MEDICARE, MEDICAID AND SCHIP BENEFITS IMPROVEMENT AND PROTECTION ACT OF 2000: HIGHLIGHTS: December 15, 2000

President Bill Clinton has indicated he will sign the "Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000," which will increase Medicare and Medicaid health care provider payments; add preventive benefits and reduce beneficiary cost sharing under Medicare; and improve health insurance options for low-income children, families and seniors. Legislation to enhance benefits and appropriately adjust Medicare and Medicaid payments has been long-sought by the Clinton-Gore Administration. The President, Vice President and Congressional Democrats are particularly pleased about recent improvements to this legislation that extend new health coverage options for children and people moving from welfare to work and increase assistance for rural and teaching hospitals, hospices and home health agencies. This legislation invests about $35 billion over 5 years,[1] with approximately $5 billion for Medicare and Medicaid beneficiary improvements, $12 billion for hospitals; $2 billion for nursing homes, $2 billion for home health agencies, $3 billion for other providers, and $11 billion for managed care plans. Of this, about $2 billion is dedicated to rural providers. The major provisions are described below.

MEDICARE BENEFICIARY PROVISIONS

- **Expands preventive benefits available to Medicare beneficiaries.** The legislation establishes new nutrition therapy and glaucoma screening benefits. It also expands the existing colon cancer screening benefit by providing for colonscopies for those at average risk of colon cancer and the cervical cancer screening benefit by covering pap smears and pelvic exams every 2 years.

- **Increases coverage of immunosuppressive drugs**. Currently, Medicare sets time limits on how long Medicare will pay for prescription drugs that help prevent rejection of transplants. This legislation lifts the limits and provides permanent coverage for immunosuppressive drugs.

- **Limits beneficiary hospital outpatient coinsurance**. The BBA included a provision to reduce the Medicare beneficiary coinsurance for hospital outpatient department services from approximately 50 percent of costs to 20 percent over a number of years. This policy would accelerate the phase-down to 40 percent by 2006 and clarify that coinsurance for all outpatient services provided during a day may not exceed the Part A deductible.

- **Extends Medicare coverage to persons with Lou Gehrig's Disease.** Even though life expectancy for patients with Lou Gehrig's Disease (amytrophic lateral sclerosis -- ALS) is less than two years, patients must wait 24 months after being diagnosed with the disease before becoming eligible for Medicare. Because of the uniquely short time period between diagnosis and death, this legislation waives the Medicare waiting period, permitting persons with ALS to receive needed health services immediately.

---

[1] Anticipated CBO scoring (final estimate not yet available). Does not include offset from Medicaid upper payment limit regulation, which yields a net cost of about $15 billion over 5 years.

- **Expands Medicare homebound definition to include adult day care.** Under current law, beneficiaries who leave home on a regular basis are not considered homebound and therefore are not eligible for home health benefits. However, for homebound persons with Alzheimer's and related dementia, seeking treatment at adult day care facilities provides much-needed relief for both the patient and the caregiver. This provision clarifies that beneficiaries may leave to attend adult day care without affecting their homebound status.

MEDICAID BENEFICIARY PROVISIONS

- **Permits enrollment of uninsured children at schools and other sites.** Many low-income uninsured children are eligible for Medicaid and S-CHIP but are not enrolled. This provision would allow states the option of enrolling uninsured children through schools, child support enforcement agencies, homeless shelters, program eligibility offices, and other sites.

- **Extends health care coverage program for those leaving welfare for work.** Currently, in order to ensure that they have the supports necessary to become self-sufficient, persons leaving welfare for work continue to be eligible for 12 months of Medicaid coverage. However, this important program expires next year. The legislation extends the program an additional year.

- **Simplifies enrollment for low-income Medicare beneficiaries.** Fewer than half of low-income seniors and people with disabilities who are eligible for Medicaid assistance with Medicare premiums and cost sharing get it – in part due to complicated and burdensome application procedures. To address this, the legislation promotes the development and use of a simple, uniform application and encourages outreach efforts through Social Security.

HOSPITALS

- **Increases inflation update for all hospitals.** The BBA set the annual update at market basket minus 1.1 percent in both 2001 and 2002. This legislation sets the update at the full market basket in 2001 and market basket minus 0.55 percent in 2002 and 2003.

- **Adjusts teaching hospital payments for medical education.** Under the BBA and BBRA, teaching hospitals' indirect medical education (IME) payment add-on was reduced to 6.25 percent in 2001, and 5.5 percent in 2002 and thereafter. This provision increases the add-on to 6.5 percent in both 2001 and 2002.

- **Provides greater hospital bad debt reimbursement.** The BBA reduced the proportion of a beneficiary's bad debt to a hospital that is reimbursable under Medicare to 55 percent. This legislation would increase the percentage to 70 percent starting with 2001 cost reports.

- **Raises hospital outpatient department prospective payments.** Currently, hospital outpatient payments are adjusted annually by market basket minus 1 percent in 2001 and 2002. This would provide a full inflation update in 2001.

- **Increases Medicaid payments to safety net hospitals.** The BBA set state-specific caps on total Medicaid disproportionate share hospital (DSH) payments. The allotments decrease from 1998-2002 and are increased by CPI in 2003. OBRA 1993 also set hospital-specific limits so that DSH payments could not exceed 100 percent of a hospital's uncompensated care costs. This legislation provides relief to safety net hospitals by setting 2001 state-specific allotments at 2000 levels adjusted for inflation and setting 2002 allotments at 2001 levels adjusted for inflation. It also allows states to provide public hospitals DSH payments up to 175 percent of net uncompensated care costs for two years.

- **Improves rural hospital programs.** This legislation modifies and improves a series of Medicare policies that support rural health care providers.

  - Makes more equitable the treatment of rural hospitals (as well as small urban hospitals) under the Medicare disproportionate share hospital (DSH) system by expanding program eligibility and increasing DSH add-on payments for such hospitals.

  - Strengthens the Critical Access Hospital (CAH) program by exempting CAH swing beds from SNF prospective payments; reimbursing physicians at 115 percent of the fee schedule; and paying emergency room physicians and ambulances at reasonable cost.

  - Permits rural hospitals to choose among three cost reporting periods to determine eligibility for the Medicare Dependent Hospital (MDH) program.

- **Increases payments for PPS-exempt hospitals**. The legislation increases payments for rehabilitation hospitals in 2002 to 100 percent of pre-BBA levels; expand bonuses from 2 percent to 3 percent for psychiatric hospitals that meet their targets; raises the national cap on long-term care hospital reimbursement by 2 percent and increases the individual long-term care hospital target amounts by 25 percent.

SKILLED NURSING FACILITIES & THERAPY SERVICES

- **Increases inflation update for skilled nursing facilities.** The BBA set the annual inflation update at market basket minus 1 percent in 2001 and 2002. The legislation adjusts the update to the full market basket in 2001 and market basket minus 0.5 percent in 2002 and 2003.

- **Improving nursing staffing ratios.** In order to address low staffing ratios resulting from a shortage of qualified nurses, this provision would increase prospective payment system reimbursement by adjusting the nursing component of the resource utilization groups (RUGs) upwards by 16.66 percent in 2001. To ensure that residents are fully informed, SNFs will be required to post staffing ratios.

- **Imposes an additional year's moratorium on payment caps**. The BBA limited yearly payments for physical / speech therapy and occupational therapy to $1,500 each per beneficiary. These limits are too low and force beneficiaries to incur high out-of-pocket costs for necessary therapy services. The BBRA delayed implementation of the therapy caps until after 2001. This legislation adds an additional year to the moratorium.

- **Provides immediate increases in payment for high-cost rehabilitation therapy.** This legislation ensures adequate reimbursement for rehabilitation therapy services by increasing rehabilitation RUGs by an additional 6.7 percent starting in 2002.

HOME HEALTH

- **Delays 15 percent cut for an additional year.** In addition to creating a new prospective payment system for home health, the BBA also required a 15 percent reduction in payment limits. The BBRA delayed implementation until a year after establishment of the PPS. This provision would delay implementation of the 15 percent reduction another year until 2002.

- **Increases inflation update for home health agencies.** BBA set the annual update at market basket minus 1.1 percent for 2001 and 2002. The legislation provides a full market basket update in 2001.

- **Assists rural home health agencies.** The BBA disproportionately affected the financial status of rural agencies. Rural home health agencies have higher costs due to the greater travel expenses associated with rural, isolated areas. This provision would provide a 10 percent add-on payment to rural agencies in 2001 and 2002.

MANAGED CARE

- **Increases rates.** This legislation raises the floor payment to $525 in urban areas with populations over 250,000 and $475 in all other areas. It also provides a one-time increase in the minimum update from 2 percent to 3 percent in 2001.

- **Enhances plan accountability by increasing penalties.** In order to encourage plans to stay in their service areas and in the Medicare program, the legislation strengthens the Secretary's enforcement authority by increasing the civil monetary penalties that the Secretary may assess on plans that violate their contracts.

- **Codifies risk adjustment phase-in for managed care plans**. The BBA required that payments to managed care plans be risk adjusted, to prevent adverse selection and to encourage plans to enroll sicker beneficiaries. This provision establishes an explicit 7-year phase-in schedule, 2 years longer than current law but 7 years less than the original Republican conference report.

- **Changes provider participation rules and quality standards**. The legislation includes a number of provisions to accommodate health plans, including: permitting premium reduction as an additional benefit; providing for elections to be effective when made; permitting a uniform coverage policy for multistate plans; requiring HCFA to approve market materials on a timely basis and prohibiting duplicative regulation; and allowing cost contractors to expand service areas and enroll more beneficiaries.

- **Interaction with fee-for-service policies.** Medicare+Choice rates are linked to growth in Medicare fee-for-service spending. Since the policies in the legislation increase fee-for-service spending, they increase managed care payments.

OTHER PROVIDERS

- **Increases payments for hospices.** Medicare reimbursement for hospices has not risen at the same rate as hospice costs. Hospices now provide more expensive services and serve sicker patients. This provision builds a 5 percent increase into the hospice payment base rates.

- **Raises payments for renal dialysis**. Prior to the BBRA, Medicare's payments for dialysis had not increased since 1991. Consistent with a recommendation from the Medicare Payment Advisory Commission, this legislation provides an additional 1.2 percent increase in the composite rate in addition to the 1.2 percent increase provided by BBRA.

- **Adjusts updates for durable medical equipment, orthotics and prosthetics, and ambulances**. The legislation provides a full CPI inflation update in 2001 for DME suppliers; a full market basket update in 2001 for suppliers of orthotics and prosthetics, and a full CPI update in 2001 for ambulance providers.

MEDICAID & STATE CHILDREN'S HEALTH INSURANCE PROGRAM

- **Closes Medicaid upper payment limit loophole.** The legislation directs the Secretary of Health and Human Services to finalize her regulation eliminating a reimbursement loophole that threatens the fiscal integrity of the Medicaid program. This provision saves the Medicaid program over $21 billion over 5 years. The legislation also provides for a six-year transition period for States with payment arrangements in effect in 1992 that may violate the new regulation.

- **Establishes enhanced prospective payment system for community health centers.** The BBA phased out the Medicaid requirement to pay federally-qualified health centers (FQHCs) and rural health clinics (RHCs) based on cost by 2000. The BBRA extended the phase-out to 2005. The legislation establishes a new prospective payment system for health centers starting in 2001 that is based on centers' FY 2000 reasonable costs. This ensures that FQHCs and RHCs receive adequate Medicaid reimbursement and continue to provide essential care to low-income and uninsured populations.

- **Adjusts the SCHIP reallocation formula**. The BBA requires that states that do not use annual SCHIP allotments within three years must return all unused funds to the federal government which would then redistribute the funds to states that have already exhausted their allotments. The legislation establishes a new reallocation formula for 1998 and 1999 allotments whereby all states would be entitled to a proportion of the unused funds. States receiving unused funds would have an additional year to spend the money.

OTHER PROVISIONS

- **Funds the Ricky Ray Trust Fund.** The Ricky Ray Hemophilia Trust Fund was authorized in 1998 to provide $750 million in relief payments to persons with hemophilia or their survivors who contracted HIV through contaminated transfusions. This budget (including funding in other bills) provides $580 million in 2001 to ensure that the Trust Fund is fully funded and eligible beneficiaries receive their payments.

- **Increases funding for diabetes research and treatment.** The BBA allocated annually $30 million each for research and education on juvenile diabetes and diabetes among Native Americans. The legislation provides an additional $70 million annually for both programs in 2001 and 2002 and an additional $100 million for both programs in 2003.

- **Increases Authorization for Title V Maternal and Child Health (MCH) program.** The legislation would raise the current authorization for the maternal and child health block grant from $705 million to $850 million.