Medicare agreement, deny payments for patients admitted after the effective date of the finding, or both, if a psychiatric hospital is found to have deficiencies which do not jeopardize the immediate health and safety of the patients,
 - A psychiatric hospital which continues non-compliance for three months after the initial finding of deficiencies will be denied Medicare payments for new admissions. If the non-compliance continues for six months, the Secretary must deny all Medicare payments until the hospital achieves compliance.

Effective Date

- o Enactment.

Eligibility of Merged or Consolidated Hospitals for Periodic Interim Payments (Section 6021)

Current Law

- o A PPS hospital may generally receive periodic interim payments (PIP) if:
 - the hospital had a disproportionate share adjustment percentage of at least 5.1 percent during FY 87 or

- the hospital is classified as rural with less than 100 beds and is receiving PIP as of June 30, 1987.

Provision

Expands current law to include:

- o A hospital created by a merger or consolidation of two or more hospitals or hospital campuses shall be eligible to receive PIP if:
 - at least one of the hospitals or campuses received PIP prior to the merger or consolidation or
 - the merging or consolidating hospitals or campuses would each meet the requirement of having a disproportionate share adjustment of at least 5.1 percent during FY 87 if treated as independent hospitals.

Effective Date

- o Applies to payments made for discharges occurring on or after October 1, 1989 regardless of the date the merger or consolidation took place.

Extension of Waiver for Finger Lakes Area Hospital Corporation (Section 6022)

Current Law

- o Payment to hospitals may be made in accordance with a State hospital reimbursement control system rather than under the Medicare PPS.
- o The Secretary may continue use of the State system at the State's request if the rate of increase in payment does not exceed the increase in payments under the national system.
- o Maryland and New York have such waivers (New York waiver only covers four counties participating in the Finger Lakes Area Hospitals Corporation Rural Hospital Payment Demonstration).

Provision

- o Requires the Secretary's test of the effectiveness of a State cost containment system to be based on the aggregate rate of increase from October 1, 1984 to the most recent date for which annual data are available.

Effective Date

- o Enactment.

Clarification of Continuation of August 1987 Hospital Bad Debt Recognition Policy (Section 6023)

Current Law

- o Medicare pays hospitals for Medicare bad debt (defined as unrecovered costs associated with unpaid Medicare deductible and coinsurance). The bad debt must be related to covered services furnished to a Medicare beneficiary in order to be considered bad debt and the hospital is required to meet certain collection criteria.
- o OBRA 87 directed the Secretary to continue payments for Medicare bad debt under policy in effect as of August 1, 1987.
- o The Technical and Miscellaneous Revenue Act of 1988 specified that criteria for indigency determination procedures, for record keeping and, for determining whether to refer a claim to an external collection agency were not subject to any policy changes.

Provision

- o Prohibits the Secretary from requiring a hospital to change its bad debt collection policy if a fiscal intermediary, in accordance with the Technical and Miscellaneous Revenue Act of 1988 provisions explained above and has accepted this policy as of August 1, 1987. For such facilities, the Secretary may not collect from the hospital on the basis of an expectation of a change in the hospital's collection policy.

Effective Date

- o Takes effect as if included in the enactment of OBRA 87.

Use of More Recent Data Regarding Routine Service Costs of Skilled Nursing Facilities (Section 6024)

Current Law

- o The Secretary sets limits on Skilled Nursing Facility (SNF) routine service costs that will be recognized as reasonable and reimbursed under the program.
- o The current schedule of Medicare cost limits for SNFs is based on cost reports submitted by SNFs for cost reporting periods ending between October 1, 1982 and September 30, 1983.

Provision

- o Requires that cost limits be determined by using cost reports

submitted by SNFs for cost reporting periods beginning not earlier than October 1, 1985.

Effective Date

- o Effective for cost reporting periods beginning on or after October 1, 1989.

Permitting Dentist to Serve as Hospital Medical Director (Section 6025)

Current Law

- o As a Medicare condition of participation for hospitals, the responsibility for organization and conduct of the medical staff can be assigned only to a doctor of medicine or osteopathy.

Provision

- o If State law permits a doctor of dental surgery or dental medicine to serve as the medical staff director of a hospital, the hospital will be considered to meet Medicare requirements for medical staff director.

Effective Date

- o Enactment.

GAO Study of Hospital-Based and Freestanding Skilled Nursing Facilities (Section 6026)

Current Law

- o No provision.

Provision

- o Requires the Comptroller General to conduct a study to assess the differences in costs and case-mix between hospital-based and freestanding skilled nursing facilities (SNFs) participating in the Medicare program.
 - Report to be submitted to the House Committee on Ways and Means and the Senate Committee on Finance.
 - Report must include recommendations concerning the payment differential between hospital-based and freestanding SNFs.
 - Report is due June 1, 1990.

Effective Date

- o Enactment.

Massachusetts Medicare Repayment (Section 6027)

Current Law

- o Massachusetts operated a State-wide hospital demonstration project from October 1, 1982 until June 30, 1986. The demonstration was required to ensure that Medicare expenditures under the demonstration were not greater than they would have been under Medicare's payment rules. The Secretary determined that overpayments were made under the Massachusetts demonstration, but OBRA 87 prohibited the Secretary from recovering overpayments resulting from the statewide hospital reimbursement demonstration.

Provision

- o Further prohibits the recovery of overpayments and accrual of interest on the overpayments until May 1, 1990.

Effective Date

- o Enactment.

Allowing Certifications and Recertifications By Nurse Practitioners and Clinical Nurse Specialists for Certain Services (Section 6028)

Current Law

- o A physician must certify (or recertify in the case where care is provided over a period of time) that an individual needs daily skilled nursing care or other skilled rehabilitation services that can only be provided in a skilled nursing facility, in order for Medicare to provide payment for services.

Provision

- o Allows a nurse practitioner or clinical nurse specialist, who does not have a direct or indirect employment relationship with the SNF but who is working in collaboration with a physician, to certify or recertify a patient's need for SNF care.

Effective Date

- o Enactment.

Part 2 -- Provisions Relating to Part B

Subpart A -- General Provisions

Extension of Reductions Under Sequester Order (Section 6101)

Current Law

- o On October 16, 1989, the President issued a final sequester order pursuant to the requirements of the Balanced Budget and Emergency Deficit Control Act of 1985 (amended by the Balanced Budget and Emergency Deficit Control Act of 1987). Under the terms of the sequester order, Medicare benefit payment for part B services rendered on or after October 17, 1989, are reduced by 2.092 percent.

Provision

- o Continues payment reductions required by the Sequestration Order for all part B services until March 31, 1990.

Effective Date

- o Enactment.

Physician Payment Reform (Section 6102)

Current Law

- o Fee Schedule - Medicare pays for physician services on a fee-for-service basis using the "customary, prevailing, and reasonable charge" (CPR) system. Medicare pays the lowest of the physician's customary charge (defined as the 50th percentile of all the physician's charges during the past year for a particular service), the prevailing charge (defined as the 75th percentile of all physicians' customary charges for that service in the area), or the actual bill.
- o Radiology - For certain radiological services furnished on or after January 1, 1989, payment was to be 80 percent of the lesser of the actual charge for the service or the amount under a new radiologist fee schedule. This fee schedule was based on a relative value scale.
- o Anesthesiology Services - Anesthesia services are paid on the basis of a reasonable charge that is determined by multiplying a reasonable charge conversion factor by the sum of allowable base and time units.

Provision

- o Payment Based on a Fee Schedule - Medicare payment for physicians' services furnished on or after January 1, 1992 will be based on the lesser of the actual charge for the service, or a fee schedule amount.
- o Transition to a Full Fee Schedule - 1992: For services provided in an area whose weighted average prevailing charge in 1991 (or, in the case of radiology services provided by a physician, the radiology fee schedule amount currently in place) is less than 85 percent of the fee schedule amount for services furnished in 1992, the Medicare payment amount will be the weighted average prevailing charge plus 15 percent of the fee schedule amount. For services provided in an area whose weighted average prevailing charge is more than 115 percent of the fee schedule amount, the Medicare payment amount will be the weighted average prevailing charge minus 15 percent of the fee schedule amount.

1993, 1994, 1995: If a physicians' service is subject to the above transition rule during 1992, then special rules apply for 1993, 1994, and 1995. In 1993, the payment amount will be 75 percent of the amount described above plus 25 percent of the fee schedule amount. In 1994, the payment amount is 67 percent of the amount described above plus 33 percent of the fee schedule amount. In 1995, the payment amount will be 50 percent of the amount described above plus 50 percent of the fee schedule amount. In 1996, fee schedules will be fully implemented.

- o Radiology and Anesthesia Services - The relative values already established for radiology and anesthesiology services will be used to establish Medicare payment. The Secretary is required to ensure that the relative values for radiology and anesthesiology services are consistent with the relative values for similar services under the new fee schedule, and that a geographic adjustment is applied. PPRC and physician groups must be consulted in carrying out this provision.
- o Establishment of Fee Schedules - Fee schedules for physicians' services must be established by regulation before January 1 of each year beginning in 1992. The payment amount for a physicians' service will be the product of the:
 - Relative value of the service;
 - Monetary conversion factor; and,
 - Geographic adjustment factor.
- o Determination of Relative Values for Physicians' Services - There are three components of the relative value of a service: work, practice expense, and malpractice expense. The Secretary

is required to develop a methodology for combining these three components to determine the relative value of each service. To determine the relative value of services for which no specific data are available, the Secretary may extrapolate from available data.

"Work" is the time and intensity required to furnish the service. The work component includes related services performed before and after direct patient contact (such as making notes in the medical record), and, in the case of surgical services, also includes pre- and post-operative physician services.

"Practice expenses" are all expenses associated with the upkeep of physicians' practices including office rent and wages of personnel, but excluding malpractice expenses, and physicians' salary and fringe benefits.

"Malpractice expenses" is the portion of the resources required to perform a service which is attributable to physicians' malpractice expenses.

- o Periodic Review and Adjustments in Relative Values - Not less than every five years, the relative values must be reviewed and adjusted where appropriate. The adjustments cannot cause an increase or decrease of more than \$20 million in total expenditures, and can be accomplished only after consultation with PPRC and physician groups.
- o Coding - A uniform procedure coding system must be established to code all physicians' services. A factor for the length of a physician visit or consultation (a time factor) can be included in the codes only after January 1, 1993, and following consultation with PPRC and physician groups.
- o Incentive for Participating Physicians - The participating physician program is preserved. For services performed on or after January 1, 1992, non-participating physicians will receive 95 percent of the fee schedule amount.
- o No Variation for Specialists - The relative values or monetary conversion factor (described below) can not vary based on the specialty of the physician performing the service.
- o Conversion Factor - During the last 15 days of October in each year beginning in 1991, the monetary conversion factor for the following year will be published.

For 1992, the conversion factor will be set so that total payments for the services included in the fee schedule will be budget neutral to total payments for those services in 1991. For 1993 and thereafter, the conversion factor will be the

conversion factor for the previous year, adjusted by an update.

- o Conversion Factor Update - Not later than April 15 of each year beginning in 1991, the recommended update in the conversion factor for the following year will be reported to Congress. The update may be different for different categories or groups or services.

The 1992 update will have a separate determination for surgical services, regarding their success in meeting the Medicare volume performance standard.

The recommendation must consider:

- The percentage change in the MEI (price increases);
- Changes in the volume or intensity of physicians' services;
- Access to physicians' services;
- Other factors which may contribute to changes in volume, intensity, or access; and,
- The success with which physicians meet the Medicare volume performance standard described below.

Other factors that may also be considered:

- Unexpected behavioral changes by physicians in response to the fee schedule;
- Changes in outlay projections;
- Changes in the quality or appropriateness of care; and,
- Any relevant factors which are not included in the payment methodology.

The update report to Congress must include a discussion of the:

- Update recommended for non-surgical services, visits, consultations, and emergency room services (and any other category of service the Secretary considers appropriate);
- Rationale for the update recommended for each category of service; and,
- Data and analysis underlying the recommended updates.

- o Default Update - If Congress fails to enact an update, the default update will be the MEI adjusted by physicians' success in meeting the volume performance standard rate of increase. However, the update cannot be lower than MEI-2.0 in 1992 and 1993, MEI-2.5 in 1994 and 1995, and MEI-3 in 1996 and thereafter.

- o Commission Review - PPRC will review the Secretary's report and update recommendation, and report to Congress its own

recommendation by May 15 of each year, beginning in 1991.

- o Geographic Adjustment to Fee Schedule Amounts - A geographic adjustment factor must be established for each of the fee schedule areas. The geographic adjustment factor will be the sum of:
 - An index which reflects the relative **practice costs** in each of the different fee schedule areas compared to the national average;
 - An index which reflects the relative costs of **malpractice expenses** in each of the different fee schedule areas compared to the national average; and,
 - An index which reflects 1/4 of the difference between the **relative value of physicians' work effort** in each of the fee schedule areas compared to the national average.

More than one index may be established for particular service types if applying only one index would be inequitable to physicians practicing in certain geographic areas.

- o Medicare Volume Performance Standard (MVPS) Rates of Increase - By April 15 of each year (beginning with 1990), recommended MVPS rates of increase for all physicians' services and for each category of services must be submitted to Congress. Physician organizations must be consulted and the following factors must be considered:
 - Inflation;
 - Changes in number of enrollees (other than HMO enrollees);
 - Aging of enrollees;
 - Changes in technology;
 - Evidence of inappropriate utilization of services;
 - Evidence of lack of access to necessary physician services; and,
 - Other appropriate factors.

PPRC must review the Secretary's recommendation and make its own recommendation to Congress no later than May 15 of the year.

If Congress does not act on the Secretary's recommendation, the MVPS rates of increase will be established through an automatic default mechanism. The MVPS must be published in the last 15 days of October of each fiscal year (beginning with 1990) the Medicare volume performance standard rates for the fiscal year beginning that year.

The default mechanism would consist of the sum of:

- The estimated adjusted historical payment for physicians' services for calendar years included in the fiscal year involved;
- The estimated percentage increase or decrease in the average number of Medicare enrollees (other than HMO) from the previous fiscal year to the fiscal year involved;
- The estimated average annual percentage growth in the volume and intensity of physician's services for the 5-fiscal-year period ending with the preceding fiscal year; and,
- The estimated percentage increase or decrease in expenditures for physician's services resulting from changes in law or regulations.

This sum is then reduced by a statutory performance standard adjustment factor. The factor is 1 percentage point for FY 1991, 1.5 percentage points for FY 1992, and 2 percentage points for each succeeding year.

Procedures must be established for providing quarterly information on compliance with the volume performance standard rates of increase to:

- The PPRC;
- The Congressional Budget Office;
- The Congressional Research Service;
- The Committees on Ways and Means and Energy and Commerce of the House of Representatives; and,
- The Committee on Finance of the Senate.

After October 1, 1991, a plan must be implemented whereby qualified physician groups could annually elect separate performance standard rates of increase other than that established for a year. Criteria and methods must be established to determine which physician groups can elect to have separate standards and how they will be developed. This information must be reported to Congress by April 15, 1991. The plan cannot be implemented unless specifically approved by Congress.

- o Limitation on Beneficiary Liability (Limits on Balance Billing) Maximum allowable actual charges (MAACs) are extended through December 31, 1990. The "limiting charge" for non-participating physicians is 25 percent above the fee schedule amount for services furnished in 1991, 20 percent above the fee schedule amount in 1992, and 15 percent above the fee schedule amount for 1993 and thereafter.

For services provided to Medicaid-eligible beneficiaries (including qualified Medicare beneficiaries) on or after April 1, 1990, Medicare payment will be made only on assignment.

- o Physician Submission of Claims - For services furnished on or after September 1, 1990, requires a physician or supplier to complete and submit a standard claim form (specified by the Secretary) for beneficiaries. No charge may be assessed for the submission of claims.

If a physician fails to complete and submit an assigned claim within one year of the date of service, the payment amount will be 10 percent less than it otherwise would have been.

- o Electronic Billing, Direct Deposit - Requires a system for the electronic submission of physician claims and direct deposit of Medicare payments. Requires that a plan be submitted to Congress by May 1, 1990 describing how this will be accomplished.
- o Monitoring of Charges - Requires monitoring the actual charges of non-participating physicians, and changes in the percent of claims paid on an assigned basis. If the percent of claims paid on assignment decreases, a plan must be developed to address the problem. Requires a report to Congress on these matters by April 15 of each year beginning in 1992. The PPRC will review the Secretary's report, and provide comments to Congress.
- o Monitoring of Utilization and Access - Requires monitoring the changes in utilization and access by geographic area and by service type. A report must be submitted to Congress by April 15 of each year beginning in 1991 on the factors which contributed to these changes, including recommendations for addressing patterns of inappropriate utilization or impediments to access. The PPRC will review the Secretary's report, and provide comments to Congress.
- o Physician Information - Requires information be sent to physicians (in conjunction with information regarding the participating physicians program) relating to the fee schedule amounts for services commonly performed by the physician, and the maximum amount the physician may charge for the service.

- o Miscellaneous Provisions

- There shall be no administrative or judicial review of the determination of the: historical payment basis, relative values and relative value units, conversion factors, geographic adjustment factors, and the establishment of the uniform coding system.

- **Definitions:**

- + **"Category" of service:** any group of services defined in regulation as a category. The definition of surgical services must be published in the Federal Register by May 1, 1990.
- + **"Fee schedule area":** the same carrier-wide localities currently in place for computing physician payments will be used for computing payment amounts for physicians' services under the fee schedules.
- + **"Physicians' services":** includes services and supplies furnished incident to a physician's professional service; outpatient physical therapy services and occupational therapy services; diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests (other than clinical laboratory tests); X-ray, radium, and radioactive isotope therapy, including materials and services of technicians; other services the Secretary may specify.
- + **"Practice expenses":** all expenses associated with providing physicians' services, except physician compensation and fringe benefits and malpractice expenses.
- **Carrier requirements to profile physicians:** Requires carriers to profile physicians' billing patterns within each locality, and provide physicians whose health care utilization patterns differ from other physicians in the same area with comparative information.
- **Rural and inner-city access adjustments:** Provides physicians in all health manpower shortage areas a 10 percent bonus payment on each service performed on or after January 1, 1991.

o **Studies**

- **HHS Studies:**

Payments to Risk-Contracting Plans: Requires a study of the fee schedule effect on Medicare payments to risk-contracting plans (HMOs), including recommendations for adjusting the payment methodology for such plans. Due April 1, 1990.

Volume Performance Standard Rates of Increase by Geography, Specialty, and Type of Service: Requires a study of the feasibility of establishing separate volume performance standards for different geographic areas, for different physician specialties, and for different types of service. Due July 1, 1990.

Visit Code Modification: Requires a study of including time as a factor in establishing physician visit codes. Due July 1, 1991.

- **PPRC Studies:**

Payment for Practice Expenses: Requires a study of the extent to which physicians' practice costs and malpractice costs vary by geographic area; the extent to which the practice cost indicators currently available accurately reflect practice costs and malpractice costs in rural areas; methods for incorporating a malpractice factor into the payment for individual physicians' services and the effect of different methods on Medicare physician expenditures by specialty, type of service, and geographic area; the special circumstances of rural independent labs in determining the geographic cost of practice index. Due July 1, 1991.

Geographic Payment Areas: Requires a study of the feasibility and desirability of using Metropolitan Statistical Areas (MSAs) or other possible payment areas for calculating Medicare physician payments. Due July 1, 1991.

Payment for Non-Physician Providers of Medicare Services: Requires a study of the implications of the fee schedule for non-physician services (including physician assistants, nurse midwives, clinical psychologists) whose services are billed under Medicare on a fee-for-service basis. The study must address payment levels and update, and whether these services should be subject to the MVPS. Due Jul 1, 1991.

Physician Fees Under Medicaid: Requires a study of the adequacy of Medicaid physician reimbursement, access to health services by Medicaid recipients, and physician participation in Medicaid. Due July 1, 1991.

- **GAO Studies:**

Alternative Payment Methodology for Malpractice Component: Requires a study of alternative ways of paying the malpractice component to ensure that Medicare pays its share of physicians' malpractice expenses. The report must include an examination of alternative dispute resolution, no-fault payment, and mandatory arbitration. Due April 1, 1991.

Physician Anti-trust Issues: Requires a study of the possible anti-trust issues involved in physicians acting in groups to affect the medical practice patterns of their peers. The study shall also address possible anti-trust issues involved in the adoption of medical practice guidelines by insurance companies. Due July 1, 1991.

**Establishment of Agency for Health Care Policy and Research
(Section 6103)**

Current Law

- o The Public Health Service (PHS) Act, through the National Center for Health Services Research (NCHSR), is authorized to:
 - Undertake research, evaluation, and demonstration projects related to the financing, organization, quality, and utilization of health care services;
 - Consult with the Council on Health Care Technology in order to research technology diffusion, methods to assess health care technology, and criteria for making technology coverage recommendations;
 - Coordinate research, evaluation, and demonstration projects authorized by the Social Security Act (SSA) with respect to rural health care services; and
 - Publish and disseminate research results as widely as practicable. NCHSR must cooperate and consult with National Institutes of Health (NIH), Food and Drug Administration (FDA), and other interested Federal departments or agencies.
 - Administer a patient outcome assessment research program in consultation with the Council on Health Care Technology.
- o NCHSR must also:
 - Establish peer review panels to review grant and cooperative agreement applications and to review research findings;
 - Disseminate findings as widely as possible, including to the PROs; and
 - Report findings to Congress no later than 18 months after enactment.
- o A research program was established to promote appropriateness, necessity, and effectiveness research of selected medical treatments and surgical procedures.
 - Any research grant or contract application exceeding \$50,000 is subject to peer review for evaluation of its technical and scientific merits.
 - Funds are authorized to be appropriated from the Medicare trust funds in order to carry out the outcomes research.

Provision

Agency for Health Care Policy and Research - General Duties

- o Establishes a new agency within the PHS, headed by an Administrator appointed by the Secretary.
- o Requires that the Agency and Administrator:
 - Conduct and support research, demonstration projects, evaluations, as well as, training, guideline development, and dissemination of information on health care services and delivery, including activities with respect to:
 - + effectiveness, efficiency, and quality;
 - + outcomes of services and procedures;
 - + clinical practice, including primary care and practice-oriented research;
 - + technologies, facilities, and equipment;
 - + costs, productivity, and market forces;
 - + statistics and epidemiology;
 - + medical liability;
 - + delivery of services in rural and frontier areas; and health of low-income groups, minority groups, and the elderly (for which multidisciplinary health centers may be funded)
 - Coordinate with other projects and related activities authorized by the SSA;
 - Promptly publish and broadly disseminate the research project results and data;
 - + The publication or dissemination of data resulting from these research projects cannot be restricted;
 - + Information which identifies an establishment or individual cannot be used for other purposes without consent of; and
 - + The effectiveness and timeliness of dissemination of information on research projects must be improved through an interagency agreement with National Library of Medicine to others engaged in the improvement of health care delivery;
 - + Technical assistance will be provided to State and local governments and health agencies to foster dissemination;
 - Promote the development and application of health care technology assessments;

- + An information center on technologies and technology assessment would be established through an interagency agreement with the National Library of Medicine;
- + In consultation with NIH and FDA, AHCPR must recommend whether specific technology should be reimbursable. The recommendations must consider the safety, efficacy, effectiveness and cost effectiveness of technologies.

Forum for Quality and Effectiveness in Health Care

- o Establishes the Forum within the Agency, headed by a Director who is appointed by the Administrator to develop, periodically review and update:
 - clinically relevant guidelines in order to improve prevention, diagnosis, treatment, and clinical management, and
 - quality standards, performance measures, and medical review criteria to assess the quality of health care.
- o Requires that the guidelines, standards, performance measures, and review criteria be
 - based on the best available research;
 - presented in formats for use by physicians, educators and consumers; and
 - treatment-specific or condition-specific for use in clinical practice, educational programs, and quality review programs.
- o Requires that an initial set of guidelines, standards, performance measures, and review criteria be developed no later than January 1, 1991 for 3 or more clinical treatments or conditions which account for a significant portion of Medicare expenditures; have significant variation in the utilization or type of treatment; or otherwise meet the needs and priorities of the Medicare program.
- o Requires the Director to contract with public and private, nonprofit entities to convene panels of experts to develop and update the guidelines, performance measures, and review criteria, using standards developed by the Director.
 - The panel members shall be broadly representative of interested organizations, including physician organizations.
 - The Director will establish standards to ensure that contracts will be awarded only to qualified entities.

Contract award standards and standards used by the expert panels must include a requirement for appropriate consultation

and allow for the adoption of guidelines, performance standards, and review criteria. Research will support the improvement of these standards.

- o Requires the Administrator to set the agenda for the development of the guidelines, standards, performance measures, and review criteria prioritized to:
 - Benefit significant number of individuals;
 - Reduce clinically significant practice variations; and
 - Reduce clinically significant outcome variations.
- o Requires the Director to promote dissemination of the guidelines, performance standards, and review criteria through health care provider, consumer, peer review, accrediting, and other organizations.
 - Pilot tests may be conducted prior to or concurrent with dissemination.
 - Evaluations are required of effect on clinical practice.
- o Requires the Director to make recommendations to the Administrator on evaluating outcomes, developing standards and criteria, and promote the use of guidelines.

Research on Outcomes of Health Care Services and Procedures

- o Requires the Administrator to conduct and support outcomes research, including research that meets Medicare's needs and priorities, which also evaluates the comparative effects of alternative procedures.
 - Requires the Secretary to:
 - + support research to improve outcome research methodologies and criteria;
 - + review existing research findings;
 - + review existing large data base methodologies;
 - + develop new research methodologies;
 - + provide grants and contracts for research, including research on the use of prescription drugs;
 - + conduct research and demonstrations on the use of claims data and data on clinical and functional status in determining outcomes;
 - + supplement existing and develop new data bases for research purposes, including specifying uniform data definitions, common reporting formats, and confidentiality standards.

- o Requires the Secretary to assure the development of guidelines for 3 clinical procedures by January 1, 1991, and provide for their use.
 - Authorizes Medicare Trust Fund expenditures of \$1 million in 1990 and \$1.5 million in 1991 and 1992; 60 percent from the HI Trust Fund and 40 percent from the SMI Trust Fund.
- o Requires the Secretary to establish research priorities which benefit a significant number of individuals, reduces the variation in treatment or outcomes, address procedures which result in substantial expenditures, and for which data can be readily available. To establish priorities, assessments can be made of:
 - The variation in utilization rates among similar populations, uncertainties of utilizing a particular service or procedure, or inappropriate utilization.
- o Requires the Secretary to provide for the dissemination of research findings and guidelines and for the education of providers in their use, including working with professional associations and medical specialty and subspecialty organizations to educate physicians, other providers, and consumers of the research findings.
 - Research will be conducted on how to improve information dissemination.
- o Requires the Secretary to evaluate the program to determine its impact on medical practices and their outcomes.

Advisory Council for Health Care Policy, Research, and Evaluation

- o Establishes a new advisory council within the PHS to advise the Secretary and Administrator on priorities for a national health care research agenda, especially activities designated to the Agency and Forum.
- o Provides that the Council be composed of:
 - 17 appointed representatives of the public, which include: 8 health care researchers; 3 individuals who practice medicine; 2 health professionals; 2 individuals in the fields of business, law, ethics, economics, and public policy; and 2 consumer representatives; and
 - Ex officio members including the NIH Director, Centers for Disease Control Director, Administrator of HCFA, the Assistant Secretary of Defense (Health Affairs), the Chief Medical Officer of the Department of Veterans Affairs (VA), and other Federal officials.

- o Requires that the appointed Council members serve 3-year, staggered terms and receive compensation for each day of duty not exceeding basic pay for a GS-18.
- o Requires that the Council meet at least every 4 months or at the call of the Administrator or Council chair.
- o Establishes a subcouncil, consisting of 8 appointed and all the ex officio Council members, to recommend priorities for developing, reviewing, and updating practice guidelines, quality standards, performance measures, and medical review criteria, and conducting outcomes research.

Peer Review Groups

- o Requires that the Administrator establish technical and scientific peer review groups to review each application for a grant, cooperative agreement, or contract for the research projects and report findings and recommendations to the Administrator.
 - Peer review groups must be established without regard to specified law provisions relating to Federal employees, should not include individuals who are officers or employees of the U.S., and should continue to exist unless otherwise provided by law.
 - The peer review groups who review applications with respect to research, demonstration projects, or evaluations must be different from those who review applications with respect to dissemination activities or the development of research agendas.
- o Prohibits the Administrator from approving an application unless the peer review group has recommended approval.
- o Allows the Administrator to make adjustments to the peer review procedures for applications not exceeding \$50,000 in order to encourage the entry of individuals into research and to encourage clinical practice-oriented research.

Reports to Congress

- o Requires the Secretary to determine the impact of the use of guidelines on the quality, appropriateness, effectiveness, and cost of medical care and report to Congress no later than January 1, 1993.
- o Requires that the Secretary report to Congress, no later than 1 year after enactment, the feasibility of linking the Department's research-related data with similar data collected or maintained by non-Federal entities and by other Federal agencies, including the VA, Department of Defense, and Office

of Personnel Management.

- o Requires the Secretary to report to Congress by February 1 of 1991 and 1992, and every other thereafter on the progress of the activities, including the impact on medical care.

Funding

- o Authorizes the following funding from the PHS:
 - \$35 million for FY 90,
 - \$50 million for FY 91, and
 - \$70 million for FY 92, as well as an additional 40 percent of the maximum amount authorized for evaluations.
- o Authorizes the following from Medicare Trust Funds to conduct the necessary research:
 - \$50 million for FY 90;
 - \$75 million for FY 91;
 - \$110 million for FY 92;
 - \$148 million for FY 93; and
 - \$185 million for FY 94.
- o Requires that two-thirds of the authorized funds for FYs 90 through 92, and 70 percent of the authorized funds for FYs 93 and 94 be appropriated from the Medicare trust funds in the following proportions: 60 percent from the HI trust fund and 40 percent from the SMI trust fund.
- o Requires the Secretary to allocate appropriate funds for:
 - Development of guidelines, standards, performance measures, and review criteria;
 - Research and evaluation;
 - Data-base standards and development; and
 - Education and information dissemination.
- o Authorizes \$55 million for FY 88 and the necessary sums for FY 89 and 90 to support the statistical and epidemiological activities.
- o Authorizes \$300,000 for the Secretary in order to contract with IOM to develop an information center.
- o Authorizes \$1 million for FY 90 and \$1.5 million for FYs 91 and FY 92 in order to conduct the impact study. The funds should be appropriated in the following proportions: 60 percent from the HI Trust Fund and 40 percent from the SMI Trust Fund.

Miscellaneous

- o Terminates NCHSR and Health Care Technology Assessment and the Council on Health Care Technology.

- o Allows the Agency to provide financial assistance to new or existing centers in order to meet the costs planning or establishing new centers or to meet the costs of operating existing centers, for conducting multidisciplinary research projects.
- o Requires that the Secretary reduce the financial assistance by an amount equal to the costs of detailing personnel and the fair market value of any supplies, equipment, or services provided.
- o Allows the Administrator to:
 - Appoint and fix the compensation of a deputy administrator, other officers, and employees as necessary.
 - Utilize personnel, equipment, facilities, and other physical resources of the Department or other Federal, State, local public agency, or foreign government with their consent.
 - Accept voluntary and uncompensated services.
- o Allows the Secretary, as the Administrator deems advisable, to secure the assistance and advice of not more than 50 experts and consultants.
- o Provides that the Departmental personnel currently employed in functions now designated to the Agency, as well as assets, property, contracts, liabilities, records, unexpended balances of appropriations, authorizations, allocations, and other funds shall be transferred to the Administrator for appropriate allocation.
- o Allows the Secretary to acquire the appropriate facilities as deemed necessary for use not to exceed 10 years.
- o Provides that all orders, rules, regulations, grants, contracts, certificates, license, privileges, and other determinations, actions or other official documents of the Department that have been issued, made, granted or allowed will continue in effect according to their terms unless changed by law.

Effective Date

- o Enactment.

Reduction in Payments for Certain Procedures (Section 6104)

Current Law

- o Reduction in Payment Amounts - The Omnibus Reconciliation Act of 1987 (OBRA 87) reduced prevailing charges for 13 "overpriced" procedures for the period April 1, 1988 through December 31, 1988. Overpriced procedures included: bronchoscopy, carpal tunnel repair, cataract surgery, coronary artery bypass surgery, diagnostic and/or therapeutic dilation and curettage, knee arthroscopy, knee arthroplasty, pacemaker implantation surgery, total hip replacement, suprapubic prostatectomy, transurethral resection of the prostate, and upper gastrointestinal endoscopy. These reduced payment amounts have been the basis for applying the MEI since then.
- o Limits on Actual Charges - For overpriced procedures, the limit on a physician's actual charge is 125 percent of the reduced prevailing charge.

Provision

- o Reduction in Payment Amounts - Makes reductions of up to 15 percent in the prevailing charge levels of 245 procedures which have been determined to be "overvalued". A procedure is considered "overvalued" if the national average prevailing charge exceeds what the estimated payment amount would be under a resource-based fee schedule by at least 10 percent. When performing the comparison, the estimated fee schedule amount is adjusted by a practice expense ratio for each service, a geographic practice cost index for the locality, and a practice expense ratio (as specified in the Joint Explanatory Statement).

The amount of the reduction equals one-third of the difference between the 1989 prevailing charge and the locally adjusted reduced prevailing charge amount, up to a maximum of 15 percent.

- o Limits on Actual Charges of Non-participating Physicians - For 1990, the limit is the midpoint of 125 percent of the reduced prevailing charge outlined above plus one half of the difference between the reduced prevailing charges and the actual charges in 1990. For 1991, the limit is 125 percent of the reduced prevailing charge.

Effective Date

- o For services furnished on or after April 1, 1990.

Reduction in Payments for Radiology Services (Section 6105)

Current Law

- o The Omnibus Budget Reconciliation Act of 1987 established a fee schedule for radiology services provided by board certified radiologists and other physicians who receive at least 50 percent of their Medicare payments for radiology services. The fee schedule was implemented for services provided on or after April 1, 1989. Medicare payments in 1989 were limited to 97 percent of the fee schedule amount.

Provision

- o Fee Schedules for Radiologist Services Reduced - For services performed on or after April 1, 1990, the conversion factors applied to the radiology fee schedules will be reduced to 96 percent of the conversion factors which applied on December 31, 1989.
- o Special Rule for Nuclear Medicine Physicians - Special rules apply in 1990 and 1991 for Medicare payments to nuclear medicine physicians. Nuclear medicine physicians are defined as those physicians for whom 80 percent of charges made under Part B are for nuclear medicine services.

1990: For services performed on or after April 1, 1990, the fee schedule amount will be based one third on the fee schedule amount already in place, and two thirds on 101 percent of the 1988 prevailing charge for the service.

1991: For services performed on or after January 1, 1991, the fee schedule amount will be based two thirds on the fee schedule amount already in place, and one third on 101 percent of the 1988 prevailing charge for the service.

- o Interventional Radiologists - The carrier instruction which allows split billing for interventional radiologist services performed in 1989 continues through 1990.

Effective Date

- o For services furnished on or after April 1, 1990.

Anesthesia Services (Section 6106)

Current Law

- o The Omnibus Budget Reconciliation Act of 1987 required the Secretary to establish a national relative value guide to be used beginning January 1, 1989. The final regulation was

published on August 7, 1990.

- o Medicare payments for anesthesiology services currently are based on relative value units. One of the components of the payment amount is the time required to perform the service. Generally, one "time unit" applies for each 15 minutes the procedure lasts for physicians, and one time unit applies for each 30 minutes the procedure lasts for certified registered nurse anesthetists.

Provision

- o The Secretary, in consultation with physician groups, shall establish, by regulation, a relative value guide for anesthesia services provided by a physician to be used in all carrier localities. (This provision is the codification of existing authority.)
- o In making Medicare payments for anesthesia services provided by either a physician or a certified registered nurse anesthetist, the actual time the procedure takes will be used, rather than the time rounded to the nearest 15 or 30 minutes.

Effective Date

- o For services furnished on or after April 1, 1990.

Delay in Update and Reduction in Percentage Increase in the Medicare Economic Index (Section 6107)

Current Law

- o Annual increases in prevailing charges for all physicians are limited by the Medicare Economic Index. The MEI reflects yearly increases in physician overhead costs and earnings levels. The Omnibus Budget Reconciliation Act of 1987 established the increase in the MEI for 1989 at 3 percent for primary care services, and 1 percent for all other physician services.

Provision

- o Delay in Update - Increases and/or adjustments in Medicare payments for Part B services will apply for services performed on or after April 1, 1990. For the period January 1, 1990 through March 31, 1990, payments for Part B services will be determined as they were on December 31, 1989.
- o Extension of Participating Physicians Agreements - Participation agreements in effect on December 31, 1989 will remain in effect through March 31, 1990, unless a physician or

supplier requests, by December 31, 1989, that the contract be terminated. Directories listing participating physicians will be published by the Secretary at the beginning of the new contract period beginning April 1, 1990.

Maximum allowable charge limits will be provided to non-participating physicians for the 9-month period beginning April 1, 1990.

- o Percentage Increase in the MEI for 1990 - For services provided on or after April 1, 1990, the percentage increase in the MEI is:
 - 0 percent for radiology services, anesthesia services, and overvalued procedures;
 - 4.2 percent (full MEI update) for primary care services; and,
 - 2 percent for other services.

Effective Date

- o For Part B services and supplies furnished on or after April 1, 1990.

Miscellaneous Provisions Relating to Payment for Physicians' Services (Section 6108)

Current Law

- o Customary Charge for New Physicians - The customary charge for new physicians is 80 percent of the prevailing charge.
- o Limitation on Amounts for Certain Services Furnished by More Than One Specialty - Many carriers have different prevailing charges for the same service when it is performed by physicians of different specialties.

Provision

- o Customary Charge for New Physicians - The customary charge for new physicians at 85 percent of the prevailing charge beginning for services performed on or after April 1, 1990.
- o Limitation on Amounts for Certain Services Furnished by More Than One Specialty (Designated Specialty) - Limits prevailing charges for certain high volume surgery, radiology, and diagnostic services designated by the Secretary to the prevailing charge of the "designated specialty". The designated specialty is that specialty which performs the procedure most often nationally.

Effective Date

- o For services performed on or after April 1, 1990.

**Waiver of Liability Limiting Recoupment in Certain Cases
(Section 6109)**

Current Law

- o No provision.

Provision

- o The Medicare carriers are prevented from recouping overpayments that were made from July 1, 1985 through March 31, 1986 as a result of implementing a national common procedure coding system furnished in cases where the claim was reopened by the carrier on or after July 31, 1987.

Effective Date

- o Enactment.

**Reduction in Capital Payments for Outpatient Hospital Services
(Section 6110)**

Current Law

- o Hospitals' capital-related costs are paid according to reasonable cost principles.
- o OBRA 87 applied a 15 percent reduction to capital payments for inpatient hospital services, but the reduction was not applied to hospital outpatient services.
- o In regards to payments for services in hospital outpatient departments, OBRA 86 required the Secretary to submit an interim report to Congress by April 1, 1988 on the development of a fully prospective payment system for ambulatory surgery with a final report due the following year. OBRA 87 modified this provision by directing the Secretary to consult with the Prospective Payment Assessment Commission (ProPAC) in preparing the final report.

Provision

- o Requires that the Secretary reduce all capital related payments regarding costs of outpatient hospital services by 15 percent for payments attributable to portions of costs reporting periods occurring during FY 1990.

- o Provides that Sole Community Hospitals (SCHs) are exempt from reduction in capital related payments for outpatient hospital services.
- o Provides that payments for outpatient departments are paid on the basis of a blend, the cost portion of the blend includes allocated capital at 85 percent of costs.
- o Requires the Physician Review Commission to conduct a two part study of factors related to the rapid growth in Medicare payments for services in hospital outpatient departments.
 - The first part of the study is to include consideration of the effects of the step-down method used to allocate hospital capital between inpatient and outpatient hospital costs. In addition, an assessment of the extent to which hospital outpatient costs were affected by the implementation of PPS for inpatient hospital services and by the increased review of these services by peer review organizations. The report must be submitted to Congress by March 1, 1990.
 - The second part of the study examines alternative Medicare reimbursement methods for services in hospital outpatient departments. The report must include PPS methods, fee schedules, and other methods in use. In addition, recommendations on how to reduce the rate of growth in Medicare expenditures for these services is requested. Report must be submitted to Congress by March 1, 1991.

Effective Date

- o Enactment.

Clinical Diagnostic Laboratory Tests (Section 6111)

Current Law

- o Reduction of Limitation Amount on Payment Amount - The Deficit Reduction Act of 1984 provided payment for clinical diagnostic laboratory services will be made according to fee schedules established by carriers. The Omnibus Budget Reconciliation Act of 1987 provided that fee schedules were subject to ceilings set at 100 percent of the national median starting April 1, 1988 and until a national fee schedule is established.
- o Restriction on Payment to Referring Laboratory - Physicians and independent laboratories may bill for laboratory services only when they personally perform or supervise the test, with a few exceptions. The law permits an independent laboratory to bill

for all tests performed for patient even if some (but not all) of the tests were referred to another laboratory.

Provision

- o Reduction of limitation amount on payment amount - Maintains the ceiling on fee schedules at 100 percent of the national median for clinical laboratory tests through December 31, 1989. Establishes the ceiling on fee schedule payments at 93 percent of the median for laboratory tests performed beginning January 1, 1990 and until a national fee schedule is established.
- o Restriction on Payment to Referring laboratory - Provides that payment for clinical diagnostic laboratory tests to a referring laboratory may be made only if:
 - the referring laboratory is located in, or is part of, a rural hospital, and
 - is a wholly-owned subsidiary of the laboratory performing the test, or both the referring laboratory and the laboratory performing the test are wholly owned by a third entity, or
 - if not more than 30 percent of the tests for which the referring laboratory submits bills or requests payments within a year are performed by another laboratory.

Effective Date

- o Applies to clinical diagnostic laboratory tests furnished on or after January 1, 1990.

Durable Medical Equipment (Section 6112)

Current Law

- o Fees for five categories of durable medical equipment (DME) are scheduled to be updated in 1990 by the consumer price index for all urban consumers (CPI-U).
- o Indefinite rentals payments are currently allowed for parenteral and enteral infusion pumps.
- o Seat-lift chairs and transcutaneous electrical nerve stimulators are currently paid on the basis of a fee schedule.
- o Power-driven wheelchairs are currently paid for under either the category of "other" items of DME or "customized" items of DME.

- o All catheters, catheter supplies, ostomy bag and ostomy supplies (even those supplied by home health agencies) are currently paid for under the DME fee schedule for prosthetics and orthotics. These supplies are not specifically included in the definition of home health services.

Provision

- o Provides that there will be no fee schedule update for DME in 1990.
- o Establishes a cap of 15 months on rental payments for parenteral and enteral pumps and establishes coverage of reasonable maintenance and servicing fees to be paid after the period of rental payments has expired, effective April 1, 1990.
- o Reduces payment amounts for seat-lift chairs and transcutaneous electrical nerve stimulators by 15 percent for items furnished on or after April 1, 1990.
- o Moves power-driven wheelchairs to the category of inexpensive or routinely purchased durable medical equipment (excluding a customized power-driven wheelchair defined as such by the Secretary). Requires the Secretary to issue criteria for making case-by-case determinations of whether a power-driven wheelchair should be in the "customized" category or the "routinely purchased" category.
- o Excludes medical supplies provided by home health agencies (including catheters, catheter supplies, ostomy bags and ostomy supplies) from the DME fee schedule. Includes these supplies under the definition of home health services. Requires home health agencies to provide these supplies to Medicare beneficiaries who need such supplies as part of their services. Applies with respect to items or services furnished on or after January 1, 1990.

Effective Date

- o As specified above.

Mental Health Services (Section 6113)

Current Law

- o Eliminating Restriction on Psychologists' Services to Services Furnished at Community Mental Health Centers - Currently, Medicare payment for psychologists' services is limited to services furnished in risk-contracting Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs), rural health clinics, community mental health centers (CMHCs),

and services performed off-site by a CMHC because of the inability of the patient to travel to the center because of physical or mental impairment, institutionalization or a similar reason.

- o Clinical Social Worker services - Clinical social workers services are covered only if they are provided under contract with a risk-based HMO. Current law defines clinical social workers, but not clinical social worker services.
- o Eliminating Dollar Limitation on Mental Health Services - Medicare Part B payment for mental health services for treatment of mental, psychoneurotic, and personality disorders is limited to the lesser of \$1,375 or 62.5 percent of reasonable charges. Beneficiaries are required to pay a fifty percent co-payment for these services.

Provision

- o Payment for Psychologists' Services - Expands part B coverage of services of psychologists to services performed in all settings, if the services are those which the psychologist is legally authorized to perform under State law and would otherwise be covered if performed by a physician or as incident to a physician's services.
- o Clinical Social Workers - Provides for direct payment to social workers, if the clinical social worker is legally authorized to perform the service in the State in which it is furnished.

Defines social worker services as services provided by clinical social workers for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital and a skilled nursing facility) which the clinical social worker is legally authorized to perform under State law or the State regulatory mechanism provided by State law and would otherwise be covered if performed by a physician or as a incident to a physician's services. Medicare payment would be made on the basis of 80 percent of the lesser of actual charges or 75 percent of the amount paid psychologists.

- o Criteria - Requires the Secretary to develop criteria, taking into consideration concerns for patient confidentiality, for making direct payment to qualified psychologists which includes an agreement that the psychologists will consult with a patient's attending physician.
- o Mental Health Limit - Eliminates the \$1,375 annual limit on mental health services in outpatient settings. Payment for mental health services will be made on the basis of 62.5 percent of reasonable charges. The 50 percent copayment in current law would be retained.

Effective Date

- o For services furnished on or after July 1, 1990. Except, the provision eliminating the dollar limit applies to expenses incurred in a year beginning with 1990.

Coverage of Nurse Practitioner Services in Nursing Facilities (Section 6114)

Current Law

- o Services Covered - Currently, Medicare covers services of nurse practitioners when:
 - the services are performed in a rural health clinics and as an incident to these services if they are covered when performed by a physician;
 - as an incident to a physician's services; and
 - the services are furnished in a HMO or CMP and as an incident to such services if the services would be covered when performed by a physician.
- o Payment - Payment for services of nurse practitioners varies by the setting in which services are performed. Payment for nurse practitioner services furnished in a rural health clinic are made either on the basis of reasonable costs or on the basis of an all-inclusive rate established for the rural health center. In the case of services performed incident to a physician's services, payment is included within the physician's payment amount. Payment for nurse practitioner services furnished in a cost-based HMO or CMP is included as part of reasonable cost payment amount (in the case of a risk-based HMO or CMP no additional payment is made).

Provision

- o Services Covered - Provides for separate payment for services furnished by nurse practitioners when performed in a skilled nursing facility and intermediate care facility, if the service would be covered when performed by a physician. Services performed by nurse practitioners, must be in collaboration with a physician and within the scope of services authorized by State law.
- o Payment - Limits the prevailing charges for the services of nurse practitioners to a percentage of nonspecialist physicians' prevailing charges for the same services (85 percent for skilled nursing facilities and intermediate care facilities services).

Requires mandatory assignment for these services and permits payment only to the employer of the nurse practitioner.

- o Routine Visits by Members of a Team - Directs the Secretary to instruct carriers to develop mechanisms which permit routine payment for up to 1.5 team visits per month to residents of a nursing facility. The team must include a physician and a physician assistant acting under the supervision of the physician, a nurse practitioner working in collaboration with the physician, or both.
- o Definition of Collaboration - Defines collaboration as a process in which a nurse practitioner works with a physician to deliver health care services within the scope of the practitioner's professional expertise, with medical direction and appropriate supervision as provided for in jointly developed guidelines or other mechanisms as defined by State law in which the services are performed.
- o State Demonstration Projects on visit Limitations - Requires the Secretary to conduct at least 1 demonstration in one or more States, in which the 1.5 limitation on visits by a physician and physician assistant team or a physician and nurse practitioner team would be applied on an average basis over the aggregate total of residents receiving services from members of the team.

Effective Date

- o For services furnished on or after April 1, 1990.

Coverage of Screening Pap Smears (Section 6115)

Current Law

- o PAP smear screenings are not covered under the Medicare program.

Provision

- o Definition - Defines screening PAP smear as a diagnostic laboratory test consisting of a routine exfoliative cytology test (Papanicolaou test) provided to a woman for early detection of cervical cancer, including a physician's interpretation of the results of the test.
- o Permits Medicare part B payment for screening PAP smears only for women who have not had a PAP smear screen during the preceding three years, or a shorter period of time prescribed by the Secretary for a woman who is at high risk of developing cervical cancer.

Effective Date

- o For screening PAP smears performed on or after July 1, 1990.

Coverage Under, and Payment for, Outpatient Rural Primary Care Hospital Services Under Part B (Section 6116)

Current Law

- o Outpatient rural primary care hospitals (RPCCHs) are not defined in current law.
- o Services provided could be compared to those delivered by outpatient hospital departments, where: outpatient hospital services considered incident to physician services are reimbursed on the basis of reasonable costs; clinical diagnostic services are reimbursed on the basis of prospective payment; and outpatient radiology services are subject to a limit, which is the lesser of reasonable costs or charges or a blend of hospitals' costs and prevailing charges for providing the services in physicians' offices.

Provision

- o Defines outpatient rural primary care hospital services as medical and other health services furnished by a RPCH.
- o Permits RPCHs to select one of two payment methods for outpatient services provided before 1993. These include:
 - Payment for a cost-based facility fee plus professional charges. The facility fee is made on the basis of the lesser of reasonable costs or customary charges, less coinsurance, and limited to 80 percent of the reasonable costs for facility services. Reimbursement for professional medical services are made on a reasonable charges basis; or
 - Payment for both the facility services and the professional medical services is based on an all-inclusive rate to include reasonable costs related to the furnishing of services less any coinsurance or deductible payments. Payment for eligible services, excluding pneumococcal and influenza vaccines and second opinions, is limited to 80 percent of reasonable costs.
- o Requires the Secretary to develop and implement a prospective payment system for outpatient RPCH services by January 1, 1993.

Effective Date

- o Enactment.

Part 2 -- Provisions Relating to Part B

Subpart B -- Technical and Miscellaneous Provisions

Modification of Payment for Therapeutic Shoes for Individuals with Severe Diabetic Foot Disease (Section 6131)

Current Law

- o OBRA 87 required the Secretary to conduct a demonstration, beginning October 1, 1988, of the cost effectiveness of furnishing therapeutic shoes to diabetic patients under the Medicare program. Medicare payment is made for "extra-depth shoes with inserts or custom molded shoes for an individual with diabetes," if the patient has documented severe diabetic foot disease and the shoes are prescribed by a qualified physician and fitted by a qualified individual.
- o Medicare payment is limited to one pair of shoes for any individual for any calendar year, at no more than \$300 for one pair of custom molded shoes, or \$100 for one pair of extra depth shoes and \$50 for extra depth shoe inserts. The cost of fitting these shoes are included in the payment for the shoes. However, the Secretary or a carrier may establish lower payment limits than those established if shoes and inserts of an appropriate quality are available at or below lower limits.

Provision

- o Expands Medicare payment for therapeutic shoes to include one pair of custom molded shoes with inserts and two additional pairs of custom molded shoe inserts, or one pair of extra-depth shoes without inserts and three additional pairs of extra-depth shoe inserts.

Medicare would pay \$300 for one pair of custom molded shoes with an original pair of inserts, and \$50 for each additional pair of custom molded shoe inserts. Maintains payment of \$50 for each pair of extra depth shoe inserts.
- o Permits beneficiaries to substitute modification of custom molded or extra-depth shoes for additional shoe inserts, after obtaining an initial pair of shoes and inserts,.
- o Directs the Secretary to establish payment limits for modification of shoes so that there is no net increase in expenditures as a result of substituting shoe modification for additional inserts.
- o The method for updating payments for shoes and inserts remains the same as before enactment of this Act, with each dollar

amount increased by the same percentage as durable medical equipment for that year.

Effective Date

- o For therapeutic shoes and inserts furnished on or after July 1, 1989.

Payments to Certified Registered Anesthetists (Section 6132)

Current Law

- o Certain rural hospitals are paid on a reasonable cost basis for certified registered nurse anesthetist (CRNA) services, rather than through the hospital prospective payment system. A rural hospital is allowed to "pass through" CRNA costs if less than 250 surgical procedures per year are performed at the hospital. The pass-through exemption is available for 1989, 1990, and 1991.

Provision

- o Extends the pass-through for CRNA services provided in certain rural hospitals indefinitely.
 - Stipulates that only those rural hospitals performing less than 500 surgical procedures per year may be paid on a pass-through basis. The hospital can establish that it has met the conditions for exemption any time before the year the pass-through is sought.

Effective Date

- o For services furnished on or after January 1, 1990.

Increase in Payment Limit for Physical and Occupational Therapy Services (Section 6133)

Current Law

- o Medicare payment for occupational and physical therapy services is 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.

Provision

- o Increases the limit on recognized expenses for physical and occupational therapy services to \$750 a year beginning January 1, 1990.

Effective Date

- o Applies to services furnished on or after January 1, 1990.

Study of Payment for Portable X-Ray Services (Section 6134)

Current Law

- o No Provision.

Provision

- o Requires the Secretary to conduct a study of the costs of covering portable X-ray services under Part B of Medicare.
- o Requires the Secretary, within one year of the enactment, to report the results of the study to Congress. The report must include a recommendation on whether payment for such services should be made in the same way as payments for radiologists' services or on the basis of a separate fee schedule.

Effective Date

- o Enactment.
- o The report is due on or before December 19, 1990.

Extension of Municipal Health Service Demonstration Projects (Section 6135)

Current Law

- o Certain Medicare requirements may be waived when the Health Care Financing Administration enters demonstrations under its general demonstration authority. The municipal health services demonstrations were authorized under the general demonstration authority and were set to expire in December 1989.

Provisions

- o Extends municipal health services demonstration projects in Baltimore, Cincinnati, Milwaukee, and San Jose through December 31, 1993.
- o Requires the Secretary to report to Congress on this waiver program with respect to the quality of health care, beneficiary costs and any other appropriate factors.

Effective Date

- o Enactment.

Study of Reimbursement for Ambulance Services (Section 6136)

Current Law

- o No provision.

Provision

- o Requires the Secretary to conduct a study to determine the adequacy and appropriateness of Medicare payments for ambulance services. The study shall include a discussion of:
 - the effect of payment amounts on the provision of ambulance services in rural areas;
 - the relationship of payment amounts to the direct and indirect costs of providing ambulance services, including separate analyses for different types of ownership and different levels of service provided.
 - a comparison of Medicare and Medicaid payments for ambulance services; and
 - recommendations for changes in Medicare payment policy which will ensure access to quality ambulance services in rural and metropolitan areas.

Effective Date

- o Enactment.
- o The report to Congress is due no later than one year after enactment (December 19, 1990).

ProPAC Study of Payments for Services in Hospital Outpatient Departments (Section 6137)

Current Law

- o No provision. OBRA 86, however, required the Secretary to submit an interim report to Congress by April 1, 1988, concerning the development of a prospective payment system for ambulatory surgery, and a final report by April 1, 1989.
- o OBRA 87 modified the directive to require the Secretary to consult with ProPAC in preparing the final report. The interim

report was submitted in June 1988; as of December 1989, the final report had not been submitted.

Provision

- o Instructs the Prospective Payment Assessment Commission (ProPAC) to conduct a two part study of factors relating to the rapid growth of Medicare payments for services in hospital outpatient departments.
- o Requires a report to Congress to include:
 - the sources of growth in spending for hospital outpatient services;
 - the differences between the costs of delivering services in a hospital outpatient department as compared to the costs of delivering similar services in other appropriate settings, including ambulatory surgery centers and physician's offices; and
 - the effects on hospital costs of the step-down method used to allocate hospital capital between the inpatient and outpatient departments, and the extent to which the hospital outpatient costs were affected by the implementation of the prospective payment system of payment for inpatient hospital services, and by the increased review of such services by peer review organizations.
- o Requires a second report to Congress to examine and recommend alternative methods for reimbursing hospitals for services in outpatient departments under the Medicare program. Methods under study are to include prospective payment methods, fee schedules, and any other methods considered appropriate by the Commission.

Effective Date

- o Enactment.
- o The first report is due to Congress no later than July 1, 1990.
- o The second report is due no later than March 1, 1991.

PhysPRC Study of Payments for Assistants at Surgery (Section 6138)

Current Law

- o No provision.

Provision

- o Requires the Physician Payment Review Commission (PPRC) to conduct a study of Medicare payments for assistants at surgery. The study shall examine the:
 - necessity and appropriateness of using an assistant at surgery;
 - use of physician and non-physician assistants at surgery;
 - appropriateness of providing Medicare payments as well as the appropriate level of payment for such services; and,
 - effect of separate Medicare payments for physician assistant services on the employment of registered nurses as assistants at surgery.

Effective Date

- o Enactment.
- o Report to Congress is due by April 1, 1991.

GAO Study of Standards for Use of and Payment for Items of Durable Medical Equipment (Section 6139)

Current Law

- o No provision.

Provision

- o Requires the GAO to conduct a study of the appropriate uses of durable medical equipment and of the appropriate criteria for making determinations of medical necessity in the Medicare program for durable medical equipment, with particular emphasis on items that may be subject to abusive billing practices. The study shall include an analysis of:
 - the appropriate use of forms in making medical necessity determinations for items of durable medical equipment; and
 - procedures for identifying items of durable medical equipment that should no longer be covered.
- o Requires the Comptroller General to convene a panel to conduct this study, consisting of:
 - specialists in the disciplines of orthopedic medicine, rehabilitation, arthritis, and geriatric medicine;

- representatives of consumer organizations; and
- representatives of carriers under the medicare program.

Effective Date

- o Enactment.
- o The report to Congress is due by April 1, 1991.

Narrowing of Range of Amounts Recognized for Items of Durable Medical Equipment (Section 6140)

Current Law

- o Limits are established on the range of payment amounts recognized for purchase of miscellaneous devices and items, and monthly payment for oxygen and oxygen equipment. No limit is established for 1990. In 1991, the recognized payment amount for an item may not exceed 130 percent nor be lower than 80 percent of the average for all carrier service areas in the United States for that year. In subsequent years, the range may not exceed 125 percent nor be lower than 85 percent of the average.

Provision

- o Restricts the ranges of recognized payment amounts. In 1991, the recognized payment amounts may not exceed 125 percent nor be lower than 85 percent of the average for all carrier service areas. In 1992, the range is between 120 percent and 90 percent of the average.

Effective Date

- o October 1, 1990.

Physician Office Labs (Section 6141)

Current Law

- o OBRA 87 required high volume physician office laboratories performing over 5,000 tests a year (including Medicare and non-Medicare) to meet the same conditions for participation in Medicare as those required of independent laboratories. The effect of this provision is that high volume physician laboratories must be licensed under State law if licensure is required of independent laboratories and must meet other conditions established by the Secretary.

Provision

- o Repeals the requirement that high volume physician laboratories comply with the same State and Federal requirements as independent laboratories. Expands the law to require all laboratories to meet their respective State's licensure standards and comply with the certification requirements of the Clinical Laboratory Improvement Act of 1988.

Effective Date

- o Enactment.

Study of Reimbursement for Blood Clotting Factor for Hemophilia Patients (Section 6142)

Current Law

- o No provision.

Provision

- o Requires the Secretary to review the payment methodology for blood clotting factor for hemophilia patients, and evaluate the effects of the payment methodology on accessibility and affordability of blood clotting factor for Medicare beneficiaries.

Effective Date

- o Enactment.
- o The report to Congress is due no later than 6 months after enactment (June 19, 1990).

Part 3 -- Provisions Relating to Parts A and B

Subpart A -- General Provisions

Reductions Under Original Sequester Order and Applicability of New Sequester Order for Health Maintenance Organizations (Section 6201)

Current Law

- o On October 16, 1989, the President issued a final sequester order following the requirements of the Balanced Budget and Emergency Deficit Control Act of 1985 (amended by the Balanced Budget and Emergency Deficit Control Act of 1987). Under the terms of the sequester order, Medicare benefit payments for

Medicare part A services rendered on or after October 17, 1989, are reduced by 2.092 percent. The 1990 sequester reduced all part A payments (to hospitals, skilled nursing facilities, home health agencies, and health maintenance organizations) by 2.092 percent from October 17, 1989 through December 31, 1989.

- o A revised sequester order reduces payment for part A services by 1.40 percent beginning on January 1, 1990 and ending September 30, 1990.

Provision

- o Increases payment to HMOs and CMPs 1.42 percent to offset the effects of the new sequester order beginning January 1, 1990 through the remainder of FY 1990.

Effective Date

- o December 19, 1989.

Medicare as Secondary Payer (Section 6202)

Current Law

Identification of MSP situations

- o Medicare is secondary payer to employer group health plans (EGHPs) for beneficiaries over age 65, for certain EGHPs covering disabled beneficiaries, and for individuals with ESRD during the first 12 months of entitlement to Medicare. Medicare is also secondary payer to workers' compensation, automobile, medical, no-fault, and liability insurances.
- o Medicare contractors identify MSP cases through beneficiary questionnaires, provider identification of third-party coverage, and through data transfers with other Federal and State agencies.
- o Medicare contractors are currently covered under the Privacy Act because they routinely handle beneficiary-specific information, including medical histories and social security numbers. Medicare contractors are currently prohibited from unauthorized disclosure of this information, subject to criminal penalties.
- o The Internal Revenue Code (IRC) prohibits disclosure of tax information, with exceptions for authorized disclosure to certain Governmental entities in certain instances. There is no requirement that the IRS disclose information to third parties, such as employers and private insurers. Unauthorized disclosure is a felony punishable by a fine not exceeding

\$5,000 or imprisonment of more than 5 years, or both. An action for civil damages also may be brought for unauthorized disclosure.

Uniform enforcement and coordination of benefits

- o In cases involving liability insurance, providers are instructed to bill Medicare first for conditional payments. Medicare then recovers its costs from the liability insurer of the person who caused the injury.
- o Payments made by employer group health plans for the working aged, disabled and ESRD beneficiaries are credited toward Medicare's deductible and coinsurance requirements. Payments from worker's compensation, liability and related insurance are not counted toward Medicare's deductible and coinsurance.
- o Penalties exist to enforce compliance with secondary payer provisions. Employers who do not comply with the working aged provisions are subject to an excise tax of 25 percent of the group health plans' expenses. Failure to comply with the working aged provisions is a violation of the Aged Discrimination Act. Employers who violate the secondary payer provisions for ESRD beneficiaries can lose their tax deduction for group health expenses.

Special Enrollment Period for Disabled Employees

- o Aged individuals are entitled to a special enrollment period for Medicare if they are enrolled in a group health plan by reason of employment. Currently, disabled individuals are eligible for a special enrollment period only if they are covered under a large group health plan by reason of current employment.

Matching Requirements

- o Currently, no matching based on private activities is required in fiscal intermediary agreements and carrier contracts. The Secretary may terminate an agreement with an intermediary or carrier if the contractor has failed to carry out the claims processing agreements, or if that agreement is inconsistent with the efficient administration of the Medicare program.

Specifications for Employment in a Religious Order

- o The IRC permits individuals who are required to take a vow of poverty to elect Social Security coverage if they perform tasks required of an active member, and are not retired due to old age or total disability. The IRC computes the "wages" of such members in order to apply the Social Security payroll tax, and considers them to be "deemed employees."

- o Religious orders are required to provide the same health insurance coverage for their members who are age 65 and older as they do for members under age 64.

Provision

Identification of Medicare Secondary Payer Situations

- o Disclosure of Information - Amends the Internal Revenue Code is to:
 - require the Secretary of the Treasury to disclose, to the Commissioner of the Social Security Administration (SSA), filing status and taxpayer identification information related to a Medicare beneficiary's marital status (for any year after 1986), and the name and taxpayer information of the beneficiary's spouse;
 - require the Commissioner of the SSA to, with a written request, disclose information to the Administrator of HCFA regarding:
 - + the name and Taxpayer identification number (TIN) of Medicare beneficiaries who received wages from an employer in a previous year;
 - + the name and TIN of a beneficiary and of a beneficiary's spouse when the beneficiary's spouse has received wages from an employer in a previous year; and
 - + the name, address and TIN of the beneficiary's or spouse's employer, and the number of individuals the employer furnished with W-2s for the previous year;
 - permit the HCFA Administrator to disclose information from the Social Security Commissioner:
 - + to employers, the name and TIN of Medicare beneficiaries and their spouses receiving wages from the employer. This information (including the name, address and identifying number of the plan) may be disclosed to determine the period during which the beneficiary or spouse may be covered under a group health plan and which benefits are covered;
 - + to group health plans, the name of the employee and the employee's spouse (if the spouse is a Medicare beneficiary), the name and address of the employer, and the TIN of the employee and/or spouse if Medicare benefits were paid during a period when the plan was a primary plan; and

- + to any agent of the HCFA Administrator, the name and TIN of beneficiaries and spouses receiving wages from a qualified employer and the name, address and TIN of their employers;
- include special rules to provide:
 - + that the above information can only be disclosed to determine a beneficiary's coverage under a group health plan; and
 - + that the Secretary of the Treasury or the Commissioner of SSA must disclose the information requested within 120 days;
- define the following terms:
 - + Medicare beneficiary - an individual entitled to benefits under Part A, or enrolled under Part B of Medicare, but not an individual enrolled in Part A under the buy-in provisions for the aged or under the proposed buy-in provision for the disabled;
 - + Group Health Plan - any group health plan or any large group health plan, as defined in the IRC. The IRC defines Group Health Plan as any plan of, or contributed to by, an employer to provide medical care to his employees, former employees, or the families of such employees or former employees, directly or through insurance, reimbursement, or otherwise. The IRC defines Large Group Health Plan as a Group Health Plan that covers employees of at least one employer, that normally employed at least 100 employees on a typical business day during the previous calendar year;
 - + Qualified Employer - for a calendar year, an employer that has furnished W-2 statements to at least 20 individuals for wages paid in the year;
- provide that requirements for disclosing taxpayer identity information do not apply to requests made after September 30, 1991. In addition, requests made before September 30, 1991, for Social Security Commission or IRS information from 1990 or later, may not be disclosed;
- extend several existing IRC confidentiality safeguards to the taxpayer identity information for MSP purposes;
- extend an existing IRC penalty on State and other employees for unauthorized disclosure of information, to apply to the unauthorized disclosure of taxpayer identity information for MSP purposes. Unauthorized disclosure is a felony,

punishable by a fine not to exceed \$5,000, or imprisonment of not more than 5 years, or both, together with the costs of prosecution.

o Responsibilities of HCFA:

- Matching Information:

+ The Commissioner of Social Security is annually required to transmit to the Secretary of the Treasury, a list of the names and TINs of Medicare beneficiaries. The Secretary of the Treasury must also disclose to the Commissioner, filing status and Taxpayer identity information of beneficiaries' spouses.

+ The Administrator of HCFA is annually required to request the SSA Commissioner to disclose information regarding the names and TINs of beneficiaries and their spouses receiving wages from qualified employers, the name, address, and TIN of the employers, and the number of individuals for whom the employer issues W-2s.

- Disclosure to Intermediaries and Carriers:

+ The Administrator is required to disclose taxpayer identity information to intermediaries and carriers in order to determine MSP situations.

- Contacting Employers:

+ Intermediaries and carriers are required to contact qualified employers to determine the period an employee or employee's spouse may be covered under an EGHP, and to determine the nature of the coverage (including the name, address, and identifying number of the plan).

+ Employers are required to provide such information to the intermediary or carrier within 30 days of receipt of the inquiry if the inquiry is made before September 30, 1991.

+ An employer who willfully or repeatedly fails to provide a timely and accurate response would be subject to a civil money penalty not to exceed \$1,000 for each individual.

- Deadline for first request:

+ By January 2, 1990, the Social Security Commissioner is required to first transmit to the Secretary of the Treasury the list of names and taxpayer identification numbers of beneficiaries and to request from the

Secretary disclosure of taxpayer identity information.

Uniform Enforcement and Coordination of Benefits

o Requirements of Group Health Plans:

- Working Aged Under Group Health Plans:
 - + For items or services furnished to an individual age 65 or older, covered as a current employee (or as a spouse) under a group health plan, that plan cannot take into account that individual's entitlement to Medicare Part A.
 - + A group health plan must entitle any employee or spouse age 65 or older, to the same benefits and the same conditions under the plan as any employee or spouse under age 65.
 - + These requirements do not apply to:
 - * employer group health plans that have less than 20 employees for each working day, for 20 or more weeks in the current or previous year;
 - * multiple employer group health plans that have less than 20 employees for each working day for 20 or more weeks in the current or previous calendar year, if the plan elects to be excepted; or
 - * items or services furnished in a month to an individual if that individual is, or would upon application be, entitled to benefits for ESRD.
 - + Group Health Plan is defined as any plan of, or contributed to by, an employer to provide medical care to his employees, former employees, or the families of employees or former employees, directly or through insurance, reimbursement, or otherwise.
- Disabled Active Individuals in Large Group Health Plans:
 - + Large group health plans are prohibited from taking into account an active individual's entitlement to benefits under part A of Medicare, for items and services furnished on or after January 1, 1987, and before January 1, 1992.
 - + This prohibition does not apply to an item or service furnished to an individual if, for the month, the individual is, or would upon application be, entitled to ESRD benefits.

- + Active Individual means an employee, the employer, self-employed individual, an individual associated with the employer in a business relationship, or a member of the family of any such persons.
- + Large Group Health Plan is defined as a health plan provided by an employer for employees, former employees and employees' families, where the employer normally employed at least 100 employees on a typical day in the previous year.
- Individuals with ESRD:
 - + A group health plan is prohibited from taking into account an individual's entitlement to Medicare due to ESRD during the 12 months which begins with the earlier of: the month in which a regular course of dialysis is initiated, or the first month in which a transplant recipient would be eligible for Part A benefits for ESRD.
 - + A group health plan is prohibited from differentiating in the benefits it provides between individuals having end stage renal disease and other individuals covered by the plan.
 - + A group health plan may take into account that an individual is entitled to Medicare benefits on the basis of ESRD after the end of the 12 month period described above.
- o MSP Payment:
 - Medicare payment is prohibited for items or services to the extent that payment has been made, or can reasonably be expected to be made, by a group health plan, under worker's compensation, under an automobile or liability insurance policy or plan, or under no fault insurance to the extent the clause applies.
 - The definition of Primary Plan includes a group health plan or large group health plan, a worker's compensation law or plan, an automobile medical or liability insurance policy or plan, or no-fault insurance which is required to pay for enrollee medical expenses regardless of Medicare coverage.
 - Conditional Payments:
 - + Any primary Medicare payments for which a primary plan or liability insurance is responsible are to be reimbursement to the appropriate Medicare trust fund when notice or other information is received that the other policy or plan is primary.

- + To recover primary Medicare payments for individuals:
 - the Government may bring legal action against the entity responsible to pay, or against anyone that has received payment from that entity (including a physician or a provider), and may collect double damages. The government may also join or intervene in any action related to the need for the item or service;
 - the Government has the right, over an individual, to payment under a primary plan, to the extent of the Medicare payment; and
 - the Secretary is allowed to waive all or part of an MSP provision when it is in the best interest of the Medicare program.

o Enforcement:

- A private cause of action is established for individuals to sue for damages (double the amount otherwise provided), where a primary plan fails to make primary payment or appropriate reimbursement.
- The provision references the IRC, which imposes a tax on any employer or employee organization that contributes to a non-conforming large group health plan. This tax will be equal to 25 percent of the employer's or employee organization's expenses incurred during the calendar year for each large group health plan to which the employer or employee organization contributes.
- A Non-conforming Large Group Health Plan is defined as a group health plan that does not pay primary benefits for the working aged, active disabled, or those with end stage renal disease.

o Coordination of benefits:

- Where payment by a primary plan is less than the charge for an item or service and is not payment in full, Medicare payment may be made for the remainder of the charge, without regard to Medicare deductibles and coinsurance.
- Exceptions to the coordination of benefits provision are as follows:
 - + Medicare payment cannot exceed the amount that Medicare would have paid as a primary payer;
 - + The Medicare payment, when combined with the amount

payable under the primary plan, cannot exceed the amount that would be paid by Medicare for the item or service on the basis of reasonable cost or under the PPS, whichever is appropriate for that item or service; and

- + Where payment is authorized on another basis, the Medicare payment for the remainder of the charge is the greater of either the amount payable under the primary plan (without regard to its deductible and coinsurance), or the reasonable charge or other amount payable by Medicare (without regard to the Medicare deductible and coinsurance).
- o Enforcement through excise tax - For purposes of applying the excise tax on nonconforming group health plans, the following definitions in the Internal Revenue Code are amended:
 - Group health plan - any plan of, or contributed to by, an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employees, former employees, or the families of such employees or former employees.
 - Large group health plan - a plan of, or contributed by, an employer or employee organization (including a self-insured plan) to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families, that covers employees of at least one employer that normally employed at least 100 employees on a typical business day during the previous calendar year.
 - Nonconforming group health plan - a group health plan or large group health plan that at any time during a calendar year does not comply with the primary payer requirements for group health plans covering the working aged, the active disabled and those with ESRD.
- o Repeal of certain alternative enforcement provisions:
 - Repeals a section of the IRC which disallows a deduction for employer expenses for a group health plan if the plan discriminates against individuals having ESRD or needing renal dialysis.
 - Amends the Age Discrimination in Employment Act of 1967 to omit the provision that requires employers to offer group health coverage to employees and their spouses age 65 to 69, under the same conditions offered for any employee or spouse under age 65.

Special Enrollment Period For Disabled Employees

- o Makes the special enrollment period for disabled individuals in an employer group health plan comparable to the special enrollment period for the aged.

Matching Requirements

- o Prohibits the Secretary from requiring contractors to match their private data files (data obtained through activities other than administering Medicare) to identify MSP cases, as a condition of entering into or renewing contracts with the contractors.

Specification for Employment in a Religious Order

- o Provides that an individual would not be considered to be employed or to be an employee for purposes of the MSP provisions if he or she is a member of a religious order whose members are required to take a vow of poverty and are considered "deemed employees" because of an election of Social Security coverage.

Effective Date

- o The Identification of MSP Situations provisions are effective December 19, 1989.
- o The Enforcement Provision applies to items and services furnished after December 19, 1989.
- o The Special Enrollment provision applies to enrollments occurring after, and premium for months after, the second calendar quarter beginning after December 19, 1989.
- o The Data Match provision applies to agreements and contracts enter into or renewed on or after 12-19-89.
- o The religious order provision applies to items and services furnished on or after October 1, 1989.

Payment for End Stage Renal Disease Services (Section 6203)

Current Law

- o Maintenance of current composite rate - Under current law, dialysis facilities receive a prospectively determined rate for services. The rate is based on a single composite weighted formula which takes into account the mix of patients who receive dialysis at a facility or at home and the relative costs of providing such services in these settings.

- A separate rate is established for hospital-based facilities and for independent facilities. In an effort to reduce dialysis payment rates, OBRA 86 mandated that rates in effect on May 13, 1986 be reduced by \$2 (which was less of a reduction than envisioned under regulatory proposals) and that such rates be maintained until October 1, 1988.
- o Limitation on amount of payment when patients deal directly with Medicare suppliers - Currently, beneficiaries may elect to obtain home dialysis equipment and supplies from a supplier other than an approved ESRD facility (a hospital-based or independent facility being reimbursed for dialysis services on the basis of composite rate).
 - Reimbursement for such equipment and supplies is made on a reasonable charge basis. This type of reimbursement is referred to as Method II payment. Currently, average monthly payments to suppliers not participating in the ESRD facility program are nearly twice payments made under the composite rate system.

Provision

- o Maintenance of Current Composite Rate - Requires maintenance of the current composite rate for dialysis services until October 1, 1990.
 - Requires the Secretary to follow prescribed regulatory procedures (which include a notice of the proposed rules and an allowance of at least 60 days for a comment period) before changing the composite rates in effect on September 30, 1989.
- o Requirements for Patients Dealing Directly with Medicare - Limitation on amount of payment when patients deal directly with Medicare suppliers - Limits payments to suppliers who deal directly with ESRD patients, Method II payment, instead of through an approved ESRD facility to payments made under a single composite rate to an approved ESRD facility.
 - Method II payments, or any payments other than those based on a single composite weighted formula, may not exceed the amount of the median payment that would have been made under the formula for hospital-based facilities. In the case of continuous cycling peritoneal dialysis, payments may not exceed 130 percent of the amount of the median payment for hospital-based facilities.
- o Agreements with Providers of Services - Requires written agreements with suppliers who provide supplies and services directly to patients whose self-care home dialysis is not under

the direct supervision of an approved provider of services or a renal dialysis facility. The agreements must specify that the following conditions are met:

- the patient certifies that the supplier is the sole provider of dialysis supplies and equipment to the patient;
- the supplier agrees to receive payment for the cost of the supplies and equipment only on an assignment-related basis; and
- the supplier certifies that it has entered into a written agreement with an approved provider of services or with a renal dialysis facility, under which the provider or facility agrees to furnish all self-care home dialysis support services and all dialysis services and supplies. This agreement includes institutional dialysis services and supplies and emergency services.

Effective Date

- o For dialysis services, supplies, and equipment furnished on or after February 1, 1990.

Physician Ownership of, and Referral to, Health Care Entities (Section 6204)

Current Law

- o Criminal penalties are provided for those that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce business in Medicare or State health care programs. The offense is classified as a felony and is punishable by fines of up to \$25,000 and imprisonment of up to 5 years.
- o For home health services, a physician who has a significant financial interest in a home health agency may not certify a patient's need for home health services to be provided by that agency.
- o The Medicare and Medicaid Patient and Program Protection Act of 1987 provided authority to the Inspector General of the Department of Health and Human Services to exclude a person or entity from Medicare and State health care programs if they are engaged in a prohibited payment scheme. The Act also required regulations specifying approved payment practices that will not be subject to criminal prosecution and that will not cause exclusion from Medicare and State health care programs. These sanctioned payment practices are sometimes referred to as "safe harbors". The rule has not yet been published in final form.

- o COBRA 85 requires the Secretary to establish a system that provides an identifier for physicians furnishing services to Medicare beneficiaries.
- o The Deficit Reduction Act of 1984 provided a direct billing requirement, by which Medicare would only pay the person actually providing the clinical laboratory services. The purpose of the direct billing was to prevent a physician from ordering a test and billing for it at a marked up price.

Provision

- o Bright Line Rule - This provision prohibits a physician or immediate family member of a physician with a financial interest in a clinical laboratory, from making a referral to that laboratory for items or services for which Medicare would pay. It also prohibits the laboratory from billing Medicare for an item or service furnished following a prohibited referral, and requires refunds to beneficiaries if payment was made.
- o Exceptions for Group Practices - Several exceptions to the ownership and compensation arrangement prohibitions are provided. The provision does not apply:
 - in the case of physicians' services that are provided personally by another physician in the same group practice as the referring physician;
 - to in-office ancillary services if these are furnished by the referring physician or by a physician of the same group practice. This exception was intended to apply to a group practice which has set up its own central building to perform ancillary services for members of the group practice:
 - + ancillary services must be furnished in the building in which the physician or a member of the physician's group practices;
 - + services must be billed by the physician performing or supervising the services, or by the physician's group practice;
 - to services provided by a prepaid HMO or CMP, or a prepaid demonstration project.
- o Exceptions for Publicly-Traded Securities - The provision does not apply if the ownership of investment securities were purchased on terms generally available to the public and which are in a corporation that:

- is listed for trading on the New York Stock Exchange, or the American Stock Exchange, or is a national market system traded under an automated interdealer quotation system operated by the National Association for Securities Dealers; and
 - had, at the end of the corporation's most recent fiscal year, total assets exceeding \$100,000,000.
- o Exceptions for Ownership - The following are not considered to be an ownership or investment interest if the reporting and disclosure requirements are met:
- clinical laboratory services provided by hospitals in Puerto Rico, rural hospitals, or by a hospital in which a physician is authorized to perform services and the ownership interest is in the hospital itself, not merely a subdivision of the hospital.
- o Exceptions for Leases and Compensation Arrangements - Payments made for rental or lease of space are not prohibited compensation arrangements if:
- there is a written agreement specifying the space and the use of the space;
 - the lease is for at least one year, the value of the lease does not vary based on the volume or value of referrals between the parties, volume or value of referrals between the parties; and
 - that the lease would be commercially reasonable even if no referrals were made between the parties.
- o Employment and Service Arrangements - Arrangements between a hospital and a physician (or immediate family member) interested in investing are not prohibited if:
- the arrangement is for identifiable services, the amount of payment does not vary related to the volume or value of referrals by the physician, and the payment is commercially reasonable even if no referrals were made to the hospital.
- o Other Payment Arrangements - Other payment arrangements from an entity (other than a hospital) are not a prohibited if the arrangements are:
- for specific services (such as the medical director or as a member of a medical advisory board), for hospice care, or for physicians' services furnished to a nonprofit blood center.

o Payment - Payment provided by a hospital to a physician to relocate to the hospital area and to become a member of the hospital's medical staff is not prohibited if:

- the physician is not required to refer patients to the hospital, and payment is not dependent on the volume or value of any referrals.

Isolated financial transactions, such as a one-time sale of property, are not prohibited compensation arrangements if the employment and service requirements are met as they apply to the hospital.

Compensation arrangements involving payment by a group practice of the salary of a physician member of the practice is not prohibited.

o Reporting Requirements - The provision requires that requests for payment for which the entity knows or believes there has been a referral are required to include the name and provider number of the referring physician and an indication as to whether the referring physician is an investor. Medicare payment may be denied if this information is not provided and entities may be subject to civil penalties or excluded from the Medicare program if the information is knowingly and willfully not provided.

o Sanctions - No Medicare payment may be made for a clinical laboratory service which is provided following a prohibited referral.

- A person who collects money for a service provided following a prohibited referral is liable to the individual and must refund, in a timely manner, any amounts so collected.
- Civil monetary penalties of not more than \$15,000 and exclusion from Medicare are specified for persons who bill Medicare or who refuse to make a refund following a prohibited referral. Civil monetary penalties for circumvention schemes will not be more than \$100,000 for each scheme.
- Civil monetary penalties for failure to disclose information are also provided.

o GAO Study - Requires the GAO to conduct a study of ownership of hospitals by referring physicians and of joint ventures between hospitals and referring physicians. Specifically the study should examine:

- the types of ownership agreements, the returns earned by physician investors, the effect of the arrangements on

utilization by Medicare beneficiaries, Medicare expenditures, and other entities providing items and services in the communities served;

- the effect on independent providers of similar services; and
- the effect on the provision of in-office clinical laboratory services of the limitation on payment for the referrals contained in this section.

The GAO is required to report to Congress no later than February 1, 1991 on the results of the study.

- o Reports to Congress - Requires the Secretary to provide quarterly reports to Congress and to the Comptroller General, comparing utilization by Medicare beneficiaries served by entities in which the referring physician has a financial interest, and utilization by Medicare beneficiaries served by other entities.
- o Definitions - Compensation Arrangement; Remuneration - Any arrangement involving payment between a physician (or immediate family member) and an entity. Remuneration includes any payment, direct or indirect, overt or covert, in cash or in kind.
 - Employee - One is 'employed by' or an 'employee' of an entity under the usual common law rules in the Internal Revenue Code used to define the employer-employee relationship.
 - Fair Market Value - The value in arms length transactions, consistent with the general market value. For rentals or leases, it is the value of rental property for general commercial purposes (not taking into account its intended use). For the lease of space, it is not adjusted to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor where the lessor is a potential source of patient referrals to the lessee.
 - Group Practice - A group of two or more physicians legally organized as a partnership, professional corporation, foundation, not-for-profit corporation, faculty practice plan, or similar association:
 - + in which each physician member of the group provides the full range of services which the physician routinely provides through the joint use of shared office space, facilities, equipment, and personnel;
 - + for which all of the services of the group members are

provided through the group and are billed in the name of the group and amounts received are treated as receipts of the group; and

- + in which the overhead and the income from the practice are distributed among the members of the group.
- + In a faculty practice plan associated with a hospital with an approved medical residency program, physician members may provide a variety of specialty services both within and outside the group. In this case, the previous definition shall be applied only with respect to the services provided within the faculty practice plan.
- Interested Investor; Disinterested Investor - An investor who is a physician in a position to make or to influence referrals or business to an entity (or an immediate family member of such an investor). 'Disinterested investor' means an investor other than an interested investor.
- Referral; Referring Physician -
 - + Physicians Services - A 'referral' by a 'referring' physician in the case of clinical laboratory services is the request by a physician for the service, including the request by a physician for a consultation with another physician. This includes any test or procedure ordered or performed by (or under the supervision of) that other physician.
 - + Other Items - A 'referral' by a 'referring' physician for clinical laboratory services is the request or establishment of a plan of care by a physician which includes the provision of the clinical laboratory service.
 - + Clarification Respecting Certain Services Involved in a Consultation by Specialists - A request by a pathologist for clinical diagnostic laboratory tests and pathological examination services, if the services are furnished by (or under the supervision of) the pathologist following a consultation requested by another physician does not constitute a 'referral' by a 'referring physician'.

Effective Date

- o For referrals made on or after January 1, 1992.
- o Reporting requirements take effect October 1, 1990.

Costs of Nursing and Allied Health Education (Section 6205)

Current Law

- o Recognition of Costs - Direct costs of medical education programs such as nursing programs, operated by a hospital, are excluded from PPS and paid on a reasonable cost basis. HCFA has ruled that a hospital's costs of education programs operated at a hospital but controlled by another institution, such as a college or university, are not payable on a reasonable cost basis but are included in PPS payment rates.
 - The Technical and Miscellaneous Revenue Act (TAMRA) of 1988 provided an exception to the HCFA rule for a hospital paid under a demonstration waiver that expired on September 30, 1985. If such a hospital has incurred substantial costs due to a nursing program with which it shares common directors, the activities are considered to be directly operated by the hospital for Medicare purposes, and are paid as reasonable costs. Reimbursement is made on the same basis as if the costs were allowable direct costs of a hospital-operated program for cost reporting periods beginning in FY 1989, 1990, and 1991.

Provision

- o Recognition of Costs - Allows a hospital to be reimbursed on a reasonable cost basis for the costs of a hospital-based nursing school if:
 - before June 15, 1989, and thereafter, the hospital incurred at least 50 percent of the costs in training students and operating the school;
 - the nursing school and hospital share some common board members; and
 - all instruction is provided at the hospital or in the immediate proximity of the hospital (not on the campus of an institution with which the hospital is affiliated).

Allows a hospital paid under the TAMRA exception to be reimbursed for reasonable costs of training nursing students retroactively for hospital cost reporting periods, beginning in FY 1986.

- o Delay in Recoupment of Costs - Prohibits the Secretary from recouping, reducing or adjusting, Medicare payments to hospitals, before October 1, 1990, for alleged overpayments for nursing education programs. These payments were alleged to be in excess as a result of a determination that costs reported for nursing and allied health education programs were allowable

only as routine operating costs and, therefore, excluded from the medical education pass-through.

- o Regulations - Requires the Secretary to issue regulations addressing payment of costs for nursing education.
 - The Secretary must allow a comment period of not less than 60 days and must consult with ProPAC about the regulations.
 - The final rule will not be effective before October 1, 1990, or 30 days after publication of the final rule in the Federal Register, whichever is later.

The regulations must specify:

- the relationship required between a hospital and an approved nursing or allied health program for the program's cost to be attributed to the hospital;
- the types of costs for nursing or allied health programs that are allowable by Medicare;
- the distinction between costs of educational activities eligible for pass-through and those treated as hospital operating costs; and
- the treatment of other funding sources for the program.

When developing the regulations, it is intended that the Secretary will consider the relationship between a hospital and an educational program in the following ways:

- the degree of common ownership, membership, or control between the hospital and the educational institution;
- the degree to which instruction is provided in the immediate vicinity of the hospital;
- any written agreement that provides for joint activities in which the hospital incurs costs directly related to operation of an educational program;
- reporting relationships or other affiliations between the educational institutions and the hospital; and
- the responsibility and control of the hospital for administering the educational program.

Rules relating to types of allowable costs must consider clinical costs, operating costs, classroom costs, overhead, and faculty supervision. These costs should consider funding from

State or local sources and costs redistributed from non-provider sources. This criteria is not intended to prejudice the Secretary's determination of the appropriateness of cost reimbursement for other educational programs.

Effective Date

- o The Recognition of Cost provision applies to cost reporting periods beginning on or after December 19, 1989 and on or before the date regulations are issued.
- o Regulations for payment of costs of nursing education shall be issued before July 1, 1990.

Disclosure of Assumptions in Establishing AAPCC; Elimination of Coordinated Open Enrollment Requirement (Section 6206)

Current Law

- o The Secretary must announce the average adjusted per capita cost (AAPCC) for the following year no later than September 7 of each year.
- o In areas with several HMOs/CMPs, the Secretary is required to establish a single 30-day period each year in which all eligible organizations serving the area must provide for open enrollment.

Provision

- o Disclosure of Assumptions in Establishing AAPCC - Requires the Secretary to provide notice to eligible organizations of the proposed changes in methodology or benefit coverage assumptions used to calculate the AAPCC 45 days before the announcement on September 7 of each year, and provide an opportunity for organizations to comment on such changes.
 - This announcement will include an explanation of the assumptions and changes in methodology in enough detail so that HMOs and CMPs can compute their rates.
 - The Secretary must provide notice of the methodology used in making the AAPCC announcement for the 1990 rates before July 1, 1990.
- o Elimination of Coordinated Open Enrollment Requirement - Eliminates the provision for a coordinated open enrollment except in the case where a Medicare risk sharing contract of one of the HMOs or CMPs in the area is not renewed or is terminated, or reduces its service area in such a way that coverage is discontinued for enrollees in part of the area.

- In the case described above, the remaining risk contractors must have an open enrollment period for those enrollees losing coverage. The period must begin within 30 days after the Secretary notifies the organizations of the required open enrollment period and must last for 30 days.
- Enrollments take effect 30 days after the end of the open enrollment period or on a date specified by the Secretary.

Effective Date

- o Announcement of the AAPCC will begin with the announcement for the 1991 rates.
- o Open enrollment will be effective February 17, 1990, 60 days after enactment.

Extension of Expiring Authorities (Section 6207)

Current Law

- o Effective April 1, 1990, an HMO or CMP is subject to civil penalties if it makes payments to a physician as an inducement to reduce or limit services to Medicare or Medicaid beneficiaries. The penalty is up to \$2,000 for each enrollee.
- o The Secretary is prohibited from issuing any final regulation, instruction, or other policy before October 15, 1989 which would result in a net reduction in FY 1990 Medicare expenditures of more than \$50 million for hospital or physician services, unless required by law.

Provision

- o Delays the effective date in physician incentive rules until April 1, 1991.
- o Extends the prohibition on issuing a final cost-saving regulation, instruction or other policy to October 15, 1990 for net reductions in FY 1990 Medicare expenditures.

Effective Date

- o Effective December 19, 1989.

Subpart B -- Technical and Miscellaneous Provisions

Medicare Hospital Patient Protection Amendments (Section 6211)

Current Law

- o Scope of Hospital Responsibility for Screening - If an individual comes to an emergency department for treatment or examination, the hospital must provide appropriate medical screening, within the capability of the emergency department, to determine whether an emergency condition exists or if the individual is in active labor. The hospital is required to provide the services necessary to stabilize the individual.
- o Informed Refusals of Treatment or Transfers - If a patient refuses examination and treatment or transfer, a hospital is considered to have met the requirements for further examination and treatment, or appropriate and necessary transfer.
- o Authorization for Transfer - A hospital may transfer an unstable patient to another facility only if he or she requests the transfer or if a physician or a qualified medical personnel certifies that the benefits outweigh the risks. In addition, the transfer is considered appropriate if the receiving facility has space and qualified personnel and has agreed to accept the transfer.
- o Maintenance of Records - The transferring hospital must provide the receiving facility with copies of the patient's medical records.
- o Hospital and Physician Liability - If a hospital fails to meet the requirements listed above, it may be subject to termination of its provider agreement, or the Secretary may suspend the agreement. Both the hospital and the responsible physician may be subject to a civil money penalty of up to \$50,000 for each violation. The responsible physician is also subject to exclusion from the Medicare and Medicaid program for up to 5 years.
- o Terminology - The word "patient" is generally used to describe an individual who is present for emergency services.
- o Clarification of Definitions
 - "emergency medical condition" -- acute symptoms of sufficient severity such that absence of immediate medical attention would result in: placing the patient's health in severe jeopardy, serious impairment of bodily functions, or

serious dysfunction of an organ or part;

- "active labor" -- labor at a time in which: delivery is imminent, there is inadequate time to safely transfer the patient prior to delivery, or transferring the patient may pose a threat to the unborn child;
- "to stabilize" -- medical treatment necessary to insure that no material deterioration to the patient's condition is likely to result from a transfer.

Provision

- o Scope of Hospital Responsibility for Screening - Requires the hospital to provide screening within the capability of the emergency department, including ancillary services, routinely available to the emergency department.
- o Informed Refusals of Treatment or Transfer - Requires the hospital to explain to the individual who refuses treatment or examination the risks and benefits of the examination, treatment or transfer. The hospital is also required to take all reasonable steps to secure a written informed consent of refusal.
- o Authorization for Transfer -
 - Informed Consent for Transfer -- Permits an individual, at his or her request, to be transferred only after being informed of the hospital's obligations to treat and the risk of transfer, and after the individual requests, in writing, to be transferred.
 - Clarifying the Physician's Authority for Transfers -- Prohibits hospitals from transferring an individual if a physician is not present at the time of transfer unless a qualified medical person has signed a certification after a physician, in consultation, has made the determination that the benefits outweigh the risks, and subsequently countersigns the certification.
 - Standard for Authorizing a Transfer -- In the case of an individual in labor, extends the provisions for certification of transfer to include consideration of the risks and benefits to the health of the unborn child.
 - Inclusion of Summary of Risks and Benefits -- The certification for transfer must include a summary of the risks and benefits upon which the transfer is based.

- Provision of Services Pending Transfer -- Requires the transferring hospital to provide appropriate medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, to the health of the unborn child.
- o Maintenance of Records - Requires a hospital transferring an individual to send the receiving facility the medical records, including any information related to the emergency, the informed written consent, the certification, and the name and address of any on-call physician who has refused or failed to come to the hospital to treat the individual.
- o Physician Liability - Provides that a physician responsible for the examination, treatment or transfer of an individual, who knowingly violates any of the patient protection provisions, is subject to a civil money penalty of up to \$50,000 for each violation.
 - If the violation is knowing and willful or negligent on the part of the physician, he or she may be excluded from participation in Medicare and State health care programs.
 - If a physician, who is in the emergency room at the time an individual requests services, determines that the individual requires the services of an on-call physician and calls that physician, but he or she refuses to come, the emergency room physician authorizing the transfer is not liable, but the hospital and the on-call physician are subject to penalty.
- o Additional Obligations
 - Nondiscrimination -- Prohibits a hospital with special facilities or capabilities (such as a burn unit or shock-trauma unit) from refusing to accept an appropriate transfer of an individual who requires such capabilities or facilities if the hospital has the capacity to treat the individual.
 - No Delay in Examination or Treatment -- Prohibits a participating hospital from delaying the provision of an appropriate medical screening examination, medical examination, or treatment in order to inquire about the individual's method of payment or insurance status.
 - Whistleblower Protection -- Prohibits a participating hospital from penalizing or taking adverse action against a physician because he or she refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized.

- o Changes in Terminology - The word "individual" is substituted for "patient" at various points.
- o Clarification of "Emergency Medical Condition" definition -
 - Provides that "emergency medical condition" also applies when the health of a pregnant woman or her unborn child is placed in jeopardy.
 - Provides that in the case of a pregnant woman who is having contractions, an "emergency medical condition" means that there is not enough time to effect a safe transfer to another hospital before delivery, or that a transfer may pose a threat to the health or safety of the woman or the unborn child.
 - Deletes the separate definition of the term "active labor."
 - Changes the definition of "to stabilize" to include that no deterioration to the condition is likely to occur during the transfer, or (in the case of a condition that could result in serious impairment to bodily functions) that may be necessary to deliver.
 - Changes in the definition of "to stabilize" or "stabilized" to include that no material deterioration of the condition is likely, within reasonable medical probability, to occur during the transfer or (in the case of serious impairment of bodily functions) that may be necessary to deliver.

Effective Date

- o Effective July 31, 1990

**Health Maintenance Organizations and Competitive Medical Plans
(Section 6212)**

Current Law

- o OBRA 87 waived the membership requirement, which prohibits HMOs and CMPs from having a combined membership of Medicare beneficiaries and Medicaid recipients above 50 percent, for the Watts Health Foundation through January 1, 1990. The waiver could be continued after that date if the Secretary determined that the schedule for compliance with a corrective action plan submitted by Watts was approved.
- o An HMO/CMP is financially responsible for covered services furnished to an enrollee by any qualified provider in an

emergency or outside the organization's service area.

- o If an HMO/CMP's predicted costs for Medicare enrollees is lower than the capitation rate, resulting in excess profit, it must use the difference to provide additional benefits or reduce its premiums to enrollees, accept a reduced capitation rate, or request to deposit the excess in a benefit stabilization fund. This fund can be drawn upon in future years if the difference between the predicted costs and the capitation rate is insufficient to continue financing the package of additional benefits.
 - No fund may be established for a contract period beginning later than September 30, 1990.
 - Any funds not used within four years after deposit must revert to Medicare.

Provision

- o Extends the Watts membership waiver through January 1, 1994, and requires the Secretary to conduct an annual review of the organization's compliance with internal quality assurance requirements, beginning January 1, 1990. If the Secretary determines that the organization is not in compliance, he may, after notifying the organization and providing an opportunity to correct the deficiencies, suspend new enrollments or payments for beneficiaries enrolling after the date of the notice.
- o Requires physicians not under contract with an HMO/CMP, who provide emergency or out of area care to a Medicare beneficiary enrolled in an HMO, to accept as payment an amount that would be allowed under Part B of Medicare for the same service.
- o Repeals the deadline for establishing a benefit stabilization fund and the four year limit on the use of such a fund.

Effective Date

- o The provisions on the Watts waiver and the benefit stabilization fund are effective upon enactment.
- o The provision regarding payments for emergency and out of area care applies to services furnished on or after April 1, 1990.

Rural Health Clinic Services (Section 6213 (a-c))

Current Law

- o Current regulations require that a nurse practitioner or physician assistant be present to furnish patient care services at least 60 percent of the time during which a rural health clinic is open to serve patients.
- o Covered services in a rural health clinic include those furnished by a physician, a physician assistant, nurse practitioner, or clinical psychologist.
- o To be designated as a rural health clinic, a medical facility must be located in an area not defined by the Bureau of the Census as urbanized, and designated by the Secretary as an area with a shortage of personal health services or as a health manpower shortage area as defined by the Public Health Service Act.

Provision

- o Requires that a nurse practitioner, a physician assistant, or a certified nurse-midwife be available to furnish patient care services at least 50 percent of the time the clinic operates.
- o Adds the services of clinical social workers to those services covered in rural health clinics.
- o For purposes of qualifying rural health clinics, expands the definition of rural area to include:
 - Areas designated by a State governor and certified by the Secretary as an area having a shortage of personal health services; or,
 - Areas designated by the Secretary as meeting the following conditions outlined in the Public Health Service Act:
 - + an area with a shortage of personal health services,
 - + an area with a health manpower shortage,
 - + a high impact area, or
 - + an area which includes a population group determined as having a health manpower shortage.

Effective Date

- o Effective October 1, 1989.

**Dissemination of Rural Health Clinic Information
(Section 6213 (e))**

Current Law

- o No provision.

Provision

- o Requires the Secretary, in consultation with the Director of the Office of Rural Health Policy, to disseminate applications and information to health care facilities and relevant parties in each State which would enable any facility to apply for designation as a Medicare or Medicaid rural health clinic.
- o Clarification of definitions:
 - "Health care facility" means a community health center or a migrant health center, or a hospital, home health agency, or skilled nursing facility participating in Medicare or Medicaid.
 - "State" includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and the American Samoa.

Effective Date

- o Enactment.
- o Applications and information must be disseminated within 60 days of enactment (February 16, 1990).

**Treatment of Certain Facilities As Rural Health Clinics
(Section 6213 (f))**

Current Law

- o No Provision.

Provision

- o Prohibits the Secretary from denying a facility certification as a rural health clinic if it is located on an island and would otherwise be qualified, except for the requirement that the services of a physician assistant or nurse practitioner be provided in the facility.

Effective Date

o Enactment.

**Expansion of Functions of Office of Rural Health Policy
(Section 6213 (g))**

Current Law

- o The Office of Rural Health Policy is responsible for the following:
 - Overseeing compliance with requirements regarding publication of analyses on the impact of any proposed rules and regulations on small rural hospitals;
 - Overseeing compliance with the requirement that not less than 10 percent of the Medicare and Medicaid research and demonstration budget be set aside for rural health issues;
 - Establishing and maintaining a clearinghouse for the collection and dissemination of information regarding rural health care issues, research findings related to rural health care, and innovations in the delivery of health care in rural areas;
 - Coordinating Departmental activities related to rural health care; and,
 - Providing information to the Secretary regarding the activities of other Federal agencies that relate to rural health care.

Provision

- o Expands the responsibility of the Office of Rural Health to include the following:
 - Establishing and maintaining a clearing house for collecting and disseminating information on:
 - + rural health care issues, including rural mental health, rural infant mortality prevention, and rural occupational safety and preventive health promotion;
 - + innovative approaches to the delivery of health care in rural areas, including programs providing community based mental health services, pre-natal and infant care services, and rural occupational safety and preventive

health education and promotion.

- Coordinating Departmental activities relating to rural health care, including activities relating to rural mental health, rural infant mortality, and rural occupational safety and preventive health promotion.

Effective Date

- o Enactment.

Determining Eligibility of Home Health Agencies for Waiver of Liability for Denied Claims (Section 6214)

Current Law

If under 2.5 percent of claims from the previous quarter are denied, it is presumed the home health agency would not have known that services would not be covered, and liability for the denied services is waived; that is, Medicare will pay for the denied services.

Provision

- o Provides that claims will not be considered denied, for purposes of calculating the denial rate for waiver of liability, until 60 days after the date of denial or until the fiscal intermediary has made a decision on a reconsideration request.
- o Requires the Secretary to monitor home health denials must be monitored and notify Congress if the proportion of home health denials reversed on reconsideration increases significantly.

Effective Date

- o Enactment.
- o The change in calculating the denial rate is effective January 1, 1990.

Extension of Authority to Contract with Fiscal Intermediaries and Carriers on Other Than a Cost Basis (Section 6215)

Current Law

- o The Deficit Reduction Act of 1984 authorized the Secretary to enter into contracts with fiscal agents on the basis of

competitive bidding. It specifies that this authority may only be used for the purpose of replacing an intermediary or carrier which over a period of time has been in the lowest 20th percentile of all contractors. This authority concludes at the end of FY 1989.

Provision

- o Extends the Secretary's authority for competitively bid contracting through FY 1993.
- o Specifies that the period of time over which contractor performance is measured is a two-year period.
- o Authorizes the Secretary to enter into additional agreements and contracts without regard to cost reimbursement provisions if the contractor and the Secretary both agree to do so. The Secretary cannot require the contractor to waive the provisions (i.e., it must be voluntary).

Effective date

- o Effective beginning FY 1990.

Expansion of Rural Health Medical Education Demonstration Project (Section 6216)

Current Law

- o The Secretary is required to enter into three-year demonstration projects with four teaching hospitals, beginning June 1988, to assist resident physicians, who have completed one year of residency training, obtain one to three months of field experience in rural hospitals.
- o Participating hospitals must be small and located in different counties.
 - Two of the hospitals must be located in rural counties larger than 2,000 square miles, one east and one west of the Mississippi.
 - Two of the hospitals must be located in rural counties that have a severe shortage of physicians, one east and one west of the Mississippi.
- o The sponsoring/teaching hospital will count the resident in determining the indirect medical education payment and will have its direct medical education payments increased to cover

the cost of supervising the project's education and training activities.

Provision

- o Expands the number of demonstration projects from four to ten.
- o For new projects, waives the selection restrictions included in the original Act, regarding size of county and rural counties with severe physician shortage.
- o Requires that the new demonstration projects begin within six months of enactment.

Effective Date

- o Enactment.

Inner-City Hospital Triage Demonstration Project (Section 6217)

Current Law

- o No Provision.

Provision

- o Requires the Secretary to establish a three-year demonstration project in a public hospital, located in a large urban area, that has a triage system.
- o Provides reimbursement to the hospital for the reasonable costs of operating the system. Allocated funds may be used for the following:
 - to train hospital personnel to operate and participate in the system; and,
 - to provide services to patients who might otherwise be denied appropriate and prompt care.
- o Prohibits the Secretary from paying for costs determined to be unreasonable.
- o Requires that the total payment made during a single year cannot exceed \$500,000.

Effective Date

- o Enactment

**GAO Study of Administrative Costs of Medicare Program
(Section 6218)**

Current Law

- o No Provision.

Provision

- o Requires the General Accounting Office, under the direction of the Comptroller General, to conduct a study of the administrative burden of Medicare regulations and program requirements on providers, fiscal intermediaries, and carriers.
- o The study should include the following:
 - an assessment of current administrative costs to such entities and of trends in administrative costs since 1982; and,
 - + Administrative costs include personnel costs, training costs, the costs of data and communications systems affected by changes in requirements of the Medicare program, and the costs to such entities of non-compliance with requirements resulting from the failure of the Secretary to provide adequate notice of changes in program requirements.
 - a comparison of the administrative burden to such entities in providing services to individuals who are not Medicare beneficiaries.

Effective Date

- o Enactment.
- o The report is due by March 31, 1990, and must be submitted to the House Ways and Means and Energy and Commerce Committees and to the Senate Finance Committee.

**Provisions Relating to End Stage Renal Disease Services
(Section 6219)**

Current Law

- o OBRA 86 authorized the Secretary to reduce the composite rates paid to renal dialysis facilities by \$0.50 per treatment to fund administrative costs necessary to operate 17 ESRD network organizations.

Provision

- o Reallocates funds paid to each network organization for the administrative costs incurred in carrying out its responsibilities. In distributing payments to network organizations, the Secretary is required to take into account the following:
 - the geographic size of the network area; the number of ESRD providers in the network area; the number of individuals who are entitled to ESRD services in the network area; and, the proportion of the aggregate administrative funds collected in the network area.
- o Includes ESRD network organizations that have entered into contracts with the Secretary in provisions protecting PROs against liability and prohibiting disclosure of information.
- o Requires the Secretary to submit a report on the methodology and rationale used to establish a payment rate for the drug erythropoietin (EPO). The report should include the following:
 - a summary of information provided to the Secretary by the manufacturer of EPO and used to establish the payment rate; and,
 - a plan for ensuring the appropriateness of rates in the future.

Effective Date

- o Enactment.
- o The report is due by April 1, 1990, and must be submitted to the House Ways and Means and Energy and Commerce Committees and to the Senate Finance Committee.

Amendments Relating to the United States Bipartisan Commission on Comprehensive Health Care (Section 6220)

Current Law

- o The United States Bipartisan Commission on Comprehensive Health Care was established under the Catastrophic Coverage Act of 1988 to examine: shortcomings in the current health care delivery and financing mechanisms, access to health care services, and the need for Federal financing to assure the availability of long-term and comprehensive care for the elderly, disabled, and all individuals in the U.S. in general.

- o The Commission, made up of 15 members appointed by the President, President Pro Tempore of the Senate, and the Speaker of the House of Representatives, must elect a chairman and vice chairman from among its members.
- o The Commission is allowed the same mail privileges as Federal agencies.
- o The Reports required by the Commission, including the "Report on Comprehensive Long-Term Care Services for the Elderly and Disabled" and the "Report on Comprehensive Health Care Services," are due by January 1, 1989.

Provision

- o Provide that the Commission will also be known as the "Claude Pepper Commission" or the "Pepper Commission."
- o Allows the Commission to appoint four vice chairmen.
- o Amends current law to authorize the Commission to use the mail frank by a commission of Congress.
- o For purposes of costs relating to printing and binding, considers the Commission a Congressional commission.
- o Extends the report deadlines to November 9, 1989.

Effective Date

- o Enactment.

National Commission on Children (Section 6221)

Current Law

- o The National Commission on Children was established to serve as a forum on behalf of children in the U.S. and to conduct studies, hold public hearings, and submit a report on such issues as: the health of all children, social and support services, education, income security, and tax policy.
- o The interim report is due by March 31, 1990, and a final report is due by September 30, 1990, and must be submitted to the President, the Senate Committee on Finance and the Senate Committee on Labor and Human Resources, the House Committee on Ways and Means, the House Committee on Education and Labor, and the House Committee on Energy and Commerce.

Provision

- o Extends the deadline for the interim report until March 31, 1990 and the deadline for the final report until March 31, 1991.
- o Extends the Commissioners' terms until March 31, 1991.
- o Amends the current law to ensure funding for the Commission through FY 1991.
- o Authorizes the Commission to accept donations of money, property or personal services, provided that the following conditions are met:
 - Funds received from donations are to be deposited in the Treasury in a separate fund created for this purpose;
 - Funds may be used for such purposes as official reception and representation expenses, public surveys, public service announcements, preparation of special papers, analyses, documentaries, and other purposes determined by the Commission to be necessary to further its mission;
 - Money and other property donated to the Commission are considered to be gifts or bequests for purposes of Federal income tax; and,
 - Expenditure of funds are subject to the rules and regulations as adopted by the Commission and are not subject to Federal procurement requirements.
- o Authorizes the Commission to conduct public surveys in support of its review of national issues affecting children and, in conducting these surveys, the Commission is not deemed to be an "agency."

Effective Date

- o Enactment.

Continued Use of Home Health Wage Index in Effect Prior to July 1, 1989, Until After July 1, 1991 (Section 6222)

Current Law

- o In establishing cost limits for home health agency payments, the Secretary must use a wage index based on the most recent verified data available from home health agencies. The data

must be from cost reporting periods beginning on or after July 1, 1985.

Provision

- o Continues the wage index for determining the home health cost limits as the one in effect for cost reporting periods beginning before July 1, 1989, until cost reporting periods beginning on or after July 1, 1991. The wage index to be used for this period is the hospital wage index.

Effective Date

- o Enactment.

HCFA Personnel Study (Section 6223)

Current Law

- o No Provision.

Provision

- o Requires the National Academy of Public Administration to conduct a study of personnel at HCFA that would accomplish the following:
 - study personnel administration at HCFA;
 - assess the adequacy of HCFA staffing; and,
 - recommend any changes needed with respect to HCFA staffing to the Secretary and Congress.
- o In conducting the study, requires the Academy to interview management officials at HCFA and other appropriate agencies, and must include consideration of the following:
 - average years in service, years to retirement, and average age of various categories of HCFA personnel;
 - HCFA practices to recruit personnel to replace retiring and resigning employees and to train new employees;
 - the grade structure of various categories of HCFA personnel, and the need for additional nonsupervisory positions at the GS 13-15 levels for particularly skilled and expert personnel;

- the grade structure at HCFA compared to the grade structure within Federal agencies of similar size and responsibilities;
 - whether bonuses or other incentives are needed for HCFA to recruit and retain specialized personnel;
 - particular problems in hiring personnel that may prevent recruitment and retention of qualified staff;
 - Office of Personnel Management rules that may be burdensome to the hiring process; and,
 - how HCFA can more appropriately address the priorities of both Congress and the executive branch.
- o Requires the Academy to submit an acceptable application to conduct the study. If an acceptable application is not submitted, the Secretary may request one or more appropriate nonprofit private entities to submit an application for the study and may arrange for such entity to conduct the study.

Effective Date

- o Enactment.
- o The report is due by December 31, 1990 and must be submitted to the Secretary.

Peer Review Organizations (Section 6224)

Current Law

- o Only physicians can make initial determinations regarding denial of payment for substandard care furnished by another physician. However, non-physician health care practitioners must be consulted before making a determination on a case involving the services provided by a non-physician.
- o A PRO must issue a preliminary notice to a physician or provider that services will be denied. The PRO must then give the provider an opportunity for discussion and review of the proposed determination. If the PRO still disagrees, formal notification of payment denial is sent to the patient, the carrier and the fiscal intermediary.
 - If the physician requests a reconsideration, the PRO has a time limit in which to respond. This reconsideration occurs after the notification has been sent to the beneficiary and

cannot be appealed.

Provision

- o Requires PROs to establish procedures for the involvement of non-physician health care practitioners in their review process.
- o In cases where the PRO proposes to deny payment for substandard care, requires the PRO to provide the physician or provider a reconsideration of the formal determination before a notice is sent to patients, carriers and fiscal intermediaries.
 - The reconsideration would be in lieu of any subsequent reconsideration to which the provider would otherwise be entitled. The beneficiaries' right to reconsideration is preserved.
 - The notice to the patient must include the following: "In the judgement of the peer review organization, the medical care received was not acceptable under the Medicare program. The reasons for the denial have been discussed with your physician and hospital."

Effective Date

- o The amendment regarding peer review of non-physician services applies to contracts entered into after enactment.
- o The provider right to reconsideration of PRO determination provision applies to determinations with respect to which preliminary notifications are made after January 18, 1990.

Part 4 - Part B Premium

Part B Premium (Section 6301)

Current Law

Since 1984, the part B premium has been set in law at 25 percent of program costs for the elderly. In 1990, the premium reverts to the previous formula of the lower of an amount sufficient to cover half of the program costs for the elderly, or the previous year's premium increased by the Social Security cost of living adjustment.

Provision

- o Continues the part B premium at 25 percent of program costs for

the elderly in 1990.

Effective Date

- o Effective January 1, 1990.

Subtitle B -- Medicaid

Part 1 -- General Provisions

Mandatory Coverage of Certain Low-Income Pregnant Women and Children (Section 6401)

Current Law

- o Medicaid covers pregnant women and infants, and, optionally, children up to eight years of age up to 75 percent of the federal poverty level (FPL). 100 percent of FPL would have been effective July 1, 1990.

Provision

- o Requires States to extend Medicaid coverage to all pregnant women and children up to age 6 with family incomes up to 133 percent of the FPL (or up to 185 percent if already adopted by a State).
- o At a State's option, also includes children born after September 30, 1983, who have attained 6 years of age but have not attained 7 or 8 years of age (as selected by the State).

Effective Date

- o Effective for quarters beginning on or after April 1, 1990, with respect to eligibility and payment, whether or not final regulations have been promulgated. If a State requires legislation (other than appropriations) for the State plan to comply with these additional requirements, the State plan will not be considered out of compliance before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment. (In the case of a State with a 2-year session, each year will be deemed a separate regular session). [Note: this will be referred to as the "standard extension"]

Payment for Obstetrical and Pediatric Services (Section 6402)

Current Law

- o States establish their own payment levels for Medicaid services consistent with economy, efficiency and quality of care.

Provision

- o Requires that payments must be sufficient to enlist enough providers to service Medicaid beneficiaries at least to the extent services are available to the general population in the geographic area.
- o Requires States to amend their plans specifying payment rates by procedure for obstetrical/pediatric services by April 1 of each year, beginning in 1990. States must include data on how rates were established for HMOs and data to allow the Secretary to evaluate each State's compliance with the requirement.
- o Defines "obstetrical services" as services provided by an obstetrician, ob-gyn, family practitioner, certified nurse midwife, or certified family nurse practitioner and does not include inpatient or outpatient hospital care or other institutional services.
- o Defines "pediatric services" as services delivered to children under 18 years of age by a pediatrician, family practitioner or certified pediatric nurse practitioner, and does not include inpatient or outpatient hospital care or other institutional services.
- o Requires (for State plans submitted in 1992 and thereafter) data to include, for the second previous year (e.g. 1993 plans to include 1991 data), at least the statewide average Medicaid payment rates for obstetrical and pediatric services by procedure, separately for each metropolitan statistical area (MSA). States may establish higher payment levels in rural areas than in MSAs.
- o Provides payment for ambulatory services to a pregnant woman or individual under 18 years of age in a health center receiving funds under the Public Health Service Act. Section 6404 duplicates this by providing coverage of services offered in Federally-qualified health centers. Congress did not intend this duplication, and will notify the agency of its preference for the latter, section 6404.

Effective Date

- o Enactment.

Early and Periodic Screening, Diagnostic, and Treatment Services Defined (Section 6403)

Current Law

- o States are required to cover EPSDT services for Medicaid beneficiaries under 21 years of age. By regulation, States must screen participating children for health problems. In addition, States must provide dental care, necessary immunizations, vision and hearing treatment. States must establish a periodicity schedule for screening, and have the option to provide services that may not otherwise be available under the State plan.

Provision

- o Defines the term "EPSDT" to include, at intervals which meet reasonable practice standards and medical necessity, the following services:
 - Screening services which include at a minimum,
 - + a comprehensive health and developmental assessment (both physical and mental),
 - + a comprehensive unclothed physical exam,
 - + appropriate immunizations, and
 - + lab tests and health education;
 - Vision services including eyeglasses;
 - Dental care;
 - Hearing services including hearing aids; and
 - Such other services to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.
- o Requires States to provide any service covered with Federal matching funds to treat a condition identified during screening, whether or not the service is included in the State's plan. Clarifies that providers of EPSDT services need not be limited to those who are qualified to provide all of the items and services.
- o Requires States to report the following, by age group and basis of eligibility, by not later than April first after the end of each fiscal year, beginning with FY 1990:
 - the number of children provided child health screening

services;

- the number of children referred for corrective treatment;
- the number of children receiving dental services; and,
- the State's results in attaining participation goals.

- o Requires the Secretary, by no later than July 1, 1990 and every 12 months thereafter, to develop and set annual goals for each State for participation of individuals in EPSDT.

Effective Date

- o April 1, 1990 whether or not final regulations have been promulgated.

Payment for Federally Qualified Health Center Services (Section 6404)

Current Law

- o States are permitted to cover services in community health centers, migrant health centers, and programs of health care to the homeless receiving Federal grants under the Public Health Service Act. States that cover such services establish their own reimbursement methodologies.

Provision

- o Requires States to include in their Medicaid benefit package Federally-qualified health center services and any ambulatory services offered by a Federally-qualified health center and otherwise covered in the State plan.
- o Defines "Federally qualified health center services" the same as rural health clinic services that are provided on an outpatient basis under Medicare.
- o Defines "Federally qualified health centers" as community health centers, migrant health centers, or programs of health care to the homeless, as well as clinics which meet the standards of those programs but are not actually receiving grant funds. Deems references to a rural health clinic or to a physician at the clinic as references to a Federally qualified health center or to a physician at the center, respectively.
- o Requires States to pay 100 percent of reasonable costs for rural health clinic and Federally qualified health center services.

Effective Date

- o Applies to Medicaid payments for calendar quarters beginning on or after April 1, 1990 whether or not final regulations have been promulgated. States requiring legislation are given the standard extension.

Required Coverage of Nurse Practitioner Services (Section 6405)

Current Law

- o At State option, State Medicaid programs may cover medical care furnished by nurse practitioners certified and practicing under State law.

Provision

- o Requires States to include in their Medicaid benefit package services provided by a certified pediatric nurse practitioner or certified family nurse practitioner practicing within the scope of State law, regardless of whether they are under the supervision of, or associated with, a physician or other health care provider.

Effective Date

- o For services provided on or after July 1, 1990.

Required Medicaid Notice and Coordination with Special Supplemental Food Program for Women, Infants and Children (WIC) (Section 6406)

Current Law

- o State medical assistance programs must enter into cooperative arrangements with State agencies administering MCH and other health programs, and with vocational rehabilitation programs to maximize the use of those services; and to reimburse MCH programs for provision of their services which are also included under the State Medicaid plan and for which payment would otherwise be made to the State Medicaid agency.
- o OBRA 87 amended the Child Nutrition Act to mandate WIC coordination with Medicaid in addition to MCH.

Provision

- o Requires State Medicaid plans to provide for coordination

between WIC and Medicaid.

- o Requires States to notify all Medicaid eligible pregnant, breast feeding or postpartum women, or children below the age of 5, of WIC benefits. Also, requires referrals to the responsible State administering agency.

Effective Date

- o July 1, 1990, whether or not regulations have been promulgated.

Demonstration Projects to Study the Effect of Allowing States to Extend Medicaid to Pregnant Women and Children Not Otherwise Qualified to Receive Medicaid Benefits (Section 6407)

Current Law

- o No provision.

Provision

- o Authorizes demonstrations for up to three years to allow several States to extend health insurance coverage to pregnant women and children under age 20 in families with incomes below 185% of the federal poverty level (FPL) who lack insurance, and to encourage workers to obtain health insurance for themselves and their children.
- o Requires the projects to study the effect on access to health care, private insurance coverage, and costs of health care when States are allowed to extend Medicaid benefits.
- o Allows benefits to consist of Medicaid services as provided to Medicaid eligible persons in the State or, at State-option, Medicaid subsidized enrollment in alternative plans such as those authorized for employed families receiving a second six-month period of extended Medicaid assistance after loss of AFDC, e.g., enrollment in a medical plan offered by an employer.
- o Appears to limit eligibility for benefits under the projects to those who otherwise would not qualify under the alternative assistance option available during the second six-month Medicaid extension provided to AFDC families terminated due to employment.
- o Requires an employer contribution, if one or more demonstrations utilize employer coverage.

- o Prohibits charging a premium for pregnant women and children whose income levels are below 100 percent of FPL. In the case of pregnant women and children between 100 to 185 percent of FPL, a premium not to exceed 3 percent of the family's average gross monthly earnings will be charged.
- o Permits the Secretary to waive Statewideness. The Federal share of benefits paid and expenses incurred for these demonstrations is limited to \$10 million for each of FYs 1990, 1991 and 1992.
- o Requires that each project be evaluated, and an interim report submitted to Congress summarizing the evaluations no later than January 1, 1992 with a final report due no later than January 1, 1994.

Other Medicaid Provisions

Institutions for Mental Disease (Section 6408(a))

Current Law

- o The Social Security amendments of 1972 permitted States to provide Medicaid benefits for persons aged 65 or older in institutions for mental diseases (IMDs); other residents of IMDs are ineligible for Medicaid. States may also cover services in in-patient psychiatric hospitals for persons under age 21.
- o MCCA 88 defined an IMD as an institutional setting of more than 16 beds that is primarily engaged in diagnosing, treating, or caring for persons with mental diseases.

Provision

- o Directs the Secretary of HHS to conduct a study of:
 - the implementation of current law and regulation of the exclusion from coverage of certain individuals residing in IMDs;
 - the costs and benefits of using Medicaid funds to provide services in public sub-acute psychiatric facilities which serve patients who would otherwise be hospitalized.
- o Requires the Secretary of HHS to submit to Congress a report on the study by no later than October 1, 1990. The report shall recommend modifications to current law and policy, if

necessary, to accommodate changes which have occurred since 1972 in the delivery of inpatient psychiatric and other mental health services; and include recommendations on the continued coverage of Medicaid for services in sub-acute psychiatric facilities.

- o Precludes the Secretary from determining that Kent Community Hospital Complex and Saginaw Community Hospital (both in Michigan) are IMDs until 180 days after Congress has received the above report.

Extension of Texas Personal Care Services Waiver (Section 6408(b))

Current Law

- o The Secretary has general authority to conduct experiments and demonstrations under various Social Security Act titles, including Medicaid, and to waive compliance with certain program requirements in carrying out these demonstrations. Under this authority, the Secretary approved a Medicaid waiver for the project, "Modifications of the Texas System of Care for the Elderly: Alternatives to the Institutionalized Aged," beginning in January, 1980. The waiver remains in effect until January 1, 1990, unless the Secretary finds that the applicant no longer complies with terms and conditions applied as of 12/31/85.

Provision

- o Extends the period that the waiver may remain in effect to July 1, 1990.

Hospice Payment for Room and Board (Section 6408(c))

Current Law

- o Medicaid law requires States covering hospice care to pay for hospice care in the same amounts, and according to the same prospective payment methodology, as under Medicare. For Medicaid-eligible residents of nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs/MR), Medicaid law also permits a separate rate to be paid to the hospice program to take into account the room and board furnished by the facility, including performance of personal care services.

Provision

- o Requires States to pay for hospice care in amounts no lower than the amounts paid under Medicare, and to use the same methodology used under Medicare. Requires States to pay an amount for room and board (in addition to the hospice rate paid) for terminally ill residents of a NF or ICF/MR who elect hospice care. This additional amount must be at least 95 percent of the NF or ICF/MR per diem rate that would have been paid under the State plan for facility services in that facility for that individual.

Effective Date

- o For services provided on or after April 1, 1990, whether or not final regulations have been promulgated.

Medicare Buy-in for Premiums of Certain Working Disabled (Section 6408(d))

Current Law

- o No provision.

Provision

- o Requires States to cover the cost of Medicare Part A premiums and cost-sharing for certain working disabled persons who are eligible for Medicare benefits as a result of the new section 1818A of the Act. These are individuals who:
 - have not attained age 65;
 - have been entitled to Title II disability benefits but are no longer entitled due to earnings in excess of the substantial gainful activity (SGA) level;
 - continue to have the same disabling physical or mental condition which served as the basis for the determination of disability for entitlement to benefits; and,
 - are not otherwise eligible for Medicaid benefits.
- o Excludes such individuals with incomes greater than 200 percent of the FPL or resources greater than twice the level permissible under the SSI program.
- o Permits States to charge a premium for these benefits for individuals with income between 150-200 percent of the FPL. Such premiums will equal 0-100 percent of the Medicare Part A premiums, increasing in reasonable increments as income increases between 150-200 percent of the FPL.

Effective Date

- o For payments for calendar quarters beginning on or after July 1, 1990, except in cases where a change in State law is required. In these instances the standard extension will apply.

Part 2 -- Technical and Miscellaneous Provisions

Miscellaneous Technical Amendments (Section 6411)

Technical Correction to Medicare Buy-in for the Elderly (Section 6411(a))

Current Law

- o MCCA required States pay for Medicare cost-sharing for "qualified Medicare beneficiaries", those individuals whose income does not exceed 100 percent of the poverty line and whose resources do not exceed twice the amount permissible under the SSI program.
- o States have the option to provide full Medicaid benefits to all aged, blind, and disabled persons meeting these same income and resources limits.
- o 209(b) States may use eligibility standards that are more restrictive than SSI standards.

Provision

- o Makes a technical change to clarify that 209(b) States are prohibited from using more restrictive methods of determining eligibility of "qualified Medicare beneficiaries" and poverty level aged, blind, and disabled groups. States are required instead to employ the methods of the SSI program.

Effective Date

- o As if in MCCA.

Extension of Delay in Issuance of Certain Final Regulations (Section 6411(b))

Current Law

- o The Secretary is prohibited from issuing final regulations prior to May 1, 1989, that would place additional restrictions

on the use of voluntary contributions or provider-paid taxes by States to receive Federal matching funds under Medicaid.

Provision

- o Prohibits the Secretary from issuing any such regulations prior to December 31, 1990.

Effective Date

- o Enactment.

Disproportionate Share Hospitals (Section 6411(c))

Current Law

- o State Medicaid reimbursement methods and standards for hospital services must take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs.
- o Medicaid State plans must define hospitals serving a disproportionate number of low-income patients and provide for an increase in the rate or amount of payment for inpatient services provided by such hospitals.
- o Formulas have been established for identifying disproportionate share hospitals and adjusting the Medicaid reimbursement rates of such hospitals within strictly limited State choices.

Provision

- o Exempts New Jersey's payment plan for disproportionate share hospitals, which was in effect as of January 1, 1987, from the requirements of current law. Requires that the State's aggregate disproportionate share payment adjustments be at least equal to those that would have been made if the State complied with the requirements in current law.
- o Deems Missouri to have met the requirements of current law for the period July 1, 1988 through June 30, 1990 if the total amount of disproportionate share adjustment payments to hospitals is not less than the amount required by law.

Effective Date

- o For the New Jersey exemption, as if enacted in OBRA 87.
- o For the Missouri transition rule, upon enactment.

Fraud and Abuse Technical Amendment (Section 6411(d))

Current Law

- o The Secretary may exclude from Medicare and Medicaid a provider whose license has been revoked, suspended, or otherwise lost for reasons related to competence, performance, or financial integrity. Providers excluded from Medicare and/or Medicaid can be paid for emergency services provided to beneficiaries.

Provision

- o Permits exclusion of a provider who has lost the right to apply for or renew a license on the same grounds. Clarifies that the exception permitting payment for emergency services provided by excluded providers does not apply to services furnished in a hospital emergency room.
- o Clarifies that HMOs with Medicare risk sharing contracts or Medicaid prepaid plans, may not employ or contract with:
 - individuals or entities excluded from participation in Medicare or Medicaid for the provision of health care, utilization review, medical social work, or administrative services;
 - any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services.

Effective Date

- o For exclusion for the loss of right to apply or renew, and for no payment for emergency room services provisions, upon enactment.
- o For the HMO provision, 90 days after enactment.

Spousal Impoverishment (Section 6411(e))

Current Law

- o States are required to deny Medicaid coverage for long-term institutional care and certain other services for institutionalized persons who dispose of assets for less than their fair market value 30 months prior to entering an institution or applying for Medicaid. This requirement does not extend to situations in which a non-institutionalized spouse disposes of assets without fair compensation.

Provision

- o Requires that the same restrictions on Medicaid coverage apply when the non-institutionalized spouse transfers or disposes of an asset for less than fair market value;
- o Clarifies existing law by mandating that all provisions affecting treatment of income and resources for certain institutionalized spouses apply to 209(b) States;
- o Clarifies that rules for treating a couple's income when one spouse is institutionalized, apply at initial determinations and subsequent redeterminations of Medicaid eligibility.

Effective Date

- o For spousal transfers, upon enactment.
- o For other provisions, as if included in MCCA.

Health Insuring Organizations (Section 6411(f))

Current Law

- o The Tennessee Primary Care Network, a Health Insuring Organization until 1987, had been operating under a Medicaid Freedom of Choice waiver under section 2175 of OBRA 81. The original FOC waivers exempted HIOs from the 75/25 percent enrollment composition requirement in section 1903(m) of the Social Security Act.
- o In 1986, COBRA subjected HIOs to the HMO requirements but allowed a temporary continuation of contracts with HIOs that were under development or operational on January 1, 1986, and for which the Secretary had granted section 2175 waivers.
- o In 1987, the Tennessee Primary Care Network was classified as an HMO. As a new HMO, it was exempt from the 1903(m) enrollment composition requirement for three years. As of June 1990, Tennessee Primary Care Network will have to meet section 1903(m) requirements.

Provision

- o Requires the Secretary to continue the waiver allowing the Tennessee Primary Care Network, Inc. to remain exempt from the 75/25 percent requirement through June 30, 1992.

Effective Date

- o Enactment.

Day Habilitation and Related Services (Section 6411(g))

Current Law

- o States may cover clinic and rehabilitation services under their Medicaid State plans. Some States have used one or the other of these options to provide day habilitation services to mentally retarded beneficiaries in the community not otherwise covered by a home and community-based services waiver.

Provision

- o Prohibits the Secretary from denying Federal funding for day habilitation and related services in Medicaid plans on or after June 30, 1989.
- o Prohibits withdrawal of Federal approval of such a State plan provision unless regulations are promulgated, with at least 60-day public comment period, specifying the types of day habilitation and related services a State may cover and any requirements applicable to those services.
- o Provides that if a regulation is promulgated, the Secretary may find a State out of compliance; however, the determination would only apply to services furnished on or after the first day of the first quarter following the notice to the State including the basis for the finding of non-compliance.

Effective Date

- o Enactment.

Medically Needy Income Levels (Section 6411(h))

Current Law

- o States are permitted to extend Medicaid coverage to the medically needy, individuals who meet the categorical requirements for AFDC or SSI but whose income exceeds the usual eligibility thresholds.

To be eligible for Medicaid as medically needy, the family income, after deducting medical expenses, cannot exceed 133 1/3 percent of the maximum AFDC cash payment amount for a family of

the same size. Proposed regulations published September 26, 1989, would require States to base medically needy levels for one-person households on actual AFDC payments for one person where the State's AFDC program provides such a payment.

Provision

- o Prohibits the Secretary from issuing final regulations which may affect medically needy income levels for households of one person until December 31, 1990.

Effective Date

- o Enactment.

Technical Correction Concerning Transitional Coverage (Section 6411(i))

Current Law

- o The Family Support Act requires States to extend Medicaid coverage for 6 months to AFDC families who lose cash benefits due to increased earnings or hours of work (effective April 1, 1990, until September 30, 1998). Also requires States to offer coverage for an additional 6 months. During this period the State may require families to pay premiums for continued Medicaid coverage, offer reduced benefits or select alternative coverage options. Also, early termination may occur if the family ceases to include a child who meets the AFDC definition of dependency.
- o The Family Support Act suspended a provision which had required States to offer 9 months of Medicaid coverage with an option for 6 additional months of coverage. Such a suspension was necessary to assure that families losing AFDC between April 1, 1990 and September 30, 1990 who would otherwise have been eligible for 15 months of transitional coverage would receive 12 months of coverage. (Eligibility for extended coverage is based on receipt of AFDC in 3 of the 6 months preceding termination).

Provision

- o Clarifies that coverage is subject to early termination only if the family ceases to include at least one child, whether or not that child meets the AFDC definition of dependency.
- o Clarifies that the 9 month/6 month extension of coverage for working, former AFDC families continues to apply to families

who lose AFDC before April 1, 1990.

Effective Date

- o As if included in the Family Support Act.

**Minnesota Prepaid Medicaid Demonstration Project Extension
(Section 6411(j))**

Current Law

- o The State of Minnesota had a waiver to demonstrate the feasibility of HMOs for Medicaid beneficiaries in 3 locations in Minnesota. The waiver, due to expire on December 31, 1988, was extended to June 30, 1990 under section 507 of the Family Support Act of 1988.

Provision

- o Directs the Secretary to extend Minnesota's waiver until June 30, 1991.

Subtitle C - Maternal and Child Health Block Grant Program

Significant sections related to Medicaid include:

Increase in Authorization of Appropriations (Section 6501)

- o Beginning in FY 1990, increases funds available to the Maternal and Child Health (MCH) Block Grant Program to:
 - enable each State to:
 - + provide broader access to quality maternal care and child health services;
 - + reduce infant mortality; and,
 - + provide rehabilitation, family-centered and community-based services for children with special health needs; and,
 - enable the Secretary to develop and expand projects designed to increase the participation of obstetricians and pediatricians under MCH programs and under Medicaid state plans.

**Use of Allotment Funds and Application for Block Grant Funds
(Section 6503)**

- o Requires applications for block grants to contain a statewide needs assessment (to be done every 5 years) that identifies preventive and primary care services for pregnant women, mothers, and infants up to age one; and preventive and primary care services for children with special health care needs. Plans to meet those needs must include assurances that at least 30 percent will be spent on preventive and primary care, and at least 30 percent on services for children with special health needs.
- o Requires States to establish a toll-free telephone number for the use of parents to access information about health care providers and practitioners who provide Medicaid services.
- o Requires State agencies to provide for services to identify pregnant and postpartum women, and infants under one year of age who are eligible for Medicaid, and once identified, assist them in applying for Medicaid.

Report (Section 6504)

- o Beginning in FY 1991, States are required to include extensive information in their annual reports, including the number of deliveries and infants covered by Medicaid. The Secretary is required to transmit annually to the Congress a report that includes this information and an assessment of the progress being made to meet the health status goals and objectives for mothers and children.

Development of Model Applications (Section 6506)

- o No later than one year after enactment, requires the Secretary to develop and disseminate a model application form for simultaneous application for a pregnant woman or a child less than 6 years of age for benefits under maternal and child assistance programs including, the MCH block grant program; migrant and community health centers programs; homeless primary care program; WIC; Medicaid; and Head Start.
- o No later than one year after enactment, requires the Secretary to develop and disseminate a model application form for use in applying for Medicaid benefits for non-institutionalized individuals who are not receiving cash assistance under title IV-A of the Social Security Act. Prohibits the Secretary from requiring States to adopt the form as part of their State

Medicaid plan.

**Research on Infant Mortality and Medicaid Services
(Section 6507)**

- o Requires the Secretary to develop a national data system for linking, for any infant up to age one:
 - the infant's birth record,
 - any death record for the infant, and
 - information on any claims submitted under Medicaid for health care furnished to the infant or with respect to the birth of the infant.

Demonstration Project on Health Insurance for Medically Uninsurable Children (Section 6508)

- o Authorizes the Secretary to conduct four demonstration projects to provide health insurance coverage under an eligible plan for medically uninsurable children under the age of 19. Makes coverage available for at least two years and is guaranteed by the Secretary for that period of time. The plan may not restrict coverage on the basis of a child's medical condition or impose waiting periods or exclusions for preexisting conditions. Premiums shall be disclosed in advance of enrollment and will vary by individuals' incomes. The Secretary shall provide for an evaluation of the demonstration's effects on access, availability of coverage, demographic characteristics and health status, and families' out-of-pocket costs.

Subtitle D -- Vaccine Compensation Technicals

Vaccine Injury Compensation Technicals (Section 6601(1)(4))

Current Law

- o Individuals who suffer injury or death associated with the administration of a vaccine may be compensated by payment from the Vaccine Injury Compensation Trust Fund. Payment of compensation cannot be made for items or services covered by insurance policies, health benefit plans, or other compensation programs. The Trust Fund is a secondary payor to these programs.

Provision

- o Amends the Public Health Service Act to clarify that while compensation paid by the vaccine injury compensation program is secondary to Federal or State health benefits or services programs, this does not include the Medicaid program.

Subtitle E - COBRA Continuation Coverage

Extension, Under Internal Revenue Code, Under Public Health Service Act, and Under ERISA, of Coverage from 18 to 29 Months for Those with a Disability at Time of Termination of Employment (Sections 6701, 6702, 6703)

Current Law

- o Employers, group health plans, and State and local government group health plans (all with 20 or more employees) are required to provide certain employees and their family members with the option of purchasing continued health insurance coverage in the case of certain events (qualifying events). These events include:
 - termination or reduction in hours of employment,
 - death,
 - divorce or legal separation,
 - eligibility for Medicare, or
 - the end of a child's dependency under a parent's health insurance policy.

The individual must provide notice of a qualifying event to the plan administrator within 30 days, and must elect continuation coverage within 60 days.

- o Continuation coverage must be identical to the previous coverage and be offered at the group rate. The premium for continuation coverage cannot exceed 102% of the plan premium.
- o The maximum period of continuation coverage that may be elected is 36 months from the date of the qualifying event, except in the case of termination of employment or reduction of hours for which the maximum period is 18 months. Continuation coverage may be terminated earlier than the maximum 18 or 36 months in the case of certain events. These events include:
 - the end of all plan coverage to any employee,
 - failure of the beneficiary to pay the plan premium,
 - remarriage of the divorced spouse, or

- the beneficiary becomes covered under another group health plan or entitled to Medicare.

Provision

- o Extends the maximum required period of continuation coverage under termination or reduction in hours of employment from 18 to 29 months for those with a disability (determined under Title II or XVI).
- o Permits a premium increase up to 150 percent after the 18th month of continuation coverage.

Effective Date

- o Applies to plan years beginning on or after the date of enactment of this Act, regardless of when termination occurred.

Amendments to the Public Health Service Act (Section 6801(b)(2)(A)(ii)), Internal Revenue Code and ERISA (Section 7862(c)(3)(A)(ii) and (B)(ii))

Current Law

- o State and local government group health plans (with 20 or more employees) are required to provide employees and their family members with the option of purchasing continued health insurance coverage in the case of certain events (qualifying events). These events include termination or reduction in hours of employment.
- o The maximum period of continuation coverage that may be elected is 18 months in the case of termination or reduction in hours of employment. Continuation coverage may be terminated earlier than the maximum 18 months in the case of certain events. These events include beneficiaries who are reemployed and covered under another group health plan.

Provision

- o Amends the Public Health Service Act, the Internal Revenue Code, and ERISA to clarify that continuation coverage cannot terminate because of reemployment if the employee's new group health plan contains any exclusions or limitations for preexisting conditions.

Effective Date

- o Applies to reemployment after December 31, 1989.

**Subtitle F - Technical and Miscellaneous Provisions Relating
to Nursing Home Reform**

**Medicare and Medicaid Technical Corrections Relating to Nursing
Home Reform (Section 6901)**

**Moratorium on Implementation of February 2, 1989 Regulations
(Section 6901(a))**

Current Law

- o On February 2, 1989, HCFA published final regulations that revise and consolidate requirements that nursing homes must meet in order to participate in Medicare and/or Medicaid. As published in February, most of the provisions of the final regulations would have become effective August 1, 1989, although OBRA 87 specified an effective date of October 1, 1990 for similar provisions. In July, HCFA issued notice in the Federal Register that it would delay implementation of the February regulations to January 1, 1990.

Provision

- o Requires that HCFA's February 2 regulations on requirements for long-term care facilities participating in Medicare and/or Medicaid not be effective before October 1, 1990.

Effective Date

- o Enactment.

Nurse Aide Training (Section 6901(b))

Current Law

- o Effective January 1, 1990, skilled nursing facilities (SNFs) or nursing facilities (NFs) participating in Medicare/Medicaid are prohibited from using a person as a nurse aide, for more than 4 months, unless the individual has completed a State-approved training and/or a competency evaluation program, and is competent to provide nursing or nursing related services.
- o SNFs/NFs are required to provide, for nurse aides hired prior to July 1, 1989, a State-approved competency evaluation program and preparation necessary to complete such a program by January 1, 1990.
- o The Secretary must establish requirements for State approval of

nurse aide training and/or competency evaluation programs by September 1, 1988, and specify in these requirements, areas to be covered in programs. In the case of nurse aide training and competency evaluation programs, specify the content of curriculum, minimum hours of initial (75 hours) and ongoing training and retraining, qualifications of instructors, and procedures for determining competency. Allows deeming for certain individuals who completed training before January 1, 1989.

- o Federal matching payments are authorized for State activities required in connection with the review and approval of nurse aide training and competency evaluation programs, and nurse aide competency evaluation programs, whether the programs are conducted in or outside nursing facilities or regardless of the skill of the personnel involved in the programs. For the 8 calendar quarters beginning July 1, 1988, enhanced Federal matching payments are authorized for these activities (the Federal matching rate for a State plus 25 percent, not to exceed 90 percent). In subsequent years, the rate becomes 50 percent.

Provision

- o Delay in Requirements - Required Training of Nurse Aides - As of October 1, 1990, prohibits a SNF or NF from using nurse aides for more than four months unless they has completed a State-approved training and competency evaluation program, or a competency evaluation program, and is competent to provide nursing or nursing-related services.

Offering Competency Evaluation Programs for Current Employees - Requires a SNF or NF to provide a State-approved competency evaluation program and any necessary preparation for individuals used as nurse aides as of January 1, 1990 and requires that the individual complete such competency evaluation program by October 1, 1990.

- o Publication of Proposed Regulations - Requires publication of proposed regulations on requirements for nurse aide training and competency evaluation programs and for nurse aide competency evaluation programs 90 days after the date of enactment.
- o Requirements for Training and Evaluation Programs - Adds to requirements that the Secretary must establish for approval of nurse aide training and competency evaluation programs, a requirement that programs cover the care of cognitively impaired residents; and amends the specifications for nurse aide competency evaluation programs to require such programs to

cover recognition of mental health and social service needs, and care of cognitively impaired residents.

Provides that nurse aides may establish competency:

- through procedures or methods other than the passing of a written examination; and,
 - at the nursing facility at which the aide is (or will be) employed, unless the facility is out of compliance with requirements for participation within the previous two years. Prohibits the imposition on nurse aides of any charges (including any charges for textbooks and other required course materials) for either the nurse aide training and competency evaluation programs or for the nurse aide competency evaluation programs.
- o Delay and Transition in 75-Hour Training Program Requirement
- Delays effective date for States to deem individuals who completed a nurse aide training and competency evaluation program to July 1, 1989.
 - Considers a nurse aide to have met the nurse aide training and competency evaluation requirements if the nurse aide:
 - + Participated in a program that offered a minimum of 60 hours of nurse aide training to nurse aides before July 1, 1989 and if such aides received before July 1, 1989 up to 15 hours in supervised practical nurse aide training or in regular in-service nurse aide education (initial training must be at least 75 hours);
 - + Completed a course of at least 100 hours of nurse aide training and was found competent (whether or not by the State) before July 1, 1989; or,
 - + Has served as a nurse aide at one or more facilities of the same employer in the State for at least 24 consecutive months before the date of enactment.
- o Clarification of Matching
- Includes the cost of nurse aides completing competency evaluation programs in the enhanced Federal matching payments.
 - For the period July 1, 1988 to July 1, 1990, increases the Federal medical assistance percentage (FMAP) 25 percent, up to 90 percent, for costs of State review and approval of

nurse aide training and competency evaluation programs and nurse aide competency evaluation programs.

- Prohibits the Secretary from allocating costs for nurse aide training and competency evaluation programs, and competency evaluation programs, conducted before October 1, 1990 based on the proportion of residents of nursing facilities entitled to benefits under Medicare or Medicaid.

Effective Date

- o As if included in OBRA 87, except for amendments which will apply to Requirements for Training and Evaluation Programs offered on or after the end of the 90-day period beginning on the date of enactment. It will not affect competency evaluations conducted under programs offered before the end of the period.

Publication of Proposed Regulations Respecting Preadmission Screening and Annual Resident Review (Section 6901(c))

Current Law

- o The Secretary is required to issue, by not later than October 1, 1988, minimum criteria for States to use in making PASARR determinations for a mentally ill or mentally retarded individual. In May 1989, HCFA issued State Medicaid Manual Instructions.

Provision

- o Requires the Secretary to issue proposed regulations within 90 days of enactment to establish the criteria for States to use in making PASARR determinations.

Other Amendments (Section 6901)

Clarification of Applicability of Enforcement Rules to Dually-Certified Facilities (Section 6901(d)(1))

Current Law

- o For SNFs and NFs found out of compliance with requirements for participation, there are enforcement procedures to be applied to skilled nursing facilities participating in Medicare, and nursing facilities participating in Medicaid. OBRA 87 did not specifically address how enforcement actions are to be taken against nursing facilities that are certified to participate in

both Medicare and Medicaid.

Provision

- o Provides that the enforcement rules for nursing facilities participating in Medicaid also apply to those nursing facilities, or portions of nursing facilities, participating in Medicare.

Clarification of Federal Matching Rate for Survey and Certification Activities (Section 6901(d)(2))

Current Law

- o The Medicaid program authorizes a 75 percent Federal matching rate to States for costs attributable to compensation or training of skilled professional medical personnel and staff supporting such personnel. Beginning in FY 1991, enhanced Federal matching payments are authorized for State survey and certification activities. These will be at the rate of 90 percent for FY 1991, 85 percent in FY 1992, 80 percent in FY 1993, and 75 percent in FY 1994 and thereafter.

Provision

- o Clarifies that during the period before October 1, 1990, the Federal matching rate for State survey and certification of Medicaid Skilled Nursing Facilities and Intermediate Care Facilities (ICFs) is the current 75 percent.

Medicare Waiver Authority for Certain Demonstration Projects (Section 6901 (d)(3))

Current Law

- o The Secretary is prohibited from entering into an agreement with any State for the purpose of determining whether a Medicare skilled nursing facility (SNF) meets requirements unless the State uses the standard, Federally prescribed survey and certification process.

Provision

- o Allows the Secretary to waive the Medicare survey and certification requirements to carry out a demonstration project in New York to test an approved alternative survey and certification process. Applies during the period beginning November 1, 1988 and ending on October 31, 1991.

- o Allows the Secretary to waive the Medicare survey and certification requirements to carry out a pilot demonstration project in Wisconsin to test an approved alternative survey and certification process. Such waiver shall apply only during the one-year period beginning on the date of implementation of the project.

Effective Date

- o As if included in the enactment of the Omnibus Budget Reconciliation Act of 1987 (OBRA 87), except for (2) "Clarification of Federal Matching Rate for Survey and Certification Activities," which is upon enactment.

Title VIII -- Human Resources and Income Security Provisions

Permanent Extension of Medicaid Eligibility Extension Due to Collection of Child or Spousal Support (Section 8003)

Current Law

- o States are required to extend Medicaid coverage for 4 months to families who lose AFDC benefits due to the collection of child support. This provision expires 10/1/89.

Provision

- o Permanently extends coverage offered under current law.

Effective Date

- o Effective October 1, 1989.

Case Plans to Include Health and Education Records and to be Reviewed and Updated at the Time of Each Placement (Section 8007)

Current Law

- o The State is required to maintain a case plan for each child receiving maintenance payments under Title IV-E Foster Care which must include a description of the home or institution in which the child is to be placed, a discussion of the appropriateness of the placement and assurances that the child will receive needed services.

Provision

- o Adds a requirement that the case plan must include the health and education record for each child. The health record must state all known health problems of the child and the name of health care providers. The record must be furnished to the foster care provider and updated with each foster care placement.

Effective Date

- o Effective April 1, 1990.

Establishment and Conduct of SSI Outreach Programs for Children (Section 8008)

Current Law

- o No provision.

Provision

- o Requires the establishment of an SSI outreach program for disabled and blind children. Requires the Secretary of HHS to work cooperatively with organizations and agencies with knowledge of potential SSI recipients.

Effective Date

- o 3 months following enactment (March 19, 1990).

SSI Rules for Deeming to Children the Income and Resources of their Parents Waived for certain Disabled Children (Section 8010)

Current Law

- o The SSI program requires that the income and resources of a disabled child's parents are deemed to the child when he/she lives in the household with the parents. Deeming does not apply if the child is in an institution (hospital, nursing home) for 30 days or more. States are authorized to offer "home care" plans whereby a disabled child can be cared for at home and for purposes of Medicaid eligibility, deeming rules may, at the State's option, not apply.

Provision

- o Waives the SSI deeming rules in cases where a child under age

18 is being cared for at home under a "home care" plan (established either under a 1915(c) waiver or a 1902(e)(3) state plan option) and was receiving SSI benefits while institutionalized. Payment of SSI benefits will be the same as if the child were still institutionalized (\$30 per month personal needs allowance).

Effective Date

- o The first day of the sixth calendar month after enactment (June 1, 1990).

SSI Exclusion from Income of a Domestic Commercial Transportation Ticket Received as a Gift (Section 8011)

Current Law

- o The fair market value of a domestic commercial transportation ticket received as a gift is considered unearned income unless it cannot be converted to cash. This could result in the loss of SSI and Medicaid for the calendar quarter during which the gift is received.

Provision

- o Eliminates counting a gift of a domestic commercial transportation ticket received by an SSI recipient or eligible spouse as unearned income if used by the eligible individual or spouse.

Effective Date

- o The first day of the third calendar month beginning after the date of enactment (March 1, 1990).

Reduction of Time During which Income and Resources of Separated Couple must be Treated as Jointly Available for SSI Purposes (Section 8012)

Current Law

- o Disabled, blind or aged couples in which both spouses are aged, blind, or disabled, cannot be considered as individuals for purposes of eligibility and benefit amounts under the SSI program until after they have been living apart for more than 6 months. This could also affect the date on which the separated spouse becomes eligible for Medicaid.

Provision

- o Considers couples who separate as individuals for purposes of eligibility and benefit amounts under SSI in the first full month following the separation.

Effective Date

- o Effective October 1, 1990.

SSI Exclusion of Accrued Income with Respect to Certain Burial Spaces (Section 8013)

Current Law

- o The value of a burial fund, including interest accruals up to \$1500, can be excluded as a resource for purposes of determining SSI (Title XIX) eligibility. The value of a burial space may also be excluded, but interest accruals on the space are treated as unearned income.

Provision

- o Excludes interest accruals on burial spaces from income for purposes of determining SSI eligibility.

Effective Date

- o The first day of the fourth calendar month following the date of enactment (April 1, 1990).

SSI Exclusion from Resources of all Income-Producing Property (Section 8014)

Current Law

- o Income-producing property which is essential to an individual's self-support may be excluded, subject to limits the Secretary may impose, in determining SSI eligibility and benefits.

Provision

- o Prohibits the Secretary from imposing limits on property used in a trade or business or by the individual as an employee.

Effective Date

- o The first day of the fifth calendar month following the date of

enactment (May 1, 1990).

Demonstration of Effectiveness of Minnesota Family Investment Plan (Section 8015)

Current Law

- o The State of Minnesota has passed legislation permitting field tests of the Minnesota Family Investment Plan (MFIP) as an alternative to the State's AFDC program. The MFIP is designed to simplify the State's current welfare program and provide additional work incentives. The MFIP calls for an agreement between the State and the Federal government and requires authorizing legislation.

Provision

- o Permits the State of Minnesota to conduct a demonstration of the MFIP in two field locations, one urban and one rural, for up to 6,000 families. This demonstration is subject to the approval of the Secretary of HHS.
- o For purposes of Medicaid eligibility, deems project participants to be AFDC recipients and eligibility extensions on the basis of increased income due to employment or receipt of child support will apply. Federal financial participation for medical assistance and administrative costs for participants will be the same as for non-participants and aggregate amounts limited to what would have been paid in the absence of the project.
- o Authorizes the project for five years but permits termination by the Secretary with six months notice for failure to comply with this provision. Requires an evaluation plan be developed and the State to issue interim and final reports. Within three months of the final report, requires the Secretary to report to Congress.

Effective Date

- o Enactment.

TITLE X - MISCELLANEOUS AND TECHNICAL SSA AMENDMENTS

Subtitle D -- Human Resource and Income Security Provisions

Demonstration Project (Section 10404)

Current Law

- o No provision.

Provision

- o Appropriates \$1 million for each of FYs 1990 and 1991 and \$2 million for each of FYs 1992, 1993, and 1994 for demonstrations in up to 10 communities to determine whether costs of care can be reduced by volunteer senior aides providing basic medical assistance to families with disabled or chronically ill children.

Agent Orange Settlement Payments (Section 10405)

Current Law

- o Under SSI and other means-tested programs, all forms of income generally count against eligibility for benefits unless there is a statutory provision under which the income must be disregarded.
- o Court awarded settlement payments received by disabled veterans who were exposed to the toxic herbicide Agent Orange, are counted as income and may result in the denial or loss of benefits for the veterans under Federal or Federally assisted programs.

Provision

- o Exclude payments made from the Agent Orange settlement Fund or any other fund established to award the benefits from income and resources in determining eligibility for SSI, AFDC, Medicaid, the Social Services Block Grant and several other means-tested Federal assistance programs.

Effective Date

- o Effective January 1, 1989.