TO: BOARD OF DIRECTORS
COUNCIL OFFICERS
COMMITTEE CHAIRS
COMMITTEE STAFF LIAISONS
ALL COMMITTEE MEMBERS
THROUGH: GORDON WHEELER
FROM: ANN LABELLE
JENNIFER SEARFOSS
DATE: JANUARY 3, 2001
RE: END OF 106TH CONGRESS WRAP-UP

OVERVIEW

The Second Session of the 106th Congress came to an official end on December 15, 2000, approximately two months beyond the original target adjournment date of October 6. Republican leaders began the Session with an ambitious agenda which included tax breaks and measures to reinforce local autonomy over federal education dollars. The Democrats held Medicare expansion for prescription drugs and an increase in the minimum wage as main objectives. Both sides failed to resolve many of their key issues. Prolonged disputes between the House, Senate and the Administration coupled with the uncertain presidential election race caused Congress to pass an unprecedented 21 temporary funding measures between October 1 and December 15. Yet the battle over appropriations resulted in $10 billion more in spending than the President had requested in his original budget proposal.

PATIENTS' BILL OF RIGHTS/ACCESS TO EMERGENCY MEDICAL SERVICES

For more than seven years, ACEP has sought passage of legislation assuring access to emergency medical services based on the prudent layperson standard. With each Congress, the breadth of support has increased. In the 105th Congress, more than 200 House Members cosponsored H.R. 815. Almost one-third of the Senate (28) cosponsored the companion bill in the Senate, S. 356. In this Congress, ACEP's legislative strategy shifted the emphasis from seeking a large number of cosponsors to legislation (H.R. 904) to calling for votes on the House floor. ACEP-supported language was included in the several patients' bill of rights that surfaced in both sessions of the 106th Congress. In fact, acceptable language was approved by a majority of the Members in the House of Representatives. Forty-eight Senators, an insufficient number to assure passage in that body, voted for ACEP-backed language. This record of success, albeit a few votes short of enacting a bill into public law, constitutes a significant achievement and reflects the involvement of ACEP members at the grassroots level.

APPROPRIATIONS AND BUDGET MEASURES

Throughout the 106th Congress, ACEP worked to gain passage of other measures of particular interest to ACEP, including funding for: poison control centers; trauma care planning; bioterrorism-related activities undertaken by the Office of Emergency Preparedness within the Centers for Disease Control; child passenger protection education; and the National Highway Transportation Safety Administration. The final appropriations levels for fiscal year 2001 are attached.

EMTALA

Emergency physicians are keenly aware of their obligations under this statute. They are also cognizant that this landmark statute is an unfunded federal entitlement. Since its enactment in 1986, ACEP has worked with the Health Care Financing Administration (HCFA) and others on regulation implementing the law. Over the years, court decisions and the government's regulatory interpretations have expanded the scope of EMTALA. During this same period, the Office of the Inspector General has also increased the number of cited EMTALA violations.

The conference agreement on the Benefits Improvement and Protection Act (BIPA) directs the General Accounting Office (GAO) to report to Congress by May 1, 2001 on the effect of EMTALA on hospitals, emergency physicians and physicians covering emergency departments calls. The report is to evaluate such effects as the extent to which these physicians provide uncompensated care services in relation to EMTALA and the extent to which regulatory requirements and enforcement have expanded beyond EMTALA's original intent. ACEP worked to have this provision included in BIPA and hopes that the information collected by the GAO will be helpful in persuading HCFA to recognize the true costs of EMTALA-mandated care (see below).

PRACTICE EXPENSE

Emergency Physicians are also conscious of HCFA's efforts to gain recognition of the true practice expenses tied to EMTALA. For several years, ACEP has been advocating that HCFA develop a policy and methodology that recognize the significant uncompensated care costs of emergency physicians that relate to the statutory requirements of EMTALA. We have urged HCFA to recognize these costs under the practice expense component of the Medicare physician fee schedule. On behalf of ACEP, the Lewin Group conducted a study that explored the issue in detail in 1998. HCFA has made adjustments on ACEP's behalf in the past and expressed a willingness to review data that confirms ACEP's position on uncompensated care. Within BIPA, the General Accounting Office is directed to conduct a study on the transitional refinements to the practice expense relative value units. The study will evaluate how the Secretary of HHS has accepted and used the practice expense data submitted under the 1999 Balanced Budget Refinement Act (BBRA). The report will include recommendations regarding improvements to the process and use of practice expense data.

MEDICARE

BIPA included many provisions returning funds cut by the 1997 Balanced Budget Act (BBA). Hospitals received about $11.5 billion in "give back" provisions. Of particular note are: payment for "on call" emergency services for certain Critical Access Hospitals in rural areas; improvements for funding both indirect medical education and direct graduate medical education; better payment for ambulance services; and significant changes to the Medicare beneficiary appeals process. More detailed descriptions of the provisions are attached.

MEDICAID/SCHIP

After months of negotiations, Congress and the White House agreed to restore some BBA funding cuts made to Medicaid and SCHIP. See the attached document for more information.

Benefits Improvement and Protection Act of 2000 (BIPA)

The Benefits Improvement and Protection Act of 2000 (BIPA) is the latest Balanced Budget Act (BBA) "give back" bill for Medicare, Medicaid and SCHIP. The package passed Congress on Dec. 15, 2000, as part of a larger funding bill H.R. 4577 and was signed into law on Dec. 21 as P.L. 106-554. The final package breaks down over five years as follows:

MEDICARE: Prospective Payment System (PPS) Hospitals

Medicare inpatient payments. Inpatient PPS payments will be updated to a full market basket in FY2001. Payments will rise by 3.4 percent in FY2001, up from 2.3 percent under the BBA. Based on current estimates, payments in FY2002 will rise by 3.05 percent, up from an estimated 2.5 percent under the BBA. Restores: $3.7 billion over five years.

Disproportionate Share Hospital (DSH). An additional one percent cut will be made to Medicare DSH payments in FY2001 and FY2002. The agreement also provides for the same threshold eligibility for Medicare DSH payments for rural and urban hospitals. It modifies the DSH payments for Sole Community Hospitals (SCHs) and Rural Referral Centers (RRCs) and small rural hospitals and urban hospitals with less than 100 beds. Restores: $1.45 billion over five years.

Indirect medical education (IME). The level of payment adjustment is frozen at an average of 6.5 percent in FY2001, 6.5 percent in FY2002 and 5.5 percent in FY2003 and in subsequent years. Restores: $700 million over five years.

Direct graduate medical education (GME). Floor payments per resident are increased to 85 percent of the locality adjusted national average per resident amount. Restores: $300 million over five years.

Bad debt payments. Starting in FY2001, Medicare will pay beneficiaries an increased 70 percent for uncollectable beneficiary deductibles and coinsurance. Restores: $700 million over five years.

MEDICARE: Hospital Outpatient Services

Medicare outpatient payments. For calendar year 2001, a full market basket update will be made to Medicare hospital outpatient services. Payments will rise by 4.4 percent in calendar year 2001, up from 2.4 percent under the BBA. Restores: $900 million over five years.

Provider-based status. The existing arrangement will be grandfathered for two years. Facilities or organizations requesting approval for provider-based status between October 1, 2000 through September 30, 2002 are to be treated as if they have such status while determination is pending. The provision also adds a geographic market area option. Restores: $200 million over five years.

Beneficiary coinsurance for outpatient services. The reduction in beneficiary coinsurance for outpatient services is accelerated from established levels. The total amount of coinsurance for any hospital outpatient service received yearly by a beneficiary will be limited to the amount of the inpatient hospital deductible for that year. Restores: $1.8 billion over five years.

MEDICARE: Rural Provider Provisions

Sole Community Hospitals (SCHs). Any SCH will be able to elect payment based on hospital-specific updated FY 1996 costs. Restores: $100 million over five years.

Medicare Dependent Hospitals (MDHs). The MDH criteria will be modified to permit qualifying small rural hospitals to be classified as a MDH under new standards. Restores: $100 million over five years.

Payment for professional services provided by a critical access hospital (CAH). Medicare payment of CAHs for outpatient services will be based on reasonable costs or Medicare will pay a facility fee based on reasonable costs plus a percent of the Medicare fee schedule for professional services. Restores: $100 million over *ten* years.

Payment in CAHs for emergency room on-call physicians. When determining the allowable, reasonable costs of outpatient CAH services, the Secretary will recognize amounts for compensation and related costs of on-call emergency room physicians who are not present on the premises, are not otherwise furnishing services and are not on-call at any other provider or facility. The Secretary will define the reasonable payment amounts and the meaning of the term "on-call." Restores: $100 million over five years.

Treatment of ambulance services furnished by certain CAHs. Ambulance services provided by a CAH will be paid on a reasonable cost basis if it is the only provider located within a 35 mile distance of the CAH. Restores: $100 million over *ten* years.

Assistance for ambulance services providers in rural areas. Increased payments will be given to providers of ground ambulance services for trips greater than 17 miles and up to 50 miles originating in a rural area. In addition, the General Accounting Office is required to study the costs of efficiently providing ambulance services for trips originating in rural areas. Restores: $200 million over five years.

Expansion of Medicare payment for telehealth services. Payment provisions were revised for telemedicine services provided by a physician or practitioner at a distant site to an eligible beneficiary. Restores: $100 million over five years.

MEDICARE: Related Provisions of Interest to ACEP

Payment for ambulance services. Any phase-in of the ambulance fee schedule will provide for the full payment of national mileage rates in states where separate mileage payments were not made prior to the implementation of the fee schedule. Restores: $100 million over five years.

Revisions to Medicare's coverage process. Clarification is provided on when and under what circumstances Medicare coverage policy can be challenged. An additional administrative level of review of coverage decisions is created. An affected party may submit a request to the Secretary to issue a national coverage or non-coverage determination, if one has not been issued. Public hearings are required by the Secretary and certain other information regarding coverage policy will be made public. Restores: $400 million over five years.

Changes in Medicare's appeals process. Significant changes are made to the Medicare appeals process. Initial claims determinations (Part A and Part B) must be made within 45 days from the date the Secretary receives a claim for benefits. A request for a reconsideration must be initiated within 180 days of the date the individual receives the initial determination.

Expanded Medicare benefits. A number of benefit expansions are included in the final BIPA package. Medical nutrition services for beneficiaries with diabetes or renal disease will be covered under Medicare, as will screening colonoscopies, biannual screening pap smear and pelvic exams, mammograms on a more frequent basis, and glaucoma screening for high-risk individuals. In addition, the time limitation on coverage for immunosuppressive drugs following transplantation will be removed and balanced billing will be prohibited for Part B covered outpatient drugs. BIPA also provides that the 24-month waiting period – otherwise required for an individual to establish eligibility on the basis of a disability – will be waived for persons determined to have amyotrophic lateral sclerosis (ALS).

MEDICAID

Disproportionate Share Hospitals (DSH). Medicaid DSH state allotments for FY 2001 are at the FY 2000 level; increased only by the consumer price index (CPI), rather than continuing the phase-down called for in the BBA. There is also a special rule that exempts Medicaid DSH payments from the allotment to public hospitals that had not been receiving DSH payments prior to October 1, 2000 and have a low-income utilization rate above 65 percent. Restores: $3.9 billion over five years.

Medicaid upper payment limit rule. The proposed rule on upper payment limits (UPL) for state facilities will be published on January 12, 2001. The regulation must specify two transition periods for states with payment arrangements that are non-compliant, one for states with such arrangements effective on or after October 1, 1999 and the other for those states with arrangements that were effective before that date. The agreement also requires the final regulation to stipulate a third set of rules governing the transition for certain states. *Reduction to Medicaid*: $21.5 billion over five years.

Extension of welfare-to-work transition. The sunset on transitional medical assistance is extended by one-year (from September 30, 2001 to September 30, 2002) for families no longer eligible for welfare.

Expansion of presumptive eligibility for low-income children. Several entities are added to the list of those qualified to make Medicaid presumptive eligibility determinations for children. These include agencies that determine eligibility for Medicaid or SCHIP, or certain schools, including those operated by the Bureau of Indian Affairs.

Development of uniform QMB/SLMB application form. The Secretary is required to develop a simplified national application form for States to use at their option for individuals who apply for medical assistance for Medicare cost-sharing under the Medicaid program.

New Prospective Payment System (PPS) for FQHCs and RHCs. A prospective payment system for FQHCs and RHCs will be established beginning in 2001, taking into account any change in the scope of services during the fiscal year. Restores: $300 million over five years.

SCHIP

Availability of redistribution of unused funds. BIPA adopts new rules for unspent funds under SCHIP. The program gives states annual allotments of funds to be used to expand coverage for children which must be spent within two years beyond the year of the allotment. Amounts remaining after that time are to be redistributed to states that did exhaust their allotments. This legislation allocates approximately 40 percent of the unspent funds to States exhausting their allotments and allows those states that did not expend their entire allotments to continue to have access to approximately 60 percent of those funds. Up to 10 percent of the unspent funds can be used for outreach activities. The unspent funds will be available to the states through 2002. The legislation also clarifies states' authority to conduct presumptive eligibility determinations, as defined in Medicaid law, under separate (non-Medicaid) SCHIP programs.

Application of Medicaid child presumptive eligibility provisions. The legislation clarifies states' authority to conduct presumptive eligibility determinations, as defined in Medicaid law, under separate (non-Medicaid) SCHIP programs.

FISCAL YEAR 2001 APPROPRIATIONS

Labor, Health and Human Services and Education Appropriations

- Poison Control Centers $20 million

- Trauma Care Planning $3 million

- Saginaw Cooperative Hospitals, Inc., Michigan $360,000
  The conference agreement includes bill language identifying $226 million for the construction and renovation of health care and other facilities.

- University of Michigan Emergency Telemedicine Network $300,000

- Emergency Medical Services for Children $19 million

- Bioterrorism $60.1 million
  Approximately $8 million is earmarked for the following projects:
  - $1,000,000 for the West Virginia University Virtual Medical Campus, to conduct an assessment for Disaster Medical Assistance Teams, National Guard Civilian Support Teams and hospital emergency and administrative personnel for medical preparedness and readiness for Weapons of Mass Destruction or similar events. A report is due to the Congress by June 30,2001 on this initiative;
  - $900,000 for the Rhode Island Hospital disaster preparedness initiative;
  - $1,400,000 for the Charlotte Mecklenburg Advanced Local Emergency Response Team (ALERT) project in Charlotte, North Carolina;
  - $1,900,000 for the Public Health Service Mobile Training Center at Fort McClellan, Alabama for bioterrorism training; and
  - $2,200,000 for the Washington Hospital Center, the University of Pennsylvania Department of Emergency Medicine and the University of Tennessee ER One initiative.

- Ryan White AIDS Program $1.8 billion

Transportation Appropriations

- NHTSA $116.8 million

- Child Passenger Protection Education $7.5 million