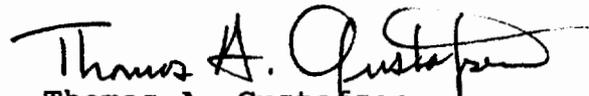


HCFA LEGISLATIVE SUMMARY

SEP 28 1993

THE OMNIBUS BUDGET RECONCILIATION ACT OF 1993 (OBRA 93)

On August 10, 1993, the President signed into law, the Omnibus Budget Reconciliation Act of 1993, Public Law 103-66. Summaries of the Medicare, Medicaid, and other relevant provisions are attached.



Thomas A. Gustafson
Acting Director
Office of Legislation and Policy

OMNIBUS BUDGET RECONCILIATION ACT OF 1993
P. L. 103-66
HEALTH CARE, HUMAN RESOURCES, INCOME SECURITY, AND
CUSTOMS AND TRADE PROVISIONS

Subchapter A -- Medicare

PART I -- PROVISIONS RELATING TO PART A

<u>Section</u>	<u>Page</u>
13501 Payments for PPS Hospitals	1
(a) Inpatient Hospital Services Update	1
(b) Hospital Wage Index	2
(c) Hospital Outlier Payments	3
(d) Regional Referral Centers	3
(e) Medicare-Dependent, Small Rural Hospital Payment Extension	4
(f) Extension of Regional Floor	5
13502 PPS-Exempt Hospitals	5
13503 Skilled Nursing Facility Services	6
13504 Payments for Hospice Care	7
13505 Hemophilia Pass-Through Extension	8
13506 Graduate Medical Education Payments in Hospital-Owned Community Health Centers	8
13507 Extension of Rural Hospital Demonstration	8
13508 Reduction in Part A Premium for Certain Individuals with 30 or More Quarters of Social Security Coverage	9

PART II -- PROVISIONS RELATING TO PART B

Subpart A -- Physicians' Services

13511 Reduction in Default Update for Conversion Factor for 1994 and 1995	10
13512 Reduction in Performance Standard Rate of Increase and Increase in Maximum Reduction Permitted in Default Update	10
13513 Practice Expense Relative Value Units	11
13514 Separate Payment for Interpretation of Electrocardiograms	12
13515 Payments for New Physicians and Practitioners	12
13516 Payments for Anesthesia	12

<u>Section</u>	<u>Page</u>
Subpart A -- Physicians' Services (continued)	
13517 Extension of Physician Payment Provisions to Nonparticipating Suppliers and Other Persons	13
13518 Antigens Under Physician Fee Schedule	14
Subpart B -- Outpatient Hospital Services	
13521 Extension of 10 Percent Reduction in Payments for Capital-Related Costs of Outpatient Hospital Services	15
13522 Extension of Reduction in Payments for Cost-Related of Outpatient Hospital Services	15
Subpart C -- Ambulatory Surgical Center Services	
13531 Ambulatory Surgical Center Services	16
13532 Designation of Certain Hospitals as Eye or Eye and Ear Hospitals	16
13533 Reduction in Payments for Intraocular Lenses	16
Subpart D -- Durable Medical Equipment	
13541 Payment for Parenteral and Enteral Nutrients, Supplies, and Equipment During 1994 and 1995	17
13542 Revisions to Payment Rules for Durable Medical Equipment	17
13543 Treatment of Nebulizers, Aspirators, and Certain Ventilators	17
13544 Payment for Ostomy Supplies and Other Supplies	18
13545 Payments for Transcutaneous Electrical Nerve Stimulatory (TENS)	18
13546 Payments for Orthotics, Prosthetics, and Prosthetic Devices	19
Subpart E -- Other Provisions	
13551 Payments for Clinical Diagnostic Laboratory Tests	20
13552 Extension of Alzheimer's Disease Demonstration	20
13553 Oral Cancer Drugs	21

<u>Section</u>	<u>Page</u>
Subpart E -- Other Provisions (continued)	
13554 Clarification of Coverage of Certified Nurse-Midwife Services Performed Outside the Maternity Cycle	21
13555 Increase in Annual Cap on Amount of Medicare Payment for Outpatient Physical Therapy and Occupational Therapy Services	22
13556 Treatment for Certain Indian Health Programs and facilities as Federally Qualified Health Centers FQHCs	22
13557 Extension of Municipal Health Services Demonstration Projects	22
PART III -- PROVISIONS RELATING TO PARTS A AND B	
13561 Medicare as Secondary Payer	24
(a) Data Match Program	24
(b) Extension of Medicare Secondary Payer Provision for Disabled Beneficiaries	24
(c) Extension of 18-Month Rule for ESRD Beneficiaries	25
(c) Application of Medicare Secondary Payer ESRD Rules to Additional Groups of Beneficiaries	25
(d) Use of IRS Aggregation Rules for Medicare Secondary Payer	25
(e) Revision to Definition of Individuals Subject to Medicare Secondary Payer Disability Provision	26
(f) Retroactive Medicare Secondary Payer Exemption for Religious Orders	26
13562 (a)(1) Physician Ownership and Referral amending Sections 1877	27
(a)(1) Prohibition of Certain Referrals - General	27
(a)(2) Prohibition of Certain Referrals -- Financial Relationship Specified	27
(b)(1) General Exceptions to Both Ownership and Compensation Arrangement Prohibitions -- Physicians' Services	28
(b)(2) General Exceptions to Both Ownership and Compensation Arrangement Prohibitions -- In-Office Ancillary Services	28
(b)(3) General Exceptions to Both Ownership and Compensation Arrangement Prohibitions -- Prepaid Plans	29
(c) General Exception Related Only to Ownership or Investment Prohibition for Ownership in Publicly Traded Securities and Mutual Funds	30
(d) Additional Exceptions Related Only to Ownership or Investment Prohibition	31

<u>Section</u>	<u>Page</u>
PART III -- PROVISIONS RELATING TO PARTS A AND B (continued)	
(e)(1) Exceptions Relating to Other Compensation Arrangements -- Rental of Office Space, Rental of Equipment	31
(e)(2) Exceptions Relating to Other Compensation Arrangements -- Bona Fide Employment Arrangements	32
(e)(3)(A) Exceptions Relating to Other Compensation Arrangements -- Personal Service Arrangements; General	33
(e)(3)(B) Exceptions Relating to Other Compensation Arrangements -- Personal Service Arrangements; Physician Incentive Plan Exception	33
(e)(4) Exceptions Relating to Other Compensation Arrangements -- Remuneration Unrelated to the Provision of Designated Health Services	34
(e)(5) Exceptions Relating to Other Compensation Arrangements -- Physician Recruitment	35
(e)(6) Exceptions Relating to Other Compensation Arrangements -- Isolated Transactions	35
(e)(7) Exceptions Relating to Other Compensation Arrangements -- Certain Group Practice Arrangements with a Hospital	35
(e)(8) Exceptions Relating to Other Compensation Arrangements -- Payments by a Physician for Items and Services	36
13562 (a)(2) Definitions amending Sections 1877	
(h)(1) Definitions -- Compensation Arrangement; Remuneration	37
(h)(4) Definitions -- Group Practice	38
(h)(5) Definitions -- Referral; Referring Physician	39
(h)(6) Definitions -- Designated Health Services	39
13562 (a)(3) Reporting Requirements amending Section 1877 (f)	40
13562 (a)(4) Sanctions -- Denial of Payment amending Section 1877 (g)	40
13563 Direct Graduate Medical Education	41
13564 Reduction in Payments for Home Health Services	42
13565 Immunosuppressive Drug Therapy	43
13566 Reduction in Payments for Erythropoietin	43
13567 Extension of Social Health Maintenance Organization Demonstrations	44
13568 Timing of Claims Payment	44
13569 Extension of Waiver for Watts Health Foundation	45

<u>Section</u>	<u>Page</u>
PART IV -- PROVISION RELATING TO PART B PREMIUM	
13571 Part B Premium	46
PART V -- PROVISION RELATING TO DATA BANK	
13581 Medicare and Medicaid Coverage Data Bank	47
Subchapter B -- Medicaid	
PART I -- SERVICES	
13601 Personal Care Services Furnished Outside the Home as Optional Benefit	48
13602 Additional Federal Savings Through Modifications to Drug Rebate Program	48
13603 Optional Medicaid Coverage of TB-Related Services for Certain TB-Infected Individuals	50
13604 Emergency Services for Undocumented Aliens	50
13605 Nurse-Midwife Services Outside the Maternity Cycle	51
13606 Treatment of Certain Clinics as Federally-Qualified Health Centers (FQHCs)	51
PART II -- ELIGIBILITY	
13611 Transfers of Assets; Treatment of Certain Trusts	53
(a) Periods of Ineligibility for Transfers of Assets	53
(b) Treatment of Trust Amounts	55
13612 Medicaid Estate Recoveries	57
PART III -- PAYMENTS	
13621 Limits on Payments to Disproportionate Share Hospitals	59
13622 Liability of Third Parties to Pay for Care and Services	60
13623 Medical Child Support	61
13624 Application of Medicare Rules Limiting Certain Physician Referrals	62
13625 State Medicaid Fraud Control	63

<u>Section</u>	<u>Page</u>
PART IV -- IMMUNIZATIONS	
13631 Medicaid Pediatric Immunization Provisions	64
PART V -- MISCELLANEOUS	
13641 Increase in Limit on Federal Medicaid Matching Payments to Puerto Rico and Other Territories	66
13642 Extension of Moratorium on Treatment of Certain Facilities as Institutions for Mental Diseases	66
13643 Demonstration Projects	67
13644 Extension of Period of Applicability of Enrollment Mix Requirement to Certain Health Maintenance Organizations Providing Services Under Dayton Area Health Plan	68
SOCIAL SECURITY PROVISIONS AFFECTING MEDICAID	
13732 Exclusion from Income and Resources of State Relocation Assistance	69
13733 Prevention of Adverse Effects on Eligibility for and Amount of Benefits when Spouse or Parent of Beneficiary is Absent from the Household on Active Military Service	69
13734 Eligibility for Children of Armed Forces Personnel Residing Outside the United States other than Foreign Countries	70
13735 Valuation of Certain In-Kind Support and Maintenance when there is a Cost of Living Adjustment in Benefits	70
13736 Exclusion from Income of Certain Amounts Received by Indians from Interests Held in Trusts	71

OMNIBUS BUDGET RECONCILIATION ACT OF 1993

TITLE XIII -- REVENUE, HEALTH CARE, HUMAN RESOURCES, INCOME SECURITY, CUSTOMS AND TRADE PROVISIONS, FOOD STAMP PROGRAM, AND TIMBER SALE PROVISIONS

Subchapter A -- Medicare
Part I -- Provisions Relating to Part A

Payments for Prospective Payment System (PPS) Hospitals (Section 13501)
Inpatient Hospital Services Update (Section 13501 (a))

Prior Law

- o The update factor for urban hospitals is set equal to the percentage increase in the hospital market basket for FY 1994 and after; the update factor for rural hospitals is set equal to the increase in the market basket plus 1.5 percentage points for FY 1994 and for FY 1995 the factor is set equal to the market basket increase plus the amount needed to equal the standardized amount for urban areas with no more than one million people. After FY 1995, both rural and urban areas receive the same update factor.
- o Sole community hospitals and Medicare-dependent small rural hospitals are paid based on the higher of the applicable standardized amount or a hospital-specific rate. The hospital-specific rate is updated annually effective with the beginning of the hospital's cost reporting period. The update is set equal to the projected percentage increase in the hospital market basket for the fiscal year in which the cost reporting period begins.

Provision

- o Establishes the following update factors for PPS hospitals:
 - For FY 1994
 - urban hospitals: Market Basket - 2.5 percent
 - rural hospitals: Market Basket - 1.0 percent
 - For FY 1995
 - urban hospitals: Market Basket - 2.5 percent
 - rural hospitals: the amount necessary to equalize the rural and "other urban" standardized amounts.
 - For FY 1996
 - all hospitals: Market Basket - 2.0 percent
 - For FY 1997
 - all hospitals: Market Basket - 0.5 percent

- For FY 1998 and after, the update is set equal to the percentage increase in the hospital market basket.
- o Establishes update factors for hospital-specific rates applicable to sole community hospitals or Medicare-dependent small rural hospitals:
 - For FY 1994: Market Basket - 2.3 percent
 - For FY 1995: Market Basket - 2.2 percent
 - For FY 1996 and after: the update is set equal to the update factors for all hospitals.
 - Effective date of the update is moved to October 1.
- o Reduces the unadjusted standard Federal rate for capital payments for PPS hospitals by 7.4 percent in FY 1994. Requires the Secretary to determine which capital payment methodology should be applied to each hospital to take account of this reduction.

Effective Date

- o October 1, 1993.

Hospital Wage Index (Section 13501 (b))

Prior Law

- o When changing classification of hospitals for purposes of the wage index from one geographic area to another, the following may occur:
 - the wage index may be lowered in the case of an urban area whose index is already lower than a rural area's wage index for the State; and
 - the wage index may be lowered for an urban area if there are no rural areas located in the State.

Provision

- o A change in classification of hospitals from one area to another will not result in:
 - a reduction in the wage index for an urban area whose wage index is below the rural wage index for the State; and
 - a reduction in the wage index for an urban area if the area is the only urban area in a State with no rural areas.

Effective Date

- o Retroactive to October 1, 1991.

Hospital Outlier Payments (Section 13501 (c))

Prior Law

- o The Secretary must make additional payment for outlier cases, which are cases involving long stays or extraordinary costs as compared to other cases in the same DRG.

Provision

- o This provision addresses the distribution of outlier payments between long-stay outlier cases and cost outlier cases, phasing out payments for long stay outlier cases, beginning in FY 1995 and ending in FY 1998. The proportion of outlier payments for long-stay outlier cases would be reduced from the proportion in FY 1994 as follows:

- FY 1995: 25 percent
- FY 1996: 50 percent
- FY 1997: 75 percent
- FY 1998: no payment

The proportion of outlier payments for cost outlier cases would increase accordingly.

- o Sets the payment threshold for cost outlier cases at the applicable DRG payment plus a fixed dollar amount, as determined by the Secretary.

Effective Date

- o October 1, 1994.

Regional Referral Centers (Section 13501 (d))

Prior Law

- o Hospitals classified as regional referral centers (RRCs) on September 30, 1989 retain such status through cost reporting periods beginning before October 1, 1992.

Provision

- o All hospitals classified as RRCs on September 30, 1992 retain their RRC classification until September 30, 1994 unless the hospital is located in an area that has been redesignated as a Metropolitan Statistical Area (MSA).
- o The Secretary must make lump sum payments to these hospitals for the additional payments that would have been made had they not lost classification as RRCs.

- Hospitals that lost RRC status as a result of a decision of the Medicare Geographic Classification Review Board for FY 1993 or 1994 can decline the Board's reclassification and retain referral center status.

Effective Date

- o Upon enactment; August 10, 1993.

**Medicare-Dependent, Small Rural Hospital Payment Extension
(Section 13501 (e))**

Prior Law

- o Rural hospitals qualifying as Medicare dependent hospitals (MDH) receive special payment. To be classified as a Medicare dependent hospital, a hospital must:
 - be located in a rural area;
 - have no more than 100 beds;
 - not be classified as a sole community hospital; and
 - have at least 60 percent Medicare inpatient days or Medicare discharges during the cost reporting period beginning in FY 1987.
- o Medicare dependent hospitals have the same payment rules as sole community hospitals for cost reporting periods beginning on or after April 1, 1990 and ending before April 1, 1993.
- o Payments to all rural hospitals are based on the same standardized amount as payment to hospitals in "other urban" areas effective October 1, 1994.

Provision

- o Special payments for small, rural Medicare dependent hospitals would be continued for discharges occurring through September 30, 1994 on a phase-down basis.
 - Existing MDH payments for discharges occurring during the first 3 12-month cost reporting periods beginning on or after April 1, 1990.
 - Payment of 50 percent of the difference between the existing MDH payment and the payment under PPS for discharges occurring during subsequent cost reporting periods and through September 30, 1994.
- o The Secretary must make lump sum payments to these hospitals for the additional payments that would have been made had they not lost classification as MDHs.

- Hospitals that lost MDH status as a result of a decision of the Medicare Geographic Classification Review Board for FY 1993 or FY 1994 can decline the Board's reclassification and retain Medicare dependent hospital status.

Effective Date

- o Upon enactment; August 10, 1993.

Extension of Regional Floor (section 13501 (f))

Prior Law

- o Payments to PPS hospitals in census regions where regional standardized amounts exceed the national standardized amount are paid based on 15 percent of the regional amount and 85 percent of the national amount for discharges occurring from April 1, 1988 through September 30, 1993.

Provision

- o Extends the alternate payment methodology for regions where the regional standardized amounts exceed the national standardized amount through FY 1996.

Effective Date

- o Upon enactment; August 10, 1993.

PPS Exempt Hospitals (Section 13502)

Prior Law

- o Beginning with the FY 1994 cost reporting period, target amounts for PPS-exempt hospitals are increased by the projected increase in the hospital market basket. The Secretary may grant exceptions or adjustments to the target amounts for extraordinary circumstances.

Provision

- o Establishes the following update factors for PPS-exempt hospitals:
 - For FY 1994-1997: Market Basket - 1.0 percent
 - For FY 1998 and after, the update is set equal to the percentage increase in the hospital market basket.

- A hospital whose operating costs during a cost reporting period beginning in FY 1990 exceeded its target amount by 10 percent or more will be exempt from these reductions, and partial reductions will be applied to hospitals near the 10 percent threshold.
- o The Secretary may not consider the reductions in granting exceptions or adjustments to target amounts.
- o The Secretary should promptly submit the overdue report on revising the current payment system for PPS-exempt hospitals that was due April 1, 1992.

Effective Date

- o October 1, 1993.

Skilled Nursing Facilities (Section 13503)

Prior Law

- o Payments to skilled nursing facilities (SNFs) are made on a reasonable cost basis, subject to per diem cost limits. The limits are:
 - for free-standing facilities: 112 percent of the mean per diem routine service costs;
 - for hospital-based facilities: the cost limit for free-standing facilities plus 50 percent of the difference between 112 percent of the mean per diem costs for free-standing facilities and 112 percent of the mean per diem costs for hospital-based facilities.
- o The Secretary must pay for costs of a hospital-based facility attributable to excess overhead costs allocated to the facility.
- o Any SNF can receive an exception to the cost limits based on case mix or circumstances beyond its control.
- o Proprietary SNFs receive payments for costs of providing services and in addition receive a return on equity payment.
- o The labor-related portion of SNF cost limits is adjusted by the hospital wage index and is updated every 2 years.

Provision

- o No changes in the cost limits (including no adjustments for changes in the wage index on applicable MSAs) for cost reporting periods beginning in FY 1994 and 1995.

- o Requires the Secretary when granting or extending exceptions to cost limits, to limit any exception to the amount that would have been granted if there were no restriction on changes in cost limits.
- o Repeals additional payments for excess overhead costs for hospital-based SNFs for cost reporting periods beginning on or after October 1, 1993.
- o Requires the Secretary to develop recommendations for the a SNF prospective payment system (PPS) to be implemented no later than October 1, 1995. The report will:
 - address whether the differential payment for hospital-based facilities should be maintained; and
 - develop an interim PPS for inpatient routine service costs.
- o Eliminates return on equity payments to proprietary SNFs.
- o Requires the Secretary, within one year of enactment, to begin to collect data on employee compensation and hours of employment specific to SNFs, for potential use in development of a SNF wage index.

Effective Date

- o October 1, 1993.

Payments for Hospice Care (Section 13504)

Prior Law

- o Payment rates for hospice services are updated each year by the projected increase in the hospital market basket.

Provision

- o Establishes the following update factors:

For FY 1994: Market Basket - 2.0 percent
 For FY 1995: Market Basket - 1.5 percent
 For FY 1996: Market Basket - 1.5 percent
 For FY 1997: Market Basket - 0.5 percent
 For FY 1998 and after: the update is equal to the percentage increase in the hospital market basket.

Effective date

- o October 1, 1993.

Hemophilia Pass-through Extension (Section 13505)

Prior Law

- o Additional payments to hospitals for the costs of administering blood clotting factor to Medicare beneficiaries with Hemophilia admitted for hospital stays were applied to clotting factor furnished between June 19, 1990 and December 19, 1991.

Provision

- o Extends additional payments for Hemophilia clotting factor furnished through September 30, 1994.

Effective Date

- o Retroactive to December 19, 1991.

Graduate Medical Education Payments in Hospital-Owned Community Health Centers (Section 13506)

Prior Law

- o Additional payments to hospitals for the indirect costs of medical education are based on the ratio of interns and residents at the hospital to the number of beds in the hospital. Interns and residents training in a hospital outpatient department are included for purposes of determining the ratio.

Provision

- o Services of an intern or resident in a community health center (as defined in the Public Health Service Act) that is wholly owned or controlled by a hospital will be counted for purposes of determining the hospital's intern and resident-to-bed ratio if the hospital incurs all or substantially all of the cost of such services.

Effective Date

- o Upon enactment; August 10, 1993.

Extension of Rural Hospital Demonstration (Section 13507)

Prior Law

- o The Secretary may waive provisions of Title XVIII as necessary in order to conduct any limited-service rural hospital demonstration project entered into by the Secretary prior to the enactment of OBRA 89. (The only project that qualifies

under this program is Montana's Medical Assistance Facility Demonstration.)

Provision

- o The Secretary must continue such demonstration projects at least through July 1, 1997.
- o The conferees expect that the Secretary will make recommendations by January 1995 to make the limited-service rural hospital demonstration projects permanent. The recommendations should consider: adequacy of the current payment system, staffing and service standards, and quality assurance procedures.

Effective Date

- o Upon enactment; August 10, 1993.

Reduction in Part A Premium for Certain Individuals with 30 or More Quarters of Social Security Coverage (Section 13508)

Prior Law

- o In general, individuals become entitled to benefits under Medicare Part A when they reach age 65 and are also eligible for monthly Social Security retirement or survivor benefits or Railroad Retirement benefits. Individuals aged 65 and over, who are not entitled to benefits under Part A, may enroll in the program if they pay a monthly premium. The monthly premium is based upon the actuarial value of benefits under Part A.

Provision

- o The Part A premium is reduced, on a phased-in basis, for individuals with 30 or more quarters paid into the Social Security system. Spouses of such individuals receive the same reduction. The Part A premium will be reduced by 25 percent in 1994, 30 percent in 1995, 35 percent in 1996, 40 percent in 1997, and 45 percent in 1998 and subsequent years.
- o The reduction in Part A premium payments also applies to the surviving spouse, or divorced spouse of an individual with 30 or more quarters paid into the Social Security system.

Effective Date

- o Effective for monthly premiums beginning January 1, 1994.

**Part II -- Provisions Relating to Part B
Subpart A -- Physicians' Services**

Reduction in Default Update for Conversion Factor for 1994 and 1995 (Section 13511)

Prior Law

- o If Congress does not direct otherwise, the physician fee schedule conversion factor is updated each year by a "default formula" comprised of two elements: (a) the Medicare Economic Index, and (b) an adjustment based on how the actual rate of increase in physician spending for a year compares to the target rate of increase (the Medicare Volume Performance Standard (MVPS)) for that year for each category of services. If the actual rate of increase exceeds the MVPS for the year, the update is reduced by the number of percentage points by which the MVPS was exceeded, up to a maximum reduction of 2 1/2 percentage points for 1994 and 1995 and a maximum of 3 percentage points thereafter. If the actual rate of increase is less than the MVPS for the year, the update is increased by the number of percentage points by which the rate of increase in expenditures was less than the MVPS.

Provision

- o Reduces the 1994 and 1995 "default" update for all services except primary care services, which receive the full default update in both years. In 1994, the default update is reduced by 3.6 percentage points for surgical services and 2.6 percentage points for all other services except primary care. In 1995, the default update is reduced for all services except primary care by 2.7 percentage points.

Effective Date

- o Effective for services furnished on or after January 1, 1994.

Reduction in Performance Standard Rate of Increase and Increase in Maximum Reduction Permitted in Default Update (Section 13512)

Prior Law

- o Unless Congress provides otherwise, the MVPS for each fiscal year is established by a "default formula" for surgical services and for non-surgical services. The formula is comprised of four elements: inflation, changes in program enrollment, historical average increases in the volume and intensity of services, and changes in law or regulation. These four elements are combined and reduced by a performance standard factor of 2 percentage points.

Provision

- o Reduces the MVPS default by increasing the performance standard factor to 3 1/2 percent for FY 1994, and 4 percent for FY 1995 and thereafter.
- o Creates a third category for purposes of the MVPS (primary care services) and moves anesthesia services into the surgical services category for purposes of the MVPS beginning with FY 1994.
- o Reduces the default update by increasing the restriction on downward adjustments to 5 percentage points for CY 1995 and thereafter.

Effective Date

- o MVPS's beginning with FY 1994 and services furnished on or after January 1, 1995.

Practice Expense Relative Value Units (Section 13513)

Prior Law

- o The relative value for each physicians' service is based on three components: (a) a work component, (b) a practice expense component, and (c) a malpractice component. These three components are combined into a single relative value for each service. The work component is based on the relative resources of physician time and effort for a procedure, but the practice expense and malpractice relative value components are based on historical charges.

Provision

- o Reduces practice expenses relative value units by one-quarter of the difference between practice expense and work relative value units in each of 1994, 1995, and 1996. However, no practice expense relative value units would be reduced below 128 percent of work relative value units. Services with no work component and services performed at least 75 percent of the time in the office would be exempted.

Effective Date

- o Services furnished on or after January 1, 1994.

**Separate Payment for Interpretation of Electrocardiograms
(Section 13514)**

Prior Law

- o OBRA-90 eliminated separate payments for interpretation of electrocardiograms (EKGs) performed or ordered to be performed as part of, or in conjunction with, a medical visit or consultation, effective January 1, 1992. The fee schedule bundled payments for EKGs into Medicare payments for visits and consultations.

Provision

- o Restores separate payment for EKG interpretations. Requires adjustment of RVU's for visits and consultations to pay for it.

Effective Date

- o Services furnished on or after January 1, 1994.

Payments for New Physicians and Practitioners (Section 13515)

Prior Law

- o Payments for new physicians and practitioners, except for primary care services and those in certain rural areas, are phased in during their first 4 years of practice. Payments are 80 percent of the fee schedule or prevailing charge otherwise recognized during the first year of practice, 85 percent during the second year, 90 percent during the third year, 95 percent during the fourth year, and 100 percent during the fifth year and thereafter.

Provision

- o Repeals the phase-in of payment to new physicians. Reduces fee schedule to pay for it.

Effective Date

- o Services furnished on or after January 1, 1994.

Payments for Anesthesia (Section 13516)

Prior Law

- o When anesthesia services are provided by a team consisting of an anesthesiologist medically directing a certified registered

nurse anesthetist (CRNA), Medicare payments to the anesthesiologist are based on reduced base and time units. The statute also specifies a separate conversion factor for medically directed CRNAs.

Provision

- o Phases-in over 4 years a limit on Medicare payment for anesthesia teams set at 100 percent of the Medicare payment if the anesthesia were furnished only by a physician. When an anesthesia team is used, specifies that 50 percent of the Medicare payment is for the physician and 50 percent for the CRNA. Repeals the separate conversion factor for medically directed CRNAs.
- o Requires that the base and time unit methodology be the same for payment of physicians, physician medical direction of CRNAs and payment of CRNAs and that the methodology be the same as the one in place on enactment.

Effective Date

- o Services furnished on or after January 1, 1994.

Extension of Physician Payment Provisions to Non-participating Suppliers and Other Persons (Section 13517)

Prior Law

- o The 5-percent differential in payments and the limiting charge for non-participating physicians does not apply when a service is furnished by a non-participating supplier or other person nor to services that the Secretary removes from the fee schedule.

Provision

- o Extends the 5-percent participation payment differential and balance billing limits to all suppliers and other persons paid under the fee schedule but not covered by payment differential and to services the Secretary removes from the fee schedule (i.e., drugs).

Effective Date

- o Services furnished on or after January 1, 1994.

Antigens under Physician Fee Schedule (Section 13518)

Prior Law

- o Antigens are paid on the basis of reasonable charges rather than under the physician fee schedule.

Provision

- o Puts antigens under the physician fee schedule and subjects them to charge limits.

Effective Date

- o Services furnished on or after January 1, 1995.

Subpart B -- Outpatient Hospital Services

Extension of 10 Percent Reduction in Payments for Capital-Related Costs of Outpatient Hospital Services (Section 13521)

Prior Law

- o Medicare payments for hospital outpatient capital-related costs are based on reasonable costs subject to a 10 percent reduction through FY 1995. The reduction does not apply to sole community hospitals or rural primary care hospitals.

Provision

- o Extends the current 10-percent reduction in capital-related costs for hospital outpatient services for currently affected hospitals to fiscal years 1996 through 1998.

Extension of Reduction in Payments for Cost-Related Outpatient Hospital Services (Section 13522)

Prior Law

- o Medicare payments for hospital outpatient services based on costs or the cost portion of a blended payment are reduced by 5.8 percent through FY 1995. The reduction does not apply to sole community hospitals or rural primary care hospitals.

Provision

- o Extends the current 5.8 percent reduction for cost-related hospital outpatient services for currently affected hospitals to FYs 1996 through 1998.

Subpart C -- Ambulatory Surgical Center Services

Ambulatory Surgical Center Services (Section 13531)

Prior Law

- o An annual CPI-U update is applied to ambulatory surgical center (ASC) rates.

Provision

- o Eliminates any inflation update to ASC rates in FYs 1994 and 1995.

Effective Date

- o January 1, 1994.

Designation of Certain Hospitals as Eye or Eye and Ear Hospitals (Section 13532)

Prior Law

- o Hospitals designated as eye or eye and ear hospitals receive a blended payment for the facility costs of ambulatory surgical procedures based on 75 percent of costs and 25 percent of the ambulatory surgical center (ASC) rate for cost reporting periods beginning before January 1, 1995.

Provision

- o Extends eligibility for designation as an eye or eye and ear hospital to hospitals meeting specified criteria.

Reduction in Payments for Intraocular Lenses (Section 13533)

Prior Law

- o Payment for an intraocular lens (IOL) provided in an ASC was established at \$200 through 1992. The Secretary has since continued that payment amount.

Provision

- o Reduces payment for an IOL provided in an ASC in 1994 through 1998 to \$150.

Effective Date

- o January 1, 1994.

Subpart D -- Durable Medical Equipment

Payment for Parenteral and Enteral Nutrients, Supplies, and Equipment During 1994 and 1995 (Section 13541)

Prior Law

- o Fees for parenteral and enteral nutrients, supplies, and equipment are currently updated annually by the CPI-U.

Provision

- o Eliminates the update for parenteral and enteral nutrients, supplies, and equipment in 1994 and 1995.

Effective Date

- o January 1, 1994.

Revisions to Payment Rules for Durable Medical Equipment (Section 13542)

Prior Law

- o Medicare pays for durable medical equipment (DME) on the basis of fee schedules that are subject to national payment limits and floors. The national upper payment limit is based on the weighted average of all local payment amounts for each item, and the floor is based on 85 percent of the weighted average.

Provision

- o Revises the payment methodology for DME to base the national payment limits and floors on the median rather than the weighted average of the local payment amounts.

Effective Date

- o January 1, 1994.

Treatment of Nebulizers, Aspirators, and Certain Ventilators (Section 13543)

Prior Law

- o Nebulizers, aspirators, ventilators, and IPPB machines are included in the category of DME for items requiring frequent servicing. Medicare makes unlimited monthly rental payments for these items.

Provision

- o Removes nebulizers, aspirators, and certain ventilators (continuous airway pressure devices and intermittent assist devices with continuous airway pressure devices) from the category of items requiring frequent servicing. By doing so, these items could be purchased or rented. If rented, the number of rental payments would be limited.
- o Provides for separate payment for accessories used with nebulizers, aspirators, and the two excluded ventilators.

Effective Date

- o January 1, 1994.

Payment for Ostomy Supplies, Tracheostomy Supplies, Urologicals, and Surgical Dressings (Section 13544)

Prior Law

- o Ostomy supplies, tracheostomy supplies, and urologicals are included in the fee schedule for prosthetics and orthotics, which is subject to regional payment limits. Payment for surgical dressings is based on reasonable charges.

Provision

- o Requires that payment for ostomy supplies, tracheostomy supplies, urologicals, and surgical dressings be made in accordance with the DME fee schedule for inexpensive and frequently purchased items. These items will be subject to national payment limits based on the median of local fee schedule amounts. Requires that the fee schedule for surgical dressings be initially calculated based on average reasonable charges during 1992 and increased by the CPI-U for 1993 and 1994.

Effective Date

- o January 1, 1994.

Payment for Transcutaneous Electrical Nerve Stimulators (Section 13545)

Prior Law

- o Payment for transcutaneous electrical nerve stimulators (TENS) is made on the basis of a fee schedule. OBRA 1989 required that payment for TENS be reduced by 15 percent, and OBRA 1990

required that payment be reduced by an additional 15 percent.

Provision

- o Reduces payment for TENS by an additional 30 percent.

Effective Date

- o Items furnished on or after January 1, 1994.

**Payments for Orthotics, Prosthetics, and Prosthetic Devices
(Section 13546)**

Prior Law

- o Payment for orthotics, prosthetics, and prosthetic devices is made in accordance with a fee schedule that is updated annually by the CPI-U.

Provision

- o Eliminates the update for prosthetics, orthotics, and prosthetic devices in 1994 and 1995.

Effective Date

- o January 1, 1994.

Subpart E -- Other Provisions

Payment for Clinical Diagnostic Laboratory Tests (Section 13551)

Prior Law

- o A national limit is set on payment for clinical laboratory services of 88 percent of the median of all carrier fee schedule amounts.

Provision

- o Reduces payment limits for the Medicare clinical laboratory fee schedule from 88 percent of the median of fee amounts in all carrier areas to: 84 percent of the median in 1994; 80 percent of the median in 1995; and 76 percent of the median in 1996 and thereafter.

Effective Date

- o January 1, 1994.

Extension of Alzheimer's Disease Demonstration, (Section 13552)

Prior Law

- o OBRA 1986 directed the Secretary to conduct at least 5 (and not more than 10) demonstration projects to determine the effectiveness, cost, and impact of providing comprehensive services to Medicare beneficiaries who are victims of Alzheimer's disease or related disorders. The projects were to be conducted over a 3-year period at geographically diverse sites, in States with a high proportion of Medicare beneficiaries, and in areas readily accessible to a significant number of beneficiaries. Up to \$40 million from the Medicare Part B trust funds was authorized for the demonstration project.
- o OBRA 90 extended the demonstration to 4 years and increased the authorized expenditures to \$55 million.

Provision

- o Extends the demonstration for 1 year to November 1994.
- o Increases the authorized expenditure to \$58 million.
- o Increases the amount that may be spent for the evaluation from \$3 million to \$5 million.

Oral Cancer Drugs (Sec. 13553)

Prior Law

- o With exceptions for immunosuppressive drugs and erythropoietin, Medicare does not cover self-administered outpatient drugs including oral cancer drugs.
- o Medicare carriers have authority to determine whether off-label uses of anti-cancer drugs are safe, effective, and medically accepted, and, therefore, covered under Medicare.

Provision

- o Provides Medicare coverage for oral, self-administered, anti-cancer chemotherapeutic medication that is FDA-approved for a given indication if it contains the same active ingredient as found in the covered, non-self-administered form.
- o Provides for coverage of off-label uses of anti-cancer drugs for medically accepted indications unless the Secretary determines the use is not medically appropriate. Off-label uses of anti-cancer drugs are covered if: (1) the use of the drug is supported in one or more of three national compendia, unless the off-label use is unfavorably reported in one or more compendia or (2) the carrier determines that the use is medically accepted based on guidance provided by the Secretary for determining medically accepted uses. The carrier must use clinical evidence presented in peer reviewed medical literature in periodicals identified by the Secretary.

Effective Date

- o January 1, 1994.

Clarification of Coverage of Certified Nurse-Midwife Services Performed Outside the Maternity Cycle (Section 13554)

Prior Law

- o Medicare covers certified nurse-midwife services provided to mothers and babies throughout the maternity cycle.

Provision

- o Eliminates the limitation on coverage of certified nurse-midwife services. Services provided by certified nurse-midwives outside the maternity cycle will now be covered.

Effective Date

- o January 1, 1994.

Increase in Annual Cap on Amount of Medicare Payment for Outpatient Physical Therapy and Occupational Therapy Services (Section 13555)

Prior Law

- o Outpatient physical therapy and occupational therapy services covered by Medicare are subject to an annual limit of \$750.

Provision

- o Increases the annual limit on covered outpatient physical therapy and occupational therapy services to \$900.

Effective Date

- o January 1, 1994.

Treatment of Certain Indian Health Programs and Facilities as Federally Qualified Health Centers (FQHCs) (Section 13556)

Prior Law

- o Medicare covers services provided in certain facilities designated as FQHCs. The definition of a FQHC does not include outpatient facilities operated by tribal organizations. These programs, however, may already be designated FQHCs under Medicaid.

Provision

- o Would expand the definition of FQHCs to include outpatient programs operated by tribes, tribal organizations under the Indian Self-Determination Act, or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act and allow them to receive payment from Medicare as FQHCs.

Effective Date

- o As if included in OBRA-90; October 1, 1991.

Extension of Municipal Health Services Demonstration Projects, (MHSP), (Section 13557)

Prior Law

- o In 1979, a Memorandum of Agreement between Robert Wood Johnson Foundation and HCFA resulted in HCFA granting Medicare demonstration waivers to the cities of Baltimore, San Jose,

Cincinnati, St. Louis, and Milwaukee to allow 100 percent reimbursement of reasonable costs for the provision of expanded Part B services. The MHSP demonstration, originally planned as a 5-year program, has been extended to 14 years by Congress. St. Louis no longer participates.

- o The primary objectives of the MHSP were to improve access to care in underserved urban areas, to shift the focus of delivery of care away from high cost emergency room settings, and to reduce inpatient costs by providing primary care and preventive care in an ambulatory setting.
- o MHSP participants do not pay the standard Medicare Part B deductibles or coinsurance. Patients receive primary, preventive, and ancillary care services at no cost. Ancillary services include: prescription drugs and supplies, optometry, dentistry, dentures, audiology, physical therapy, speech therapy, occupational therapy, mental health, transportation, EKG, nutrition, and psychology. A 50-percent co-payment is required for eyeglasses.

Provision

- o Extends the demonstration from December 31, 1993 to December 31, 1997.
- o Expands the evaluation to study the costs to Medicaid and other payers, utilization of services, access, outcomes, and beneficiary satisfaction.

Part III -- Provisions Relating to Parts A and B

Medicare as Secondary Payer (MSP) (Section 13561)

Medicare Secondary Payer - Data Match Program (Section 13561 (a))

Prior Law

- o IRS, SSA, and HCFA are required to share certain information that each agency has about Medicare beneficiaries and their spouses to identify situations where another insurance plan is primary to Medicare. This information identifies employers whose health plans may cover Medicare beneficiaries. HCFA is then required to contact the identified employers to ascertain health coverage information and to recover any mistaken Medicare payments from health plans that should have paid. The data match requirements expire on September 30, 1995.
- o As part of the data match, SSA must report on every Medicare beneficiary or spouse who received any wages in a given year.

Provision

- o Extends the IRS/SSA/HCFA data match through September 30, 1998.
- o Simplifies the data match process by allowing the Secretary to determine an income threshold for required reporting by SSA. Thus, if a threshold is established, SSA would no longer have to report on beneficiaries with very low income who most likely do not have employer-based health insurance.

Effective Date

- o Upon enactment; August 10, 1993.

Extension of Medicare Secondary Payer Provision for Disabled Beneficiaries (Section 13561 (b))

Prior Law

- o Medicare is secondary payer for certain disabled beneficiaries covered by an employer's large group health plan. This authority expires on September 30, 1995.

Provision

- o Extends the MSP provision for the disabled until September 30, 1998.

Extension of 18-Month Rule for ESRD Beneficiaries (Section 13561 (c))

Prior Law

- o OBRA 1990 lengthened the period of time for which Medicare is secondary payer for ESRD beneficiaries from 12 to 18 months (i.e., the first 18 months of an individual's entitlement to Medicare on the basis of ESRD). This provision expires on January 1, 1996, after which the 12-month rule will apply.

Provision

- o Extends until October 1, 1998 the provision lengthening the MSP period for ESRD beneficiaries from 12 to 18 months.

Application of Medicare Secondary Payer ESRD Rules to Additional Groups of Beneficiaries (Section 13561(c))

Prior Law

- o Medicare is secondary payer for beneficiaries with ESRD if the beneficiary is entitled to Medicare solely on the basis of ESRD. If a beneficiary with ESRD is also entitled to Medicare on the basis of age or disability, Medicare is the primary payer.

Provision

- o Amends the MSP ESRD provisions so that they apply to all beneficiaries with ESRD, regardless of whether an individual is entitled to Medicare on the basis of age, disability or ESRD.

Effective Date

- o Upon enactment; August 10, 1993.

Use of IRS Aggregation Rules for Medicare Secondary Payer (Section 13561 (d))

Prior Law

- o The MSP provisions for the working aged apply to employers with 20 or more employees. The MSP provisions for the disabled apply to health plans contributed to by at least one employer with 100 or more employees. Large employers can avoid having the MSP rules apply to them by simply organizing themselves into small groups.

Provision

- o Requires the use of IRS aggregation rules to determine employer size for MSP purposes. Employers treated as single employers as defined in the Internal Revenue Code of 1986 would be treated as single employers for MSP.

Effective Date

- o Ninety days after enactment; November 8, 1993).

Revision to Definition of Individuals Subject to Medicare Secondary Payer Disability Provision (Section 13561 (e))

Prior Law

- o Under the MSP disability provisions, Medicare is secondary for disabled "active individuals". This term includes not only individuals who are employed but individuals who have a relationship with an employer indicative of employee status, even though they are not currently employed.

Provision

- o Deletes the concept of "active individual" and applies the MSP disability provision only to individuals who are covered under a group health plan by reason of their current employment or that of a family member.

Effective Date

- o Upon enactment; August 10, 1993.

Retroactive Medicare Secondary Payer Exemption for Religious Orders (Section 13561 (f))

Prior Law

- o Certain members of religious orders who have taken a vow of poverty are exempted from the MSP provisions for items and services furnished on or after October 1, 1989.

Provision

- o Exempts from the MSP provisions members of religious orders who have taken a vow of poverty and who received services prior to October 1, 1989, but which the Secretary had not identified as of that date.

**Physician Ownership and Referral:(Section 13562)
Prohibition of Certain Referrals - General (Section 13562 (a)(1)
and (2))**

Prior Law

- o Physicians are prohibited from referring Medicare patients to clinical laboratories with which the physician or an immediate family member has a financial relationship.

Provision

- o Extends prior law to the following designated health services: (1) Clinical laboratory services; (2) Physical therapy services; (3) Occupational therapy services; (4) Radiology or other diagnostic services; (5) Radiation therapy services; (6) Durable Medical Equipment; (7) Parenteral and enteral nutrients, equipment and supplies; (8) Prosthetics, orthotics, and prosthetic devices; (9) Home health services; (10) Outpatient prescription drugs; and, (11) Inpatient and outpatient hospital services
 - Section 13624 applies the Medicare rules regarding limitations on physician ownership and referrals to the Medicaid program. Applies to referrals made on or after December 31, 1994.

Effective Date

- o January 1, 1992 for clinical lab and January 1, 1995 for other designated health services.

**Prohibition of Certain Referrals - Financial Relationship
Specified (Section 13562 (a)(1) amending Section 1877 (a)(2))**

Prior Law

- o Unless otherwise excepted, a financial relationship of a physician (or an immediate family member) with an entity is an ownership or investment interest in the entity; or a compensation arrangement between the physician (or immediate family member) and the entity. An ownership or investment interest may be through equity, debt, or other means.

Provision

- o Expands prior law to specify that an ownership or investment interest includes an interest in an entity that holds an ownership or investment interest in any entity providing the designated health service.

Effective Date

- o The existing ownership or investment interest definition is applicable until January 1, 1995 for clinical labs and will apply to all designated health services, including clinical labs, on that date.

General Exceptions to Both Ownership and Compensation Arrangement Prohibitions - Physician's Services (Section 13562 (a)(1) amending Section 1877 (b)(1))

Prior Law

- o An exception to both the ownership and compensation arrangement prohibition is granted for physician services that are provided personally by, or under personal supervision of, another physician in the same group practice as the referring physician.

Provision

- o No change.

General Exceptions to Both Ownership and Compensation Arrangement Prohibitions - In-Office Ancillary Services (Section 13562 (a)(1) amending Section 1877 (b)(2))

Prior Law

- o For sole practitioners and group practices, an exception to both the ownership and compensation arrangement prohibition is granted for in-office ancillary services that are furnished: (1) personally by: the referring physician; a member of the group practice; or, an employee that is personally supervised by the referring physician or a group physician; (2) in a building in which any group physician furnishes services unrelated to the furnishing of clinical laboratory services; or, (3) in the case of the referring physician who is a group member, in another building that the group uses for the centralized provision of the group's clinical laboratory services. In these cases, the services must be billed by the physician performing or supervising the services, by a group practice in which the physician is a member, or by an entity that is wholly owned by the physician or group. In addition, the ownership or investment interest in such services must meet other Secretarial requirements that protect against program or patient abuse.

Provision

- o Broadens the exception for in-office ancillary services to all designated health services under this section except for DME (excluding infusion pumps) and parenteral and enteral nutrients, equipment, and supplies. Eliminates the requirement that an individual furnishing in-office ancillary services must be employed by the physician but requires direct supervision by a physician.

For group practices, there is a change in the locations in which services can be performed. Services must be performed in the same building in which the referring physician or a member of the same group practice furnishes services unrelated to the designated health services. Alternatively, clinical lab services can be furnished in another building which is used by the group practice for providing some or all of the group's clinical lab services, or in another building which is used by the group for the centralized provision of the group's designated health services other than clinical lab services.

If the group bills for services, the group's billing number must be used.

Effective Date

- o January 1, 1992 for clinical laboratory services and January 1, 1995 for all other designated health services. The billing requirement that if the group bills for services, the group's billing number must be used is effective January 1, 1995 for all designated health services, including clinical lab.

General Exceptions to Both Ownership and Compensation Arrangement Prohibitions - Prepaid Plans (Section 13562 (a)(1) amending Section 1877 (b)(3))

Prior Law

- o An exception to both the ownership and compensation arrangement prohibition is granted for certain prepaid plans.

Provision

- o Modifies the list of prepaid plans that are excepted to allow an exception for federally qualified HMOs as defined under Title 13 of the PHS Act, and to allow the Secretary to specify in regulations other financial relationships that are excepted because they do not pose a risk of program or patient abuse.

Effective Date

- o January 1, 1992 for clinical laboratory services and January 1, 1995 for all other designated health services.

General Exception Related Only to Ownership or Investment Prohibition for Ownership in Publicly-Traded Securities and Mutual Funds (Section 13562 (a)(1) amending Section 1877 (c))

Prior Law

- o Ownership of investment securities which were purchased on terms generally available to the public is not considered to be an ownership or investment interest if the following conditions are met. The securities are: (1) listed for trading on the NY Stock Exchange, the American Stock Exchange, or (2) are a national market system security traded under an automated interdealer quotation system operated by the National Association of Securities Dealers. The securities must be in a corporation that had at the end of the most recent fiscal year total assets exceeding \$100 million.

Provision

- o Modifies prior law provision of what is not considered an ownership or investment interest to include securities which may be purchased on terms generally available to the public. They can now be listed on a regional exchange and foreign securities listed on a foreign, national, or regional exchange. Modifies the asset threshold to state that the securities must be in a corporation that had at the end of the most recent fiscal year, or on average during the three previous fiscal years, stockholder equity exceeding \$75 million. The exception also applies to ownership of shares in a regulated investment company if the company has total assets exceeding \$75 million.

Effective Date

- o Modifications to prior law become effective January 1, 1995 for all designated health services, including clinical lab. Pre OBRA rules are in effect till January 1, 1995 for clinical lab services.

Additional Exceptions Related Only to Ownership or Investment Prohibition (Section 13562 (a)(1) amending Section 1877 (d))

Prior Law

- o An exception to the ownership or investment prohibition is provided for services furnished: (1) by a hospital in Puerto Rico; (2) by a lab in a rural area; and, (3) by a hospital if the referring physician is authorized to perform services at the hospital, and the ownership or investment interest is in the hospital itself and not merely a subdivision of the hospital.

Provision

- o Modifies the rural area exception to apply to designated health services furnished in a rural area by an entity if substantially all the designated health services are furnished to individuals residing in the rural area.

Effective Date

- o Modifications to prior law become effective January 1, 1995 for all designated health services, including clinical lab. Pre OBRA rules are in effect till January 1, 1995 for clinical lab services.

Exceptions Relating to Other Compensation Arrangements - Rental of Office Space, Rental of Equipment (Section 13562 (a)(1) amending Section 1877 (e)(1))

Prior Law

- o Payments made for the rental or lease of office space is not considered a compensation arrangement if there is a written agreement for the rental or lease of the space that meets specified requirements.
- o There is no exception for the rental of equipment.

Provision

- o Modifies the exception for the rental of office space and adds an exception for the rental of equipment. Payments made for renting or leasing office space or equipment are not considered compensation arrangements if: (1) there is a signed written agreement specifying the premises or equipment covered by the lease; (2) the space or equipment does not exceed that which is reasonable and necessary for legitimate business purposes and is being used exclusively by the lessee (in the case of space, an exception is provided for common

areas); (3) the lease is for a term of at least 1 year; (4) the rental charges are set in advance, are consistent with fair market value, and are not based on volume or value of referrals or other business generated between the parties; (5) the lease would be commercially reasonable even if no referrals were made between the parties, and (6) the lease meets other requirements established by the Secretary.

Effective Date

- o The changes to the rental of office space exception and the new exception for the rental of equipment are effective January 1, 1995 for all designated health services, including clinical lab. Pre OBRA rules are in effect till January 1, 1995 for clinical lab services.

Exceptions Relating to Other Compensation Arrangements - Bona Fide Employment Arrangements (Section 13562 (a)(1) amending Section 1877 (e)(2))

Prior Law

- o An arrangement between a hospital and a physician (or immediate family member) for employment of the physician (or immediate family member) or for the provision of administrative services is not a prohibited compensation arrangement if: (1) the arrangement is for identifiable services; (2) the amount of the remuneration is consistent with the fair market value of the services and is not based on volume or value of referrals; (3) the remuneration is commercially reasonable even if no referrals were made to the hospital; and, (4) the arrangement meets other Secretarial requirements to protect against program or patient abuse.

Provision

- o Broadens the exception for employment arrangements beyond hospitals to include any amount paid by an employer to a physician (or immediate family member) with a bona fide employment relationship. The same standards apply to this broader exception, except that payment of remuneration in the form of a productivity bonus based on services performed personally by the physician (or immediate family member) is also allowed.

Effective Date

- o January 1, 1992 for clinical laboratory services and January 1, 1995 for all other designated health services.

Exceptions Relating to Other Compensation Arrangements - Personal Service Arrangements; General (Section 13562 (a)(1) amending Section 1877 (e)(3)(A))

Prior Law

- o Remuneration from an entity (other than a hospital) is not a prohibited compensation arrangement if the arrangement is for: (1) specific, identifiable services as a medical director or member of a medical advisory board pursuant to a requirement of title 18; (2) specific, identifiable physicians' services to an individual receiving hospice care; (3) specific physicians' services furnished to a nonprofit blood center; or (4) specific, identifiable administrative services under exceptional circumstances identified by the Secretary in regulation.

Provision

- o Broadens the current law exception for certain service arrangements by allowing remuneration from an entity under an arrangement (including remuneration for specific physicians' services furnished to a nonprofit blood center) if: (1) the arrangement is in writing, is signed, and specifies the services; (2) the arrangement includes all services that the physician (or family member) will provide; (3) the services furnished do not exceed those that are reasonable and necessary for legitimate business purposes; (4) the arrangement is for at least 1 year; (5) the compensation is set in advance, does not exceed fair market value, and is not based on the volume or value of any referrals or business generated (except for physician incentive plans); (6) the services under arrangement do not violate any State or Federal law; and, (7) the arrangement meets other Secretarial requirements to protect against program or patient abuse.
- o Service arrangements must also meet the fair market value and other standards listed in 1877 (e)(2)(B) and (C), and any other requirements prescribed by the Secretary in regulations.

Effective Date

- o January 1, 1992 for clinical laboratory services and January 1, 1995 for all other designated health services.

Exceptions Relating to Other Compensation Arrangements - Personal Service Arrangements; Physician Incentive Plan Exception (Section 13562 (a)(1) amending Section 1877 (e)(3)(B))

Prior Law

- o No provision.

Provision

- o In personal service arrangements, allows an exception from the definition of compensation arrangements for physician incentive plans. Defines a physician incentive plan as a compensation arrangement between an entity and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided to individuals enrolled in the entity. Under this exception, the compensation may be determined in a manner (such as a withhold capitation or a bonus) that takes into account the volume or value of referrals or other generated business if: (1) no specific payment is made under the plan to the physician or group as an inducement to reduce or limit medically necessary services provided to a specified individual enrolled with the entity; (2) in the case of a plan that places the physician or group at substantial financial risk, it must comply with the requirements imposed by the Secretary under Medicare risk sharing contracts; and, (3) the entity provides descriptive information as requested by the Secretary.

Effective Date

- o January 1, 1992 for clinical laboratory services and January 1, 1995 for all other designated health services.

Exceptions Relating to Other Compensation Arrangements - Remuneration Unrelated to the Provision of Designated Health Services (Section 13562 (a)(1) amending Section 1877 (e)(4))

Prior Law

- o A financial relationship between a hospital and a physician (e.g., ownership, investment, or compensation) is not prohibited if the relationship did not relate to providing lab services.

Provision

- o Provides that remuneration by a hospital to a physician is not a prohibited compensation arrangement if the remuneration does not relate to the provision of designated health services.

Effective Date

- o January 1, 1992 for clinical laboratory services and January 1, 1995 for all other designated health services.

**Exceptions Relating to Other Compensation Arrangements -
Physician Recruitment (Section 13562 (a)(1) amending (e)(5))**

Prior Law

- o Remuneration provided by a hospital to a physician to induce him to relocate to the hospital's service area and join the hospital medical staff is not considered to be a prohibited compensation arrangement if: (1) the physician is not required to refer patients to the hospital; (2) the amount of remuneration is not based on the volume or value of referrals; and (3) the arrangement meets other Secretarial requirements.

Provision

- o No change.

Exceptions Relating to Other Compensation Arrangements - Isolated Transactions (Section 13562 (a)(1) amending Section 1877 (e)(6))

Prior Law

- o An isolated transaction, such as a one-time sale of property, is not considered to be a prohibited compensation arrangement if: (1) the amount of the remuneration is consistent with the fair market value and is not determined in a way that accounts for volume or value of referrals; (2) the agreement would be commercially reasonable even if no referrals were made to the entity and, (3) the arrangement meets other Secretarial requirements to protect against program or patient abuse.

Provision

- o Revises the exception to include the additional example of a one-time sale of a practice.

Effective Date

- o January 1, 1992 for clinical laboratory services and January 1, 1995 for all other designated health services.

Exceptions Relating to Other Compensation Arrangements - Certain Group Practice Arrangements with a Hospital (Section 13562 (a)(1) amending Section 1877 (e)(7))

Prior Law

- o No provision.

Provision

- o An arrangement between a hospital and a group under which designated health services are provided by the group but billed by the hospital is not considered to be a prohibited compensation arrangement if:
 - (1) with respect to services provided to an inpatient of a hospital, the arrangement is pursuant to the provision of inpatient hospital services under Section 1861 (b)(3);
 - (2) the arrangement began before December 19, 1989, and has continued without interruption;
 - (3) substantially all of the covered designated health services furnished to hospital patients are furnished by the group under the arrangement;
 - (4) the arrangement is written and specifies the services to be provided and the compensation;
 - (5) the compensation is consistent with fair market value and the per unit compensation is fixed in advance and not based on the volume or value of any referrals or other business generated between the parties;
 - (6) the agreement would be commercially reasonable even if no referrals were made to the entity; and
 - (7) the arrangement meets other Secretarial requirements to protect against program or patient abuse.

Effective Date

- o January 1, 1992 for clinical laboratory services and January 1, 1995 for all other designated health services.

Exceptions Relating to Other Compensation Arrangements - Payments by a Physician for Items and Services (Section 13562 (a)(1) amending Section 1877 (e)(8))

Prior Law

- o No provision.

Provision

- o Payments made by a physician to: (1) a lab in exchange for the provision of clinical lab services; or (2) an entity as compensation for other items or services if they are furnished at a fair market value price are not considered to be prohibited compensation arrangements.

Effective Date

- o January 1, 1992 for clinical laboratory services and January 1, 1995 for all other designated health services.

Definitions - Compensation Arrangement; Remuneration (Section 13562 (a)(2) amending Section 1877 (h)(1))

Prior Law

- o "Compensation arrangement" means any arrangement involving remuneration between a physician (or immediate family member) and an entity. "Remuneration" includes any remuneration, directly or indirectly, overtly or covertly, in cash or in kind.

Provision

- o Revises the definitions of "compensation arrangement" and "remuneration". Remuneration involved in any of the following circumstances is not considered a compensation arrangement:
 - (1) the forgiveness of amounts owed for inaccurate tests or procedures, mistakenly performed tests or procedures, or the correction of minor billing errors;
 - (2) the provision of items, devices, or supplies that are used solely to collect, transport, process, or store specimens for the entity providing the item, device, or supply, or to order or communicate the results of tests or procedures for such entity;
 - (3) a payment made by an insurer, or self-insured plan to a physician to satisfy a claim, submitted on a fee-for-service basis, for the furnishing of health services to an individual covered by their policy or plan, if: (i) the health services are not furnished and payment is not made pursuant to a contract or other arrangement between the insurer/plan and the physician; (ii) the payment made to the physician is made on behalf of the covered individual and would otherwise be made directly to the individual; (iii) the payment amount is set in advance, does not exceed fair market value, and is not based on the volume or value of any referrals; and, (iv) the payment meets other Secretarial requirements.

Effective Date

- o January 1, 1992 for clinical laboratory services and January 1, 1995 for all other designated health services.

Definitions - Group Practice (Section 13562 (a)(2) amending Section 1877 (h)(4))

Prior Law

- o A "group practice" is defined as two or more physicians legally organized as a partnership, professional corporation, foundation, not-for-profit corporation, faculty practice plan, or similar association in which: (1) each member furnishes substantially the full range of services which the physician routinely provides through the joint use of shared office space, facilities, equipment, and personnel; (2) substantially all of the services of the physician members are furnished through the group and billed in the name of the group with payment made to the group; (3) overhead expenses of and income generated by group members are distributed in accordance with methods previously determined by group members; and, (4) any other Secretarial standards are met.
- o In the case of a faculty practice plan associated with a hospital, institution of higher education, medical school with an approved medical residency training program, the definition of group practice applies only to those services provided within the faculty practice plan.

Provision

- o Expands standards for defining a group practice to include the following:
 - No group physician may be compensated directly or indirectly based on the volume or value of referrals. A physician, however, may be paid a share of overall group profits or a productivity bonus based on services personally performed or incident to personally performed services, as long as the share or bonus is not determined in any manner by referral volume or value.
 - Group members must personally conduct 75 percent or more of the physician-patient encounters of the practice.

Effective Date

- o The expansion to the group practice standards definition is effective January 1, 1995 for all designated health services, including clinical lab. Pre OBRA rules are in effect until January 1, 1995 for clinical lab services.

Definitions - Referral; Referring Physician (Section 13562 (a)(2) amending Section 1877 (h)(5))

Prior Law

- o A "referral" by a "referring physician" does not include a request by a pathologist for clinical diagnostic laboratory tests and pathological examination services, if such services are furnished by or under the supervision of such pathologist pursuant to a consultation requested by another physician.

Provision

- o Modifies prior law to specify that a request by a radiologist for diagnostic radiology services and a request by a radiation oncologist for radiation therapy, if furnished by or under supervision of such radiologist or radiation oncologist in response to a consultation request by another physician, do not constitute a "referral" by a "referring physician".
- o Applies to all designated health services.

Effective Date

- o January 1, 1992 for clinical laboratory services and January 1, 1995 for all other designated health services.

Definitions - Designated Health Services (Section 13562 (a)(2) amending Section 1877 (h)(6))

Prior Law

- o No provision.

Provision

- o (A) Clinical laboratory services
- o (B) Physical therapy services
- o (C) Occupational therapy services
- o (D) Radiology or other diagnostic services
- o (E) Radiation therapy services
- o (F) Durable Medical Equipment
- o (G) Parenteral & enteral nutrients, equipment & supplies
- o (H) Prosthetics, orthotics, and prosthetic devices
- o (I) Home health services
- o (J) Outpatient prescription drugs
- o (K) Inpatient and outpatient hospital services

Effective Date

- o January 1, 1992 for clinical laboratory services and January 1, 1995 for all other designated health services.

Reporting Requirements (Section 13562 (a)(3) amending Section 1877 (f))

Prior Law

- o Every entity providing items or services covered under Title 18 must provide the Secretary with ownership arrangement information including: (1) the covered items and services provided by the entity; and, (2) the names and UPINs of all physicians (or names of immediate family members) with an ownership or investment interest in the entity. An exception must be made for those providers that the Secretary determines are providing Medicare covered services very infrequently or to items or services provided outside the U.S. This information must first be provided no later than October 1, 1991 in a format determined by the Secretary and later be provided at such times and in such form and manner as the Secretary specifies.
- o The Secretary may waive these requirements if reporting occurs in at least 10 states, except for providers of clinical lab services. The Secretary may also waive provider reporting requirements within the chosen states except for parenteral and enteral suppliers, ESRD facilities, ambulance service suppliers, hospitals, physical therapy entities, and entities providing any type of diagnostic imaging services.

Provision

- o Extends prior law reporting requirement to apply to all designated health services.

Effective Date

- o January 1, 1992 for clinical laboratory services and January 1, 1995 for all other designated health services.

Sanctions - Denial of Payment (Section 13562 (a)(4) amending Section 1877 (g))

Prior Law

- o No payment may be made under Medicare for a clinical laboratory service provided under violation of the physician referral prohibition.

Provision

- o Extends prior law prohibition to apply to all designated health services.

Effective Date

- o January 1, 1992 for clinical laboratory services and January 1, 1995 for all other designated health services.

Direct Graduate Medical Education (Section 13563)

Prior Law

- o Payments to hospitals for direct costs of graduate medical education are based on Medicare's share of each hospital's direct costs per full-time equivalent (FTE) resident, in a base year, updated each year by the CPI.
- o Medicare payments for the direct costs of medical education are based on the recognized costs during a resident's so-called "initial period" of residency. This period is defined as the period necessary to be board eligible plus 1 year, but no more than 5 years. Up to 2 years of a geriatric residency or fellowship are treated as part of the initial residency period, but the time spent in the geriatric program is not counted toward the limitation on the initial residency period.
- o The Secretary must determine the resident amount based on approved FTE resident amounts for comparable programs for hospitals that did not have an approved medical residency training program or were not participating in the Medicare program during the base year.
- o No adjustments to the GME base-year costs for FICA taxes.

Provision

- o Eliminates cost-of-living updates in GME per resident amounts for cost reporting periods beginning during FYs 1994 and 1995 except for primary care and OB-GYN residents.
- o To determine whether a resident is in an initial residency period for payment purposes, a resident in a preventive care residency program would be treated the same as a geriatric resident; that is, up to 2 years of such training would be treated as part of the initial residency period and would not count towards the limitation on such period.

"Initial residency period" is the minimum number of years required for board eligibility. Effective July 1, 1995.

- o For a facility: (1) whose only medical residency program in the cost reporting period that began in fiscal year 1984 was in family and community medicine, (2) who received Federal, State or local funding, directly or indirectly, and (3) who had a base year per resident amount of \$10,000 or less; the Secretary must estimate the reasonable costs as if the program had not received any government assistance other than Medicare or Medicaid. The Secretary will reduce the payment amount so determined by the proportion of Medicare payments during the base period for cost reporting periods beginning on or after October 1, 1992.
- o For a hospital that did not pay FICA taxes or make other specified retirement contributions for residents in the base year and must now pay such taxes or contributions as a result of OBRA 1990, the Secretary shall redetermine the FTE resident amount to reflect those FICA payments for the base year for cost reporting periods beginning on or after October 1, 1992.

Effective Date

- o Upon enactment (August 10, 1993) except where otherwise noted.

Reductions In Payments for Home Health Services (section 13564)

Prior Law

- o Home health services are reimbursed on a reasonable cost basis, subject to aggregate cost limits, which are updated annually. OBRA 87 limited payment for home health agency costs to 112 percent of the mean labor-related and non-labor per visit costs for free-standing HHAs. For hospital-based HHAs, the Secretary must make appropriate adjustments in the limits for general and administrative costs. A HHA may receive an exception to the cost limits based on the special care needs of patients or circumstances beyond its control.

Provision

- o Per visit cost limits established for home health services will not be updated, or adjusted for changes in the wage index or applicable MSAs, for cost reporting periods beginning on or after July 1, 1994 and before July 1, 1996. Repeals the requirement for the special adjustment to the administrative costs of hospital-based HHAs effective for cost reporting periods beginning after fiscal year 1993.

Effective Date

- o Upon enactment; August 10, 1993.

Immunosuppressive Drug Therapy (Sec. 13565)

Prior Law

- o Immunosuppressive drugs are covered for 12 months after the date of a covered transplant.

Provision

- o Lengthens the period coverage for immunosuppressive drugs after a covered transplant to 18 months in 1995, 24 months in 1996, 30 months in 1997, and 36 months thereafter.

Effective Date

- o Phased-in expansion of benefit period, beginning January 1, 1995.

Reduction in Payments for Erythropoietin (Sec. 13566)

Prior Law

- o Medicare is the principal purchaser of erythropoietin (EPO), an anti-anemia drug given to ESRD beneficiaries receiving dialysis who have a specified red blood cell count. Payment for the drug is in addition to the composite rate paid to facilities for dialysis treatment. Payment to facilities is made in increments of 1,000 unit doses, rounded to the nearest hundred units, with a maximum payment of \$11 per thousand units.
- o Medicare covers the self-administration of EPO by home dialysis patients only.

Provision

- o The facility payment for EPO is \$10/thousand units.
- o Covers the self-administration of EPO by all -- home and in-center -- dialysis patients.

Effective Date

- o January 1, 1994.

Extension of the Social Health Maintenance Organization Demonstrations (S/HMO), (Section 13567)

Prior Law

- o The S/HMO demonstration for acute and long term care settings was enacted by Congress in DEFRA 1984 and extended through 1992 by OBRA 87 and through 1995 by OBRA 90.
- o The S/HMO has four basic organizational and financing features:
 - A single organizational structure provides a full range of acute and long term care services to voluntarily enrolled Medicare beneficiaries. Beneficiaries pay a monthly premium. In addition to the basic Medicare benefits, services include nursing home, home health, homemaker, transportation, drugs, and similar services.
 - A coordinated case management system is used to authorize long term care services for those members who meet specific disability criteria, within a fixed limit of about \$6,000 to \$12,000 per year.
 - The S/HMOs are designed to serve a cross-section of the elderly population, including both the functionally impaired and unimpaired elderly.
 - Financing is accomplished through prepaid capitation by pooling funds from Medicare, Medicaid, and premiums. The initial financing risk was shared by the S/HMOs and HCFA; after 30 months of the demonstration the S/HMO sites assumed full financial risk for service costs.

Provision

- o Extends the demonstrations to December 31, 1997.
- o Raises the limit on the number of beneficiaries who can be enrolled at any one site from 7,500 to 12,000.

Timing of Claims Payment (Section 13568)

Prior Law

- o From October 1, 1990 to December 31, 1992, a payment "floor" of 14 days existed for all Medicare clean claims; that is, Medicare could not pay clean claims earlier than 14 days after the date of receipt of the clean claim. Payment "ceilings" also existed. Medicare claims must have been paid within 17 days after the date of receipt of the clean claim for

participating physicians and within 24 days after the date of receipt of the clean claim for all other providers.

- o HCFA's FY 1993 appropriation authorized a 1-year payment "floor" differential for electronic claims; electronic claims could not be paid until the 14th day after the date of receipt while paper claims could not be paid until the 27th day after the date of receipt.

Provision

- o OBRA 93 makes this differential permanent. The "floor" for clean electronic claims is 13 days after the date of receipt and the "floor" for clean paper claims is 26 days after the date of receipt. Thus, clean electronic claims can be paid on the 14th day after the date of receipt, and clean paper claims can be paid on the 27th day after the day of receipt. OBRA 93 also authorized a permanent payment "ceiling" of 30 days after the date of receipt for clean claims.

Effective Date

- o Applies to claims received on or after October 1, 1993.

Extension of Waiver for Watts Health Foundation, (Section 13569)

Prior Law

- o Watts Health Foundation of Los Angeles received a 3-year waiver of the "50/50" membership rule in 1985, which expired March 31, 1988. This waiver was extended in OBRA 87 to January, 1990 and in OBRA 89 through January 1, 1994.
- o The 50/50 rule requires that Medicaid HMOs have no more than 50 percent of their members in either Medicare or Medicaid.

Provision

- o Extends waiver of "50/50" rule for Watts Health Foundation through January 1, 1996.

Part IV -- Provision Relating to Part B Premium

Part B Premium (Section 13571)

Prior Law

- o OBRA 90 established the monthly Part B premium for each year through 1995 in order to cover 25 percent of program costs. These premiums are: \$29.90 in 1991, \$31.80 in 1992, \$36.60 in 1993, \$41.10 in 1994, and \$46.10 in 1995. In 1996 and thereafter, the premium is established based on the previous year's premium and updated by the cost-of-living adjustment under the Social Security program.

Provision

- o Establishes the Part B premium at 25 percent of program costs for three additional years - 1996 through 1998.

Effective Date

- o Upon enactment; August 10, 1993.

Part V -- Provision Relating to Data Bank

Medicare and Medicaid Coverage Data Bank (Sec. 13581)

Prior Law

- o No provision for Medicare.
- o States must take all reasonable methods to ascertain the availability of third parties who are legally liable to pay for the medical care of Medicaid recipients.

Provision

- o Creates a Medicare and Medicaid Coverage Data Bank to help identify situations where payments for services received by Medicare or Medicaid beneficiaries are the responsibility of third party payers. Employers providing health insurance coverage must report annually to the Secretary certain information on all covered individuals, including the following: the name and taxpayer identification number (TIN) of the covered individual; the type of group health plan elected; the name, address, and number of the group health plan; the name and TIN of every other person included within the covered individual's group health plan; the period during which such coverage is elected; and the name, address, and TIN of the employer. The Secretary must establish fees to cover the administrative costs of the Data Bank.
- o Adds use of the newly created Medicare and Medicaid Coverage Data Bank and additional measures as specified to the reasonable methods that states must use to collect third party payments for Medicaid recipients.
- o Employers must report for each calendar year beginning on January 1, 1994 and before January 1, 1998.

Effective Date

- o January 1, 1994.

Subchapter B -- Medicaid

Part I -- Services

Personal Care Services Furnished Outside the Home as an Optional Benefit (Section 13601)

Prior Law

- o Repeals provision in prior law that makes personal care services a mandatory Medicaid services, effective October 1, 1994.

Provision

- o Allows States to offer personal care services as an optional Medicaid service. Such services must be authorized by a physician under a plan of care or otherwise authorized as part of a services plan approved by the State, must be provided by a qualified, non-family member, and may be furnished at home or in another location. Eliminates the requirement for supervision by a registered nurse.

Effective Date

- o As if enacted in OBRA 1990; October 1, 1994.

Additional Federal Savings Through Modifications to the Drug Rebate Program (Section 13602)

Prior Law

- o Effective January 1, 1991, subject to certain exceptions, Federal financial participation (FFP) is denied for the prescription drugs of manufacturers that do not enter into rebate agreements with the Secretary to provide specified rebates to States on a quarterly basis. States that offer prescription drug coverage under their Medicaid programs must cover all of the drugs of any manufacturer operating under such an agreement, with certain statutorily allowed exclusions from coverage or other restrictions.

Drugs not subject to denial of FFP are: (1) certain drugs that the State determines essential to the health of Medicaid beneficiaries and the use of which the State subjects to prior authorization and (2) vaccines. Manufacturers' new drugs may not be subject to prior authorization for the first six months after FDA approval.

- o In CY 93, the rebate for sole source and innovator multiple source drugs is the greater of 15.7 percent of the average

manufacture's price (AMP) or the difference between AMP and the manufacturer's "best price" for that drug with no maximum rebate.

- o In addition, an inflation adjustment is added to the rebate for single-source and innovator multiple source drugs to reflect the difference between the AMP on October 1, 1990 and the AMP in subsequent years. Prior to 1994, the index is calculated on a drug-by-drug basis in quarters subsequent to January 1, 1991. Beginning in 1994, the index is calculated on an aggregate basis for each manufacturer's product line, weighted for volume in each State. The "best price" is not indexed.
- o The rebate for non-innovator multiple source and over-the-counter drugs will be 10 percent of the AMP in CYs 1991 through 1993 and 11 percent of the AMP thereafter.

Provision

- o Permits coverage restrictions for drugs if the State establishes a formulary which meets specified requirements. The formulary must:
 - be developed by an appropriate Governor-appointed committee or the State drug use review board;
 - Exclude only those drugs with no significant, clinically meaningful therapeutic advantage, in terms of safety, effectiveness, or clinical outcome, over other drugs included in the formulary and have written explanation of the reasons available to the public;
 - cover even excluded drugs under prior authorization meeting statutory requirements; and
 - meet other requirements as the Secretary may impose to achieve program savings consistent with protecting the health of beneficiaries.
- o Clarifies that a prior authorization program established by a State under section 1927(c)(5) is not a formulary subject to the above requirements.
- o Removes the 6 months prohibition against prior authorization of new drugs.
- o Repeals the weighted AMP inflation formula for calculating the additional rebate which was to be effective as of January 1, 1994, and continues the drug-by-drug additional rebate.

- o Changes the base period for the additional rebate from October 1, 1990 to the calendar quarter ending October 1, 1990.

Effective Date

- o October 1, 1993.

Provision

- o Makes other program modifications to clarify ambiguities and facilitate implementation.

Effective Date

- o As if included in OBRA-1990; January 1, 1991.

Optional Medicaid Coverage of TB-Related Services for Certain TB-Infected Individuals (Section 13603)

Prior Law

- o No provision

Provision

- o Allows States (at their option) to offer Medicaid coverage to TB-infected individuals who meet the State's income and resource tests for categorically needy disabled individuals (SSI tests except in 209(b) States and territories). TB-related services must include prescription drugs, physician services, laboratory and X-ray services, clinic services, case management services, and services designed to encourage completion of regimens of prescribed drugs. Coverage of individuals eligible under this provision are limited to these services.

Effective Date

- o For services provided on or after January 1, 1994.

Emergency Services for Undocumented Aliens (Section 13604)

Prior Law

- o Medicaid covers services necessary for the treatment of an emergency medical condition (including emergency labor and delivery) for otherwise eligible aliens who are neither lawful permanent residents nor permanently residing in the U.S. under color of law (PRUCOL).

Provision

- o Clarifies that Medicaid-covered emergency services for undocumented aliens do not include care and services related to organ transplant procedures.

Effective Date

- o Effective as if included in OBRA-1986; January 1, 1987. No disallowance for services furnished before August 10, 1993.

Nurse-Midwife Services Outside of Maternity Cycle (Section 13605)

Prior Law

- o Medicaid covers the services of nurse-midwives provided to mothers and newborns throughout the maternity cycle. The maternity cycle includes pregnancy, labor, birth, and the immediate postpartum period.

Provision

- o Expands Medicaid coverage of certified nurse-midwife services to include services outside the maternity cycle that midwives are authorized to perform under State law.

Effective Date

- o October 1, 1993.

Treatment of Certain Clinics as Federally-Qualified Health Centers (Section 13606)

Prior Law

- o Medicaid Federally qualified health centers (FQHCs) include entities that (1) receive grants under sections 329, 330, and 340 of the Public Health Service Act; (2) receive funding under contract with such a grant recipient and independently meets the grant requirements; and (3) do not receive such grants but meet the requirements to do so as determined by the Secretary. FQHCs include outpatient health programs or facilities operated by a tribe or tribal organization under the Indian Self-Determination Act.

Provision

- o Includes as FQHCs, entities that were treated by the Secretary as comprehensive Federally funded health centers as of January 1, 1990. (Note: Section 13631(f)(2) also expands FQHCs to include public housing health centers under section 340A of

the Public Health Service Act and certain programs and facilities operated by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act for the provision of primary health services.)

Effective Date

- o Applies to calendar quarters beginning on or after July 1, 1993.

PART II -- ELIGIBILITY

Transfers of Assets; Treatment of Certain Trusts (Section 13611) Periods of Ineligibility for Transfers of Assets (Section 13611 (a))

Prior Law -- Penalty for whom and what services:

- o States are required to deny eligibility for nursing facility or equivalent services and for home and community-based waiver services to institutionalized persons who (or whose spouses) dispose of resources for less than fair market value. Institutionalized individuals include inpatients in nursing facilities (NFs), inpatients in medical facilities receiving a NF level of care, and recipients of services under a home and community-based waiver.

Provision

- o States are required to deny eligibility for nursing facility or equivalent services and for home and community-based waiver services to institutionalized persons who, or whose spouses, dispose of assets for less than fair market value. At their option, States may also deny eligibility to otherwise eligible non-institutionalized persons for: home health, personal care, and any other medical care or remedial care recognized under State law and specified by the Secretary, community supported living arrangements services (as defined in section 1930 of the Act), and, at State option, any other long-term care services covered under the plan.

In the case of jointly owned assets, any reduction or elimination of an individual's control or ownership resulting from an action taken by the individual or any other person is penalized as an uncompensated transfer.

"Assets" are defined to include all income and resources of the individual (or spouse), including that which the individual (or spouse) is entitled to receive but does not due to the action of the individual, spouse, or other agent.

Prior Law -- Look-back and Penalty Periods

- o The look-back period for uncompensated transfers made by persons eligible for Medicaid on admission extends 30 months from the month of admission to an institution. For transfers occurring before application is made for Medicaid by persons qualifying after admission to an institution, the look-back period extends 30 months from the month of application for Medicaid.

- o The penalty period begins with the month in which the assets were transferred. Its length is calculated by dividing the uncompensated value of the transfer by the average private pay rate for nursing facility services in the State (or in the community in which the individual is institutionalized, at State option) at the time of application for Medicaid. The maximum penalty lasts 30 months.

Provision

- o For persons in institutions, the look-back period extends 36 months before the individual is institutionalized and has applied for Medicaid or 60 months in the case of assets placed in revocable or irrevocable trusts that are considered to have been transferred. For non-institutionalized persons, look-back is 36 months (or 60 months) before the later of either the date the person applies for Medicaid or transfers resources.
- o The penalty begins on the first day of the first month during or after which the asset was transferred and which month does not occur in any other period of ineligibility due to an asset transfer. For persons in institutions, the length of the penalty period equals the total, cumulative uncompensated amount transferred during the look-back period divided by average monthly nursing facility costs to a private patient in the State or, at State option, in the local community at the time of the application. For non-institutionalized persons, the penalty period may not exceed the number of months for institutionalized persons. The uncompensated value of multiple transfers is added together. Penalty periods are adjusted to account for intermittent use of institutional and other long-term care services. Penalty periods are apportioned between eligible spouses. The maximum penalty period is removed.

Prior Law -- Exceptions and Permissible Transfers

- o The penalty does not apply when a person intended to transfer the resources for fair market value or other valuable consideration or were transferred exclusively for a purpose other than to qualify for Medicaid.
- o Unlimited transfers are permitted to a spouse (or to another for the spouse's benefit), or to a disabled child.

Provision

- o Prior law exceptions are expanded to shorten the penalty period to account for assets that have been returned.
- o Unlimited transfers are permitted: to a spouse (or another for the spouse's benefit), from the spouse to another for the spouse's benefit, to a disabled child, or to a trust

(including a pooled trust) established solely for that child's benefit.

Prior Law -- Hardship

- o The penalty is waived if the State determines that undue hardship would otherwise result.

Provision

- o The penalty is waived if the State determines, under procedures, standards, and criteria established by the Secretary, that undue hardship would otherwise result.

Effective Date

- o Effective for Medicaid payments made on or after October 1, 1993, except that these amendments do not apply to assets disposed of on or before the date of August 10, 1993. Effective date is delayed for States whose legislatures must act to implement these changes.

Treatment of Trust Amounts (Section 13611 (b))

Prior Law -- What counts?

- o Medicaid qualifying trusts (MQTs) are trusts or similar legal devices that an individual (or spouse) establishes (but does not include trusts established by will). An MQT is considered to be available to the individual but only to the extent that the trustee could, by exercising the maximum discretion allowed under the terms of the trust, distribute funds from the trust to the individual. The funds are counted whether or not the trustee exercises the discretion.

Provision

- o Affected trusts are those established by the individual, a spouse, another person (including a court or administrative body) acting legally on the individual's (or spouse's) behalf or at the individual's (or spouse's) direction. They do not include trusts established by will. These provisions do not apply to portions of a trust established with the assets of another person. The definition of "assets" is the same as in the transfer provision.
- o The trust is counted as available regardless of the purpose for which it was established, whether trustees have or exercise discretion, or restrictions that the trust imposes on distributions or uses of distributions.

- o "Trust" means any legal instrument or device similar to a trust, including annuities but only as the Secretary specifies.

Prior Law -- How is it counted?

- o The corpus of the trust, any interest it earns, and any distributions actually made from it are usually treated as "income" or "resources" according to the rules of the Supplemental Security Income (SSI) programs, except where certain Medicaid-specific provisions apply (those on counting MQTs and on State flexibility regarding how income and resources are counted).

Provision

- o Medicaid-specific rules require that the corpus of revocable trusts (including interest earned by the corpus) be counted as the individual's resource. Payments from the trust to or for the individual count as the individual's income, whether the payment funds come from interest earned by the corpus or from the corpus itself. Other payments are treated as a transfer of an asset for less than fair market value.

For irrevocable trusts, portions of the corpus or portions of the income on the corpus from which payment to or for the benefit of the individual could be made under any circumstances are considered resources to that individual. Payments from these portions to or for the benefit of the individual are considered income to the individual. Any other payments are considered a transfer of assets. Portions of the corpus or income on the corpus from which no payment could ever be made to the individual are considered a transfer of assets on the date that such payment is foreclosed.

Prior Law -- Exceptions

- o All Medicaid qualifying trusts count without exception.
- o At State option, the rules may be waived in case of undue hardship.

Provision

- o The following trusts are not affected by the new requirements:
 - Trusts established for the benefit of a disabled person under age 65 with that person's assets by a parent, grandparent, legal guardian, or court, provided that any amounts remaining in the trust upon the beneficiary's death revert to the State (not to exceed the amount of medical assistance paid on the individual's behalf).

- Trusts composed of only pensions, Social Security, or other income (including accumulated trust income) of persons in States that provide Medicaid to the special income group but do not provide medical assistance for nursing facility services to the medically needy. Any amounts remaining upon the beneficiary's death revert to the State, up to the amount of Medicaid payments on the individual's behalf.
 - Trusts composed of disabled persons' assets that are established and managed by a non-profit association and are established solely for the benefit of the disabled individual by the person's parent, grandparent, or legal guardian, by the individual, or by a court. The association may pool the funds of more than one person for management and investment purposes, but must maintain separate accounts for each beneficiary of the trust. Amounts remaining in the beneficiary's account and not retained by the pooled trust after the beneficiary's death must revert to the State, up to the amount of Medicaid payments on the individual's behalf.
- o States must establish procedures, in accordance with standards and criteria specified by the Secretary, for waiving these rules where they would work an undue hardship.

Effective Date

- o Effective for Medicaid payments made on or after October 1, 1993, except that the amendments do not apply to trusts established on or before August 10, 1993. Effective date is delayed for States in which implementation requires legislative action.

Medicaid Estate Recoveries (Section 13612)

Prior Law

- o States are permitted to recover Medicaid benefits correctly paid on behalf of an individual who was age 65 or older when he or she received services. These recoveries may only be made from the individual's estate (after death). In addition, in the case of a permanently institutionalized individual, States may recover Medicaid benefits either from the estates, or upon sale of property subject to a lien (which could be during the individual's lifetime). Recoveries may be for any amount that the State paid for any Medicaid service on the individual's behalf. There was no provision for undue hardship.

Provision

- o In recovering Medicaid correctly paid, States are required to seek recovery of payments for nursing facility services, home

and community-based services, and related hospital and prescription drug services, on behalf of persons age 55 or older when they received the assistance. States also have the option to recover payments for all other Medicaid services provided to these individuals at age 55 or older.

- o States are required to seek recovery of the amounts correctly spent by Medicaid on permanently institutionalized persons for any service. These recoveries may come either from the individual's estate (after death) or from the sale of property subject to a lien (which could be during the individual's lifetime).
- o States that disregard assets or resources of persons with long-term care insurance policies must recover all Medicaid costs for nursing facility and other long-term care services from the estates of persons who have such policies. In States that already had such disregards under a State plan amendment approved as of May 14, 1993, assets remaining in the estates of deceased Medicaid recipients would be shielded from recovery to the extent of payments made by their long-term care policies.
- o States are required to establish procedures, under standards specified by the Secretary, for waiving estate recoveries when they would cause undue hardship.
- o "Estate" means, at a minimum, estate as defined under State probate law. Most States are permitted to expand the definition to include any other real and personal property and other assets in which the individual had any legal title or interest at the time of his death (to the extent of the interest), including assets conveyed to surviving individuals through arrangements such as trusts or joint tenancy.

States must use the broader definition if, after May 14, 1993, they elect to disregard assets or resources for Medicaid eligibility purposes for individuals with long-term care insurance policies. States which had an approved State plan for such disregards in effect on May 14, 1993 may elect to use the minimum or the expanded definition.

Effective Date

- o Effective for Medicaid payments made on or after October 1, 1993, except that the provisions do not apply to estates of persons who died before October 1, 1993. The compliance date is delayed for States whose legislatures must act to implement these changes.

PART III -- PAYMENTS

Limits on Payments to Disproportionate Share Hospitals (Section 13621)

Prior Law

- o States may establish their own methodologies for designating hospitals as disproportionate share hospitals (DSH).

Provision

- o States may not designate a hospital as a DSH unless the hospital has a Medicaid inpatient utilization rate of at least one percent.

Effective Date

- o State fiscal years beginning in 1994. Effective date is delayed until 1995 for States whose legislatures do not meet in 1994.

Prior Law

- o States are not limited in the amount of DSH payment adjustments they can make to individual hospitals, but their total DSH payments in any year may not exceed their DSH allotment for that year.

Provision

- o Limits DSH payment adjustments to individual hospitals to 100 percent of the hospital's costs of providing services to Medicaid recipients and the uninsured, net of payments received from Medicaid (other than DSH) and uninsured patients. "Uninsured" includes individuals receiving services at a facility subsidized with State or local funds.
- o Includes transition rules for public hospitals that serve a large number of Medicaid patients (i.e., with a Medicaid inpatient utilization rate one standard deviation above the mean for the State or the highest Medicaid volume in the State) during the State fiscal year beginning in 1994. These hospitals may receive DSH payment adjustments up to 200 percent of their uncompensated costs of serving Medicaid and uninsured patients, as long as the Governor certifies to the Secretary that the payments in excess of 100 percent of the costs are used for health services.
- o For private hospitals, the Secretary may make any modifications she considers appropriate to the manner in which the limitation on payment adjustments is applied.

Effective Date

- o Effective for public hospitals in State fiscal years beginning in 1994. Effective for private hospitals in State fiscal years beginning in 1995.

Liability of Third Parties to Pay for Care and Services (Section 13622)

Prior Law

- o States are required to take reasonable measures to ascertain the liability of third parties, such as private insurers or the Medicare program, to pay for care and services for Medicaid recipients.
- o States may not receive Federal matching payments for expenditures that a private insurer would be obligated to pay if its contract did not limit or exclude payments to insured persons because they are eligible for or receiving Medicaid.

Provision

- o Extends the current requirement for States to ascertain the liability of third parties to service benefit plans, health maintenance organizations, and group health plans under the Employee Retirement Income Security Act (ERISA) of 1974.
- o Extends current prohibitions on Federal matching to expenditures that would, but for limiting contract provisions, be paid by service benefit plans, health maintenance organizations, and group health plans under ERISA.
- o Requires that State Medicaid plans prohibit health insurers (including service benefit plans, health maintenance organizations, and group health plans under ERISA) from taking a person's status into account when enrolling the person or when making payments for benefits.
- o State law must provide that to the extent that other parties are legally liable to pay for medical services for a Medicaid recipient, those parties must repay the State for expenditures it has made on the recipient's behalf.

Effective Date

- o October 1, 1993. Effective date is delayed for States whose legislatures must act to implement these changes, for all provisions except prohibition on Federal matching.

Medical Child Support (Section 13623)

Prior Law

- o States are generally prohibited from paying medical bills for which a third party is legally liable. An exception to the general rule exists in the case of a child whose parent is required to provide medical support under a support order enforced under part D of title IV of the Social Security Act. If the legally liable third party has not paid within 30 days, after the service has been furnished, States are required to pay the medical bills for such children and then to seek reimbursement from the third party.

Provision

- o Imposes additional State plan requirements to ensure the compliance of insurers and employers with court or administrative orders for parents to provide medical support. States must have in effect laws that:
 - Prohibit insurers from denying enrollment of: children born out of wedlock, children not claimed as a dependents on the parent's Federal tax return, or children not residing with the parent or in the insurer's service area.
 - In cases where the parent is eligible for family coverage and is under court or administrative order to provide health coverage --
 - + Require insurers and employers to permit the child to be enrolled without enrollment restrictions at the request of the employed parent or, if that parent fails to enroll the child, at the request of the custodial parent request or of the State child support enforcement agency. Disenrollment of the child is restricted to specified circumstances.
 - + Require employers, subject to certain limits, to pay the employee's share of premium costs out of the employee's compensation.
 - Prohibit insurers from imposing requirements on the State Medicaid agency that differ from those it imposes on any other agent or assignee of persons it insures.
 - Require insurers to provide information to the custodial parent about how to obtain coverage through a non-custodial parent. Insurers must also permit custodial parents or providers to submit claims without the approval of the non-custodial parent and must pay claims directly to the

custodial parent, the provider, or the State agency, as appropriate.

- Provide for the recoupment of State expenditures on a child's behalf by garnishing income and by withholding tax refunds of parents who: (1) have been ordered to provide medical support; (2) have received payments from an insurer but have not used those payments to reimburse service providers or the child's other parent or guardian, as appropriate. Garnishment or withholding for purposes of child income support takes priority over child medical support.
- In all cases, "insurer" includes service benefit plans, health maintenance organizations, and group health plans under ERISA.
- o Related amendments are also made to laws governing ERISA plans to ensure that Medicaid is the payer of last resort and that such children are covered under those plans if they are under a "qualified medical child support order" and if their parents are covered. ERISA amendments are designed to facilitate State enforcement of the new Medicaid requirements. (See Section 4301 of P. L. 103-66.)

Effective Date

- o April 1, 1994. Effective date is delayed for States whose legislatures must act to implement these changes.

Application of Medicare Rules Limiting Certain Physician Referrals (Section 13624)

Prior Law

- o Provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit or receive remuneration in order to induce business reimbursed under the Medicare or State health care programs.
- o Alternative sanction authority allows the OIG to identify and prosecute physician self-referral cases.
- o Requires the Secretary, after consultation with the Department of Justice, to publish payment practices which are potentially capable of inducing referrals under Medicare or Medicaid, but which are protected from criminal prosecution or civil sanctions under the anti-kickback provisions of the statute because they may be beneficial to the community.

Provision

- o Denies payment to a State for expenditures for "designated health services" (as defined in OBRA-93 section 13562 which amends section 1877 of the Act) furnished to an individual on the basis of a physician referral that, all things being equal, would result in the denial of payment under Medicare.
- o Requires providers of designated health services to report ownership arrangements, and subjects them to a civil money penalty of not more than \$10,000 a day for failure to report.

Effective Date

- o Applies to referrals made on or after December 31, 1994.

State Medicaid Fraud Control (Section 13625)

Prior Law

- o The Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 provided enhanced Federal matching of 90 percent for three years for States to establish State Medicaid Fraud Control Units (MFCU).
- o OBRA-80 provided 90 percent funding for the first three years of operation of MFCUs and 75 percent matching thereafter.

Provision

- o States are required to demonstrate that: (1) they operate an effective MFCU according to standards established by the Secretary or (2) an MFCU would not be cost-effective because minimal fraud exists and beneficiaries would be protected from fraud and abuse without a MFCU.

Effective Date

- o The Secretary must establish the standards no later than March 31, 1994. The State requirements are effective January 1, 1995.

PART IV -- IMMUNIZATIONS

Medicaid Pediatric Immunization Provisions (section 13631)

Prior Law

- o States are required to provide age-appropriate childhood immunizations to Medicaid-eligible children as part of the early and periodic screening, diagnostic, and treatment services (EPSDT) program.
- o States may not reimburse manufacturers directly for the purchase of childhood vaccines except under a waiver. States may only make Medicaid payments to Medicaid participating providers or beneficiaries.
- o States are required to inform all Medicaid-eligible children under age 21 of the availability of EPSDT services.
- o Under EPSDT, States must provide screening services, including immunizations, at intervals which meet reasonable standards of medical practice, as determined by the State.
- o Federal Medicaid matching funds are available for the costs of single-antigen vaccines and their administration.

Provision

- o Creates a new State plan requirement under which all State Medicaid programs must establish a program for the distribution of pediatric vaccines furnished by the federal government. The program may be administered by the State's department of health.
- o The program includes the following elements:
 - The Secretary will purchase vaccines, at the current CDC price increased by the CPI-U, to be delivered to program-registered providers and administered to vaccine-eligible children at no charge to the State; purchase will also include 6-month stockpile;
 - Federal vaccine-eligible children are Medicaid-eligible, uninsured, or underinsured receiving services at FQHCs and RHCs, and Indian children;
 - States may purchase additional vaccines at the negotiated price for an additional group of children in the State;
 - Program-registered providers are licensed providers that agree to determine (but not verify) the eligibility of

children, maintain records, follow the recommended schedule of immunizations, and not charge for the cost of the vaccine; a limited vaccine administration fee may be charged to the child's parents; the State may not impose additional requirements on provider participation;

- Manufacturers must agree to deliver vaccines to providers in states that do not have a distribution system as a part of the negotiated price and submit reports to the Secretary as necessary;
 - The Secretary will recommend a schedule of vaccines to be administered under the new program in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP); and
 - States may not repeal any existing law requiring insurers to cover vaccines.
- o FFP is not available for the administrative costs required to carry out the new State Plan requirement.
 - o Group health plans covering pediatric vaccines as of May 1, 1993, may not reduce this coverage. This requirement is deemed a requirement of section 2207 of the Public Health Service Act. Effective after August 10, 1993.
 - o States may make payment directly to vaccine manufacturers for childhood vaccines provided under a Medicaid vaccine replacement program. Effective from August 10, 1993 until October 1, 1994, when the new program goes into effect.
 - o States must coordinate with title V and WIC for information and education on pediatric vaccinations, for the delivery of immunization services, and to inform all potential EPSDT recipients about the need for age-appropriate immunizations. Effective October 1, 1993. Effective date is delayed for States in which implementation requires legislative action.
 - o The EPSDT program must provide childhood vaccines in accordance with the national immunization schedule to be recommended by the Secretary. Effective 90 days after the date the Secretary's recommended vaccine schedule is first established.
 - o FFP is not available for a single-antigen vaccine and its administration if a combined-antigen vaccine was medically appropriate. Effective October 1, 1993.

Effective Date

- o October 1, 1994, unless otherwise indicated above.

PART V -- MISCELLANEOUS

Increase in Limits on Federal Medicaid Matching Payments to Puerto Rico and Other Territories (Section 13641)

Prior Law

- o Capped Federal payments to the Territories as follows:

Puerto Rico -----	\$79,000,000
Virgin Islands -----	\$2,600,000
Guam -----	\$2,500,000
Northern Mariana Islands -----	\$750,000
American Samoa -----	\$1,450,000

Provision

- o Increases the limits on Federal payments to the Territories for FY 1994 as follows:

Puerto Rico -----	\$116,500,000
Virgin Island -----	\$3,837,500
Guam -----	\$3,685,000
Northern Mariana Islands -----	\$1,110,000
American Samoa -----	\$2,140,000

- o For years after FY 1994, the limits are increased by the percentage increase in the medical care component of the consumer price index for urban consumers.

Effective Date

- o Beginning with fiscal year 1994.

Extension of Moratorium on Treatment of Certain Facilities as Institutions for Mental Diseases (Section 13642)

Prior Law

- o States may provide Medicaid benefits for persons aged 65 or older in institutions for mental diseases (IMDs); payment may not be made for services provided to other residents of IMDs, except inpatient psychiatric services for persons under age 21.
- o An IMD is an institutional setting of more than 16 beds that is primarily engaged in diagnosing, treating, or caring for persons with mental diseases.

- o The Secretary must submit to Congress a report on implementation of the IMD exclusion and is precluded from determining that two Michigan hospitals, Kent Community Hospital Complex and Saginaw Community Hospital, are IMDs until 180 days after Congress received the report. This report was sent to Congress on December 7, 1992.

Provision

- o Precludes the Secretary from determining that Kent Community Hospital Complex and Saginaw Community Hospital are IMDs until December 31, 1995.

Demonstration Projects (Section 13643)

Prior Law

- o Authorized \$40 million for 3 to 4 States to conduct 3-year demonstrations to study the effect of eliminating categorical eligibility requirements for individuals with family incomes of less than 150 percent of the Federal Poverty Level (FPL). Demonstrations were authorized for FY 1991 through 1994.
- o Authorized a 3-year demonstration for several States to provide Medicaid coverage to pregnant women and children under age 20 with family incomes below 185 percent of the FPL. A total of \$10 million per year was authorized for FY 1990, 1991, and 1992.
- o Authorized up to 15 states to conduct frail elderly demonstrations patterned after the On Lok project. Special impoverishment provisions apply to participants of such demonstrations.

Provision

- o Extends time frames of the demonstrations and retains availability of authorized funds until expended.
- o Extends time frames and authorized funds for demonstrations until expended.
- o Further clarifies that special impoverishment provisions apply to demonstration participants.

Effective date

- o August 10, 1993.

Extension of Period of Applicability of Enrollment Mix Requirement to Certain Health Maintenance Organizations Providing Services Under Dayton Area Health Plan (Section 13644)

Prior Law

- o The Dayton Area Health Plan, a Medicaid managed care program in Montgomery County, Ohio, has been exempted from the 75/25 enrollment requirement since the program's inception. The 75/25 rule requires that not more than 75 percent of plan enrollees be individuals eligible for benefits under Medicare or Medicaid.
- o The original 3-year waiver, allowed by statute, expired in April 1992. The State received a further legislative exemption from the 75/25 rule for two of the plan's participating HMOs, Health Plan Network and DAYMED, Inc., which expires on January 31, 1994.

Provision

- o Extends the legislative exemption until December 31, 1995.

Social Security Provisions Affecting Medicaid

Exclusion from Income and Resources of State Relocation Assistance (Section 13732)

Prior Law

- o Excludes from countable income and resources payments for relocation expenses made by States and local governments. This provision expires May 1, 1994.

Provision

- o Makes exclusion of such payments permanent.

Effective Date

- o August 10, 1993.

Prevention of Adverse Effects on Eligibility for and Amount of Benefits When Spouse or Parent of Beneficiary is Absent from the Household on Active Military Service (Section 13733)

Prior Law

- o When the parent or spouse of an SSI recipient leaves the household for active military duty, their income is attributed to the eligible individual at a higher rate than if they are living in the household which may cause reduction in benefits or loss of eligibility.

Provision

- o The parent or spouse of an SSI recipient who leaves the household solely due to active military duty will be considered to be still living in the household. Certain hazardous pay from calculation of income for SSI purposes.

Effective Date

- o First day of the second month beginning after enactment; October 1, 1993.

Eligibility for Children of Armed Forces Personnel Residing Outside the United States Other Than Foreign Countries (Section 13734)

Prior Law

- o SSI benefits to children who accompany their parents assigned to military duty in Puerto Rico, the trust territories, and U.S. possessions are discontinued.

Provision

- o Authorizes the continuation of SSI benefits to children who accompany their parents on military assignments to Puerto Rico, the territories, and U.S. possessions.

Effective Date

- o First day of the third month beginning after enactment; November 1, 1993.

Valuation of Certain In-Kind Support and Maintenance When There Is a Cost of Living Adjustment in Benefits (Section 13735)

Prior Law

- o Current procedures for calculating SSI payments retrospectively prevent making upward adjustments to the 1/3 reduction for in-kind support and maintenance which is charged to SSI recipients who live in the household of another person until two months after SSI cost-of-living adjustments take effect. Therefore, an individual who is subject to the 1/3 reduction when a COLA occurs does not have the value of the in-kind support and maintenance applied to their SSI payment until two months after the COLA.

Provision

- o Requires that the current month Federal SSI payment amount be used to determine the current month value for in-kind support and maintenance.

Effective Date

- o For benefits paid beginning January 1, 1995.

Exclusion from Income of Certain Amounts Received by Indians from Interests Held in Trusts (Section 13736)

Prior Law

- o Income derived from leases on privately-owned or restricted Indian lands is considered in determining SSI eligibility and benefit amount, although the value of the land is excluded from consideration as a resource.

Provision

- o Excludes the first \$2,000 of income received from leasing of privately-owned or restricted Indian lands from income in determining SSI eligibility and benefit amount.

Effective Date

- o January 1, 1994