Talking Points on Medicare Subvention

Background

Representative Dicks may call to urge the President to sign an Executive Order initiating a Department of Defense (DoD) Medicare subvention demonstration. As you know, HCFA, DoD and OMB have worked hard to craft an agreement to establish a demonstration; this agreement was reflected in legislation submitted to the Hill at the beginning of September. Neither the House nor the Senate acted on the legislation. During the course of our interagency negotiations on the agreement, it was determined that legislation is required to initiate the demonstration.

Talking Points

OMB's general counsel has determined that HCFA does not have adequate demonstration authority under current law to conduct a demonstration of Medicare subvention. **Under the Social Security Act, Medicare cannot pay other government agencies to provide services.** Legislation must be enacted in order to conduct a Medicare subvention demonstration. An Executive Order would not meet the test of enacted legislation.

The President is committed to conducting a Medicare subvention demonstration. This was clearly reflected when the Secretary of Health and Human Services, in consultation with the Secretary of Defense, submitted legislation to Congress that would provide the authority necessary to conduct a Medicare subvention demonstration.

This legislation was based on an intensive process of negotiation between HCFA and DoD in order to design a sound demonstration to test the concept of choice for military retirees and to protect the Medicare trust fund. This process resulted in a memorandum of agreement that was released to Congressional staff.

An Executive Order, at this time, could be criticized on the grounds that it circumvents budgetary considerations given CBO's estimate of the Administration's proposal as a cost to the Medicare trust fund. Moreover, **majority and** minority members of the Ways and Means Health Subcommittee **and members of the Senate Finance and Budget Committees** were extremely concerned about the cost of this proposal to the Medicare trust fund.

At the end of the session, a modification of the Administration's proposal under pressure from Senate Majority Leader Lott that would have set the reimbursement rate that DoD would pay Medicare at 50% of the AAPCC (the Administration's was 93%) with the rest made up from newly identified DoD asset sales.

Ways and Means Health Subcommittee Chairman Thomas (joined by Rep. Rangel and Rep. Stark) objected to putting the newly developed proposal on the CR unless other Medicare reforms were also included. No Medicare reforms were attached to the CR.

(NOTE): For your information, the Department of Defense indicated to Representative Dicks that the demonstration would be conducted in and around his Congressional district.

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

August 8, 1996

STATEMENT BY THE PRESIDENT

Today, I have directed Secretary of Veterans Affairs Jesse Brown to send to Congress legislation for an innovative pilot that will expand health care options for our nation's older veterans.

The "Veterans' Medicare Reimbursement Model Project Act of 1996," fulfills a recommendation made by the Vice President's National Performance Review and moves forward an idea proposed during the early days of this Administration. The proposal has the potential of multiple benefits: expanding the choice of health-care for older veterans; bringing new resources, utilization, and operational experience to the VA health-care system; and producing savings for the Medicare Trust Fund by providing health care to Medicare-eligible veterans at a lower cost in the VA system.

This bill would establish a model demonstration project under which the Department of Veterans Affairs (VA) would be reimbursed by the Department of Health and Human Services (HHS) for health care provided to certain Medicare-eligible veterans.

It would open the VA system to Medicare-eligible veterans at a limited number of sites, allowing VA to receive reimbursement from Medicare, and testing whether this is a way of improving health care access and quality for Medicare-eligible veterans while protecting the integrity of the Medicare program. The proposal incorporates a rigorous evaluation of this demonstration program.

This legislation is particularly important given the increasing number of veterans age 65 and older -- by the year 2000, the number of Medicare-eligible veterans will exceed 9.3 million, or 38 percent of the total veteran population. This model project will allow us to learn more about how we can meet the needs of veterans.

The Departments of Defense and Health and Human Services have also been working on developing specifications for a model project to allow Medicare-eligible military retirees to use military treatment facilities with Medicare reimbursement, and plan to have a proposal ready in the near future.

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Office of Public Affairs
News Service

Washington, D.C. 20420
(202) 273-5700

Department of Veterans Affairs

News Release

FOR IMMEDIATE RELEASE

VA SEEKS AUTHORITY TO TREAT MEDICARE-ELIGIBLE VETS, BE REIMBURSED FOR CARE

Washington, Aug. 9 -- The Department of Veterans Affairs (VA) has submitted proposed legislation to establish a pilot program under which certain veterans would have the option of using their Medicare benefits to obtain VA health care. The legislation also would permit VA to be reimbursed by the Department of Health and Human Services (HHS) for the services provided.

Secretary of Veterans Affairs Jesse Brown said: "This pilot program will expand the choices for many veterans, particularly some World War II and Korean Conflict veterans, who would like to come to VA but are unable to get care because of budget constraints and strict eligibility criteria. It also means that VA will be able to recover and retain the costs of the services that we provide, just as any other community provider."

Currently, higher-income, nonservice-connected veterans can receive VA health care only on a space- and resource-available basis, and those over 65 are not permitted to use their Medicare benefits. While VA is authorized to submit claims to insurance carriers to recover a portion of the cost of medical care provided to certain veterans, VA is not permitted to claim Medicare reimbursement.

"Many veterans have told me that they want to use their Medicare benefits at VA," said Brown. "They served their country, they worked hard, they paid in to the Medicare Trust Fund, and they should be able to choose where they use their Medicare benefits. Once this pilot program is in place, they will choose VA because it provides some of the best health care in the nation," he added.

The pilot program would be established at up to eight VA medical centers, or four VA medical centers and one Veterans Integrated Service Network. The sites would be determined by the Secretaries of Veterans Affairs and HHS.

-more-

Because VA is a cost-effective health-care provider, the proposed bill specifies that payments to VA from the Medicare Hospital Insurance Trust Fund would be less than what private providers receive for the same services. However, veterans participating in the project would still be subject to Medicare's regular copayments. The Medicare receipts would fund these patients' care, not VA appropriations.

The pilot program also would permit VA to establish managed health-care plans at the sites. It also would provide VA with greater authority to contract for health-care services, if necessary, and permit VA to conduct marketing and sales activities, including the use of paid advertising, for outreach purposes.

The pilot program is expected to run for three years, with a possible two-year extension. VA and HHS will arrange for an outside evaluation of the program, with a first report submitted to Congress 18 months after the establishment of the project at the first site. A final report, due to Congress no later than three and one-half years after the project begins, will include recommendations on whether the program should be expanded and whether permanent authorization should be sought.

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THE SECRETARY OF VETERANS AFFAIRS

WASHINGTON

The Honorable Newt Gingrich
Speaker of the House of
Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

There is transmitted herewith, a draft bill, "To require the Secretary of Veterans Affairs and the Secretary of Health and Human Services to carry out a model project to provide the Department of Veterans Affairs with Medicare reimbursement for Medicare health-care services provided to certain Medicare-eligible veterans." We request that it be referred to the appropriate committees for prompt consideration and enactment.

The draft bill would authorize the Department of Veterans Affairs (VA) and the Department of Health and Human Services (HHS) to conduct a model project which would give certain veterans the option to use their Medicare benefits to obtain care in the VA system. This approach has potentially multiple beneficiaries. First, the proposal could benefit veterans by expanding their choice of health care providers. Second, the proposal could benefit the Medicare trust funds which could pay less to VA for the health-care of these Medicare patients. Finally, the proposal could benefit VA by bringing new resources and operational experience to the VA health-care system and by allowing greater utilization of the existing system.

VA has long been recognized as the provider of choice for many of our nation's veterans. However, constraints on resources have required that VA limit the access of certain categories of veterans to VA's health care services. These veterans are commonly referred to as "category C veterans." As a result, veterans with higher incomes who are 65 years and older and who do not have a service-connected disability often rely on Medicare. These veterans are currently not able to use their Medicare benefits to obtain care in the VA

system. At a limited number of VA sites, the model project would open the VA system to these Medicare-eligible veterans. The care of these new users would be funded by Medicare reimbursements.

The proposed model project would be conducted at up to eight sites or at up to four sites and one Veterans Integrated Service Network (VISN). Medicare-eligible "category C veterans" who seek care at a project site would be required to obtain care under the provisions of the model project. VA would provide the care in its facilities or by contracting with private providers. A critical provision in the bill specifies that HHS would reimburse VA for the care of project participants at rates no more than 95 percent of the rates at which private Medicare providers are reimbursed. The bill also contains a provision to ensure that VA does not receive both VA appropriations and Medicare reimbursements for the care of Medicare eligible veterans (i.e., the Department would maintain its current "level of effort" in providing care for category C Medicare-eligible veterans). The proposal further would require that VA meet the same quality standards as private providers meet under the Medicare program. VA currently meets or exceeds most of these standards. Finally, veterans who participate in the model project would be charged the same cost sharing as they would be charged by private sector Medicare providers.

The project would continue for three years and could be extended for up to two additional years. During its operation, it would be evaluated by an independent entity. Not later than four years after the project's initiation, the Secretaries of VA and HHS would recommend to Congress whether the project should be continued on an expanded basis. The project would provide VA and HHS with valuable information about the total costs of health care for their dual beneficiaries. In addition, by permitting the coordination of that care by a sole provider, VA and HHS could reduce the cost and improve the quality of that care.

Enactment of this draft bill would benefit veterans, the Medicare program, and the American public.

The Honorable Newt Gingrich

The Office of Management and Budget advises that there is no objection to the submission of this legislative proposal and that its enactment would be in accord with the programs of the President.

Sincerely yours,

Jesse Brown

JB:er

104th Congress
2d Session

A BILL

To require the Secretary of Veterans Affairs and the Secretary of Health and Human Services to carry out a model project to provide the Department of Veterans Affairs with Medicare reimbursement for Medicare health-care services provided to certain Medicare-eligible veterans.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act shall be cited as the "Veterans' Medicare Reimbursement Model Project Act of 1996".

SEC. 2. MODEL PROJECT.

(a) AUTHORITY. -- (1) Not later than sixty days after the date of enactment of this Act, the Secretary of Veterans Affairs and the Secretary of Health and Human Services shall enter into an agreement to carry out a model project under which the Secretary of Health and Human Services shall reimburse the Secretary of Veterans Affairs, from the trust funds established under title 18 of the Social Security Act, for Medicare health-care services furnished to certain Medicare-eligible veterans.

(2) Under the model project authorized in paragraph (1), the Secretary of Veterans Affairs shall, notwithstanding any other provision of law, furnish Medicare-eligible veterans who are described in section 1710(a)(2) to title 38, United States Code, with needed health-care services.

(3) Payments made under subsection (c)(1) shall be made in appropriate part, as determined by the Secretary of Health and Human Services, from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund.

(4) With respect to payments made under subsection (c)(1), the Secretary of Health and Human Services may waive any requirement of part B of title XI of the Social Security Act, title XVIII of that Act, or a related provision of law.

(b) SITES. -- The model project shall be carried out at up to four sites or at one Veterans Integrated Service Network for payments on the basis described in subsection (c)(1)(A)(i) and at up to four sites for payments on the basis described in subsection (c)(1)(A)(ii). The sites and any Network shall be designated jointly by the Secretary of Health and Human Services and the Secretary of Veterans Affairs. The Secretary of Veterans Affairs may terminate the participation of any site in the model project at any time subject to any obligations to veterans who have agreed under subsection (d) to obtain care at the site.

(c) PROJECT REQUIREMENTS. -- The agreement entered into under subsection (a) shall--

(1) provide that the Secretary of Health and Human Services shall reimburse the Secretary of Veterans Affairs--

(A)(i) on the basis that payments are made under section 1876(a) of the Social Security Act, or

(ii) on the bases that payments are made under title XVIII of that Act (other than under section 1876), and

(B) in amounts equal to ninety-five percent of the amounts payable from the trust funds under that title on the bases specified in clause (i) or (ii) of subparagraph (A), as applicable, reduced as specified in the agreement entered into under subsection (a) with respect to specific components of payments made under that title, and reduced as provided by paragraph (3);

(2) specify which requirements shall be waived under subsection (a)(4) with respect to the model project;

(3) require the parties, for the purpose of avoiding the imposition on the trust funds established under title XVIII of the Social Security Act of the costs of the care that Medicare-eligible veterans would, in absence of this Act, be expected to receive from the Department of Veterans Affairs, to--

(A) determine the average amount expended by the Department of Veterans Affairs in the three fiscal years ending on September 30, 1996, for furnishing Medicare health-care services to Medicare-eligible veterans eligible for care under section 1710(a)(2) of title 38, United States Code, at the sites participating in the model project, and

(B) establish a procedure for adjusting the amount determined under subparagraph (A) for purposes of determining the amount by which the Secretary of Health and Human Services shall reduce reimbursements under paragraph (1)(B);

(4) provide that, subject to the availability of resources and appropriate charges, the Secretary of Veterans Affairs may, as the Secretary considers it appropriate, furnish Medicare-eligible veterans described in section 1710(a)(2) of title 38, United States Code, with care and services authorized by chapter 17 of that title at these sites in addition to health-care services provided under the model project;

(5) provide that the care and services furnished under paragraph (4) shall be subject to all eligibility criteria and priorities set forth in chapter 17 of title 38, United States Code; and

(6) specify a procedure for adjusting the provision of health-care services under the model project in case the number of veterans requesting care under the project from outside the usual geographic catchment area of a site significantly exceeds historical levels.

(d) MANDATORY PARTICIPATION. -- (1) Subject to paragraph (2), all Medicare-eligible veterans described in section 1710(a)(2) of title 38, United States Code, who request health-care services at a site participating in the model project must agree to obtain those services under the provisions of the model project.

(2) Medicare-eligible veterans described in section 1710(a)(2) of title 38, United States Code, who are receiving hospital care or nursing home care at a site participating in the model project before initiation of the project at that site shall not be required to agree to obtain health-care services under the provisions of the model project until after their discharge.

(e) MANAGED HEALTH-CARE PLANS. -- (1) In carrying out this model project, the Secretary of Veterans Affairs may establish and operate managed health-care plans.

(2) Any such plan shall be operated by or through a Department of Veterans Affairs health-care facility or group of facilities and may include the provision of health-care services through other public and private entities under arrangements made between the Department and the other public or private entity concerned. Any such managed health-care plan shall be established and operated in conformance with standards prescribed by the Secretary of Veterans Affairs after consultation with the Secretary of Health and Human Services.

(3) The Secretary of Veterans Affairs shall prescribe the minimum health-care benefits to be provided under the plan to veterans enrolled in the plan. Those benefits shall include at least all Medicare health-care services.

(f) COST SHARING. -- The Secretary of Veterans Affairs shall establish cost-sharing requirements for veterans participating in the model project. The cost-sharing requirements for such veterans not participating in a managed health-care plan under subsection (e) shall be the same requirements that apply to Medicare-eligible patients at non-Department of Veterans Affairs facilities.

(g) MARKETING. -- The Secretary of Veterans Affairs may conduct marketing and sales activities, which may include the use of paid advertising, for the purpose of outreach to veterans who are eligible to participate in the model project.

(h) CONTRACTING. -- (1) To carry out this model project, the Secretary of Veterans Affairs may, when the Secretary determines it necessary in order to obtain health-care resources which otherwise might not be feasibly available, or to utilize health-care resources effectively, make arrangements, by contract or other form of agreement for the sharing of health-care resources between sites participating in the project and non-Department health-care providers.

(2)(A) If the health-care resource required is a commercial service, the use of either medical equipment or space, or research, and is to be acquired from institutions affiliated with the Department in accordance with section 7302 of title 38, United States Code, medical practice groups and other entities associated with such institutions, blood banks, organ banks, or research centers, the Secretary may make such arrangements without regard to any law or regulation relating to competitive procedures.

(B) If the health-care resource required is a commercial service or the use of either medical equipment or space, and is not to be acquired from an entity described in subparagraph (i), any procurement for such resource may be conducted without regard to any law or regulation relating to competitive procedures provided it is conducted in accordance with simplified procedures established by the Secretary in consultation with the Administrator for Federal Procurement Policy that are published for public comment in accordance with section 22 of the Office of Federal Procurement Policy Act, 41 U.S.C. 418b. The simplified procedures shall require at a minimum that the Department of Veterans Affairs publish a notice in accordance with section 18 of the Office of Federal Procurement Policy Act, 41 U.S.C. 416, and sections 8(e), (f), and (g) of the Small Business Act, 15 U.S.C. 637(e), (f), (g), that permits all

responsible sources to submit a bid, proposal, or quotation (as appropriate) which shall be considered by the agency. Pending publication of the simplified procedures, these procurements shall be conducted in accordance with all procurement laws and regulations.

(C) Any procurements for health-care resources other than those covered by paragraphs (A) or (B) shall be conducted in accordance with all procurement laws and regulations.

(D) For any procurement to be conducted on a sole source basis, a written justification must be prepared that includes the information and is approved at the levels prescribed at section 303(f) of the Federal Property and Administrative Services Act, 41 U.S.C. 253(f).

(3) Arrangements entered into under this subsection shall provide for reciprocal reimbursement based on a methodology that provides appropriate flexibility to the parties concerned to establish an appropriate reimbursement rate after taking into account local conditions and needs and the actual costs to the providing facility of the resources involved. This paragraph does not apply to procurements entered into under this subsection.

(i) REVOLVING FUND. -- (1) There is established in the Treasury of the United States a revolving fund for the conduct of the model project.

(2) The Secretary of Veterans Affairs shall deposit in this revolving fund--

(A) amounts received under this section,

(B) recoveries and collections under section 1729 of title 38, United States Code, for Medicare-eligible veterans eligible for care under section 1710(a)(2) of title 38, United States Code, at the sites participating in the model project, and

(C) from the Department of Veterans Affairs medical care account, the amount needed to conduct the model project.

(3) The Secretary of Veterans Affairs shall use the amounts in this fund for conducting this model project and for reimbursing the Department of Veterans Affairs medical care account for expenditures from that account in support of this project. Amounts in the fund not needed for the conduct of the model project may be used to enhance the care of Medicare-eligible veterans not participating in this project.

(j) EVALUATION AND REPORTS. -- (1) The Secretary of Veterans Affairs and the Secretary of the Health and Human Services shall arrange for an independent entity with expertise in the evaluation of health services to conduct an evaluation of the model project. The entity shall submit annual reports on the model project. The first report shall be submitted not later than eighteen months after the date on which the model project begins operation, and the final report not later than three and one-half years after that date. The evaluation and reports shall include an assessment of the following:

(A) Compliance by the Department of Veterans Affairs with the requirements under title XVIII of the Social Security Act.

(B) The cost to the Department of Veterans Affairs of providing care to veterans under the project.

(C) Compliance by the Department of Veterans Affairs with the standards of quality required of entities that furnish Medicare health-care services.

(D) Any savings or costs to the programs under title XVIII of the Social Security Act from this project.

(E) Any change in access to care or quality of care for the veterans under this project.

(F) Any impact of the project on the access to care of veterans who did not participate in this project and of Medicare-eligible nonveterans.

Additional elements to be included in the report shall be specified in the agreement entered into under subsection (a).

(2) Not later than six months after publication of the final report under paragraph (1), the Secretary of Veterans Affairs and the Secretary of the Health and Human Services shall submit to the Congress a report containing their recommendation as to (A) whether reimbursement under title XVIII of the Social Security Act should be authorized for Medicare health-care services provided by the Department of Veterans Affairs to Medicare-eligible veterans described in section 1710(a)(2) of title 38, United States Code, on an expanded basis, and (B) if so, the terms and conditions under which reimbursement should be made.

(k) DEFINITIONS. -- For the purposes of this section:

(1) The term "commercial service" means services offered and sold competitively in the commercial marketplace, performed under standard commercial terms and conditions, and procured using firm-fixed price contracts.

(2) The term "health-care providers" includes health-care plans, insurers, organizations, institutions, or any other entity or individual who furnishes any health-care resource.

(3) The term "health-care resource" includes hospital care, medical services, rehabilitative services, and preventive health services, as those terms are defined in paragraphs (5), (6), (8), and (9) of section 1701 of title 38, United States Code, any other health-care service, and any health-care support or administrative resource.

(4) The term "Medicare health-care services" means items or services covered under part A or B of title XVIII of the Social Security Act.

(5) The term "Medicare-eligible veteran" means a veteran who is entitled to benefits under part A and B of title XVIII of the Social Security Act.

(6) The term "site" means a Department of Veterans Affairs medical treatment facility, or group of facilities that share services and administrative functions.

(7) The term "veteran" has the meaning given that term in section 101(2) of title 38, United States Code.

(8) The term "Veteran Integrated Service Network" means a field component of the Veterans Health Administration. It is based on a geographic area which encompasses a population of veteran beneficiaries and is defined on the basis of natural patient referral patterns. Health-care is provided through strategic alliances among Department of Veterans Affairs medical centers, clinics, and other sites.

(1) DURATION OF AUTHORITY. -- The model project shall operate for a period of three years unless terminated earlier or extended for up to two additional years by the mutual agreement of Secretary of Veterans Affairs and the Secretary of Health and Human Services. The Secretary of Veterans Affairs shall not accept new patients in the model project during any extension period unless such acceptance is approved under procedures established by the Secretary of Veterans Affairs and the Secretary of Health and Human Services.

ANALYSIS OF PROPOSED BILL

Section 1 of the draft bill names the Act the "Veterans' Medicare Reimbursement Model Project Act of 1996."

Section 2 contains twelve subsections:

Subsection (a)(1) would require VA and HHS to enter into an agreement to carry out the model project not later than 60 days after the date of enactment of this draft bill. Under the model project, HHS would reimburse VA from the Medicare program for "Medicare health-care services" provided to certain Medicare-eligible veterans. The term "Medicare health-care services" is defined in subsection (k) as all Medicare-covered items and services.

Subsection (a)(2) would require VA to furnish Medicare-eligible veterans who are described in section 1710(a)(2) of title 38the United States Code with needed Medicare health-care services under this model project. Veterans described in section 1710(a)(2) of the United States Code are those veterans with relatively higher incomes who do not have a service-connected disability. These veterans are commonly referred to as "category C veterans" and have the lowest priority for care in the VA system.

Subsection (a)(3) would require that HHS payments to VA under the bill would be made from the Medicare trust funds.

Subsection (a)(4) would authorize HHS to waive any requirement of the Medicare program with respect to the model project.

Subsection (b) would permit VA to be paid under the Medicare provision of law which authorizes payments on a capitated basis at up to four sites or one Veterans Integrated Service Network and establish up to four sites for providing Medicare health-care services on a fee-for-service basis. The term "site" is defined in subsection (k)(6) as a VA medical treatment facility or group of facilities that share services and administrative functions. The term "Veterans Integrated Service Network" is defined in subsection (k)(8). All sites and any Network would be designated jointly by VA

and HHS. VA would be authorized to terminate the participation of any site at any time subject to any obligations to veterans who have agreed to obtain care at the site.

Subsection (c)(1)(A)(i) would require that the agreement to be entered into by VA and HHS provide that, at project sites furnishing care on a capitated basis, HHS shall reimburse VA on the basis of the provision of law which requires HHS to annually determine a per capita rate of payment for each class of individuals who are enrolled under that provision.

Subsection (c)(1)(A)(ii) would require that the agreement to be entered into by VA and HHS provide that, at project sites furnishing care on a fee-for-service basis, HHS shall reimburse VA on the basis of the provisions of law which provide for reimbursement on a fee-for-service basis.

Subsection (c)(1)(B) would require that the agreement to be entered into by VA and HHS shall provide that amounts which HHS would reimburse VA under section 2(c)(1)(A)(i) and (ii) shall be reduced by five percent. In addition, the agreement shall specify further reductions in these amounts for specific components of the Medicare payments under those subsections. The agreement could thus specify reductions for components such as Graduate Medical Education (GME) and capital costs. Finally, this provision would require that the agreement to be entered into by VA and HHS would provide that amounts which HHS would reimburse VA under section 2(c)(1)(A)(i) and (ii) shall be reduced as provided for by section 2(c)(3). This last reduction would ensure that VA does not receive both VA appropriations and Medicare reimbursements for the care of Medicare-eligible veterans.

Subsection (c)(2) would require that the agreement to be entered into by VA and HHS specify the Medicare requirements which HHS shall waive with respect to the model project.

Subsection (c)(3)(A)-(B) would require that the agreement to be entered into by VA and HHS establish a procedure for the purpose of avoiding the imposition on the Medicare trust funds of the costs of the care that Medicare-eligible veterans would, in absence of this Act, be expected to receive from VA. Subparagraph (A) of this subsection would require that the agreement require the parties to determine

the average amount expended by VA for furnishing Medicare-reimbursable care to Medicare-eligible category C veterans over the last three fiscal years at each model project site. Subparagraph (B) would require the agreement to require the parties to establish a procedure for adjusting the amount determined in subparagraph (A). The adjusted amount would be used to reduce the Medicare payments to VA under the model project.

Subsection (c)(4) would require the agreement to be entered into by VA and HHS to provide that VA could furnish eligible participants in the model project with non-Medicare-reimbursable care and services which they would otherwise be eligible for under VA law subject to the availability of resources and appropriate charges.

Subsection (c)(5) would require the agreement to be entered into by VA and HHS to provide that all care and services furnished to participants in the model project which are not Medicare-reimbursable would be subject to all eligibility criteria and priorities set forth in VA law.

Subsection (c)(6) would require the agreement to be entered into by VA and HHS to specify a procedure for adjusting the provision of care under the model project if the number of veterans requesting care under the project from outside the usual geographic catchment area of a site significantly exceeds historical levels.

Subsection (d)(1) would provide that all Medicare-eligible category C veterans who request care at a model project site must agree to obtain those services under the provisions of the model project, subject to subsection (d)(2).

Subsection (d)(2) would provide that Medicare-eligible category C veterans who would be receiving hospital or nursing home care at a model project site before initiation of the project at that site would not be required to agree to obtain services under the provisions governing the model project until after their discharge from inpatient care.

Subsection (e)(1) would authorize VA to establish and operate managed health-care plans for purposes of the model project.

Subsection (e)(2) would require that VA operate any managed health-care plan under the model project by or through a VA health-care facility or facilities and permit the provision of care at contract entities. The provision further requires the plan to be established and operated in conformance with standards prescribed by VA after consultation with HHS.

Subsection (e)(3) would require VA to prescribe the minimum health-care benefits to be provided under the plan to veterans enrolled in the plan. The benefits must include at least all Medicare-reimbursable items and services.

Subsection (f) would require VA to establish cost-sharing requirements for veterans participating in the model project. For care being provided on a fee-for-service basis, these cost-sharing requirements must be the same requirements that apply to Medicare-eligible patients at non-VA facilities.

Subsection (g) would authorize VA to conduct marketing and sales activities which could include the use of paid advertising for the purpose of outreach to veterans who would be eligible to participate in the model project.

Subsection (h)(1) would authorize VA to make arrangements by contract or other form of agreement for the sharing of "health-care resources" between model project sites and non-VA health-care providers when VA would need to obtain such resources or utilize them effectively. The term "health-care resource" is defined in section 2(k)(3).

Subsection (h)(2)(A) would permit VA to acquire health-care resources by making arrangements with affiliated institutions; medical practice groups and other entities associated with affiliated institutions; and blood banks, organ banks, or research centers without regard to the laws requiring the use of competitive procedures if the health-care resource required is research, a "commercial service," or the use of medical equipment or space. The term "commercial service" is defined in subsection (k)(1).

Subsection (h)(2)(B) would permit VA to acquire health-care resources by making arrangements with health-care providers which are not described in section 2(h)(2)(A) without regard

to the laws requiring the use of competitive procedures if the health-care resource required is a commercial service or the use of medical equipment or space and provided that the acquisition is conducted under simplified procedures which are published for public comment. The simplified procedures must at least require VA to publish a notice in the Commerce Business Daily that permits all responsible sources to submit a bid, proposal, or quotation, as appropriate, which VA must consider. Until these simplified procedures are published, VA would be required to conduct these procurements under existing procurement laws.

Subsection (h)(2)(C) would require VA to conduct any procurement not covered by section 2(h)(2)(A) or (B) in accordance with all procurement laws.

Subsection (h)(2)(D) would require a written justification to be prepared for any procurement to be conducted on a sole source basis.

Subsection (h)(3) would provide that arrangements entered into for the sharing of health-care resources between model project sites and non-VA health-care providers shall provide for reciprocal reimbursement based on a methodology that provides appropriate flexibility to the parties concerned to establish an appropriate reimbursement rate after taking into account local conditions and needs and the actual costs to the providing facility of the resources involved. This provision would not apply to procurements entered into under this subsection.

Subsection (i)(1) would establish a revolving fund in the U.S. Treasury for the conduct of the model project.

Subsection (i)(2)(A)-(C) would require VA to deposit in the revolving fund:

- monies received under the model project;

- collections under the model project from third parties such as insurance companies and tortfeasors as authorized by the law which gives the United States the right to recover or collect for providing care to veterans; and

- monies from the VA medical care account as needed to conduct the model project.

Subsection (i)(3) would require VA to use monies in the revolving fund for conducting the model project and for reimbursing the VA medical care account for expenditures in support of the project. VA could use the monies in the revolving fund which are not needed to conduct the model project to enhance the care of Medicare-eligible veterans not participating in the model project.

Subsection (j)(1)(A)-(F) would require VA and HHS to arrange for an independent entity to evaluate the model project. The entity would be required to submit annual reports with the first report due not later than 18 months after the date on which the model project begins operation. The final report would be due not later than three and one-half years after the date of operation. The evaluation and reports would include an assessment of the following:

- Compliance by VA with Medicare requirements.
- The cost to VA of providing care to veterans under the project.
- Compliance by VA with the standards of quality required of entities that furnish items or services under the Medicare programs.
- Any savings or costs to the Medicare programs.
- Any change in access to care or quality of care for the veterans under the model project.
- Any impact of the project on the access to care of veterans who did not participate in the project and of Medicare-eligible nonveterans.

In the agreement between VA and HHS, the parties would be required to specify additional elements to be included in the independent entity's report

Subsection (j)(2) would require VA and HHS to submit to Congress a report containing their recommendation whether Medicare reimbursement to VA for the care of Medicare-eligible veterans should be authorized on an expanded basis. If the report would recommend expanding Medicare reimbursement to VA, the report would also need to recommend the terms and conditions under which reimbursement should be made.

Subsection (k)(1) would define the term "commercial service" for purposes of the provision authorizing sharing under the model project (section 2(h)). The definition is similar to but slightly modified from the definition contained in the Federal Acquisition Regulations and would encompass most health-care resources which VA would procure except for research and the use of equipment.

Subsection (k)(2) would define the term "health-care providers" for purposes of the provision authorizing sharing under the model project (section 2(h)). The definition would cover all entities and persons with whom VA would be interested in sharing health-care resources.

Subsection (k)(3) would define the term "health-care resource" for purposes of the provision authorizing sharing under the model project (section 2(h)). The definition would include any health-care service and any health-care support or administrative resource.

Subsection (k)(4) would define the term "Medicare health-care services" to mean all services which are reimbursable under Medicare.

Subsection (k)(5) would define the term "Medicare-eligible veteran" to mean a veteran who is included in the category of veterans who have the lowest priority for VA care. The veterans in this category, commonly referred to as "category C veterans," have higher incomes and do not have service-connected disabilities.

Subsection (k)(6) would define the term "site" to mean a VA medical treatment facility or group of facilities that share services and administrative functions.

Subsection (k)(7) would define the term "veteran" as having the same meaning given it in the definitions for title 38, United States Code.

Subsection (k)(8) would define the term "Veteran Integrated Service Network" to mean one of the field components of the Veterans Health Administration.

Subsection (l) would provide that the model project would continue for three years and could be extended by VA and HHS for up to two additional years. During any extension period, VA could not accept new patients in the model project unless VA and HHS establish procedures for accepting new patients.

Medicare Subvention

Today: Only veterans with service-connected disabilities or low-income veterans can get care in VA medical system (VA appropriation not sufficient to allow them to cover others); higher-income, non-service connected veterans with Medicare eligibility cannot receive care at VA and have Medicare reimburse. VA believes that allowing veterans the choice of care at VA facilities will lead to their care in less expensive settings, and thus some savings for Medicare.

NPR proposal: 3-month study (with OMB, HCFA, and VA experts) to develop Medicare reimbursement demonstration project alternatives at selected VA hospitals. These options will have defined parameters and cost impacts that will be part of decision on which/whether a pilot is implemented.

Biggest problem: VA does not account for their costs/manage costs. With no ability to determine the cost of a medical procedure, it is unclear whether they do it cheaper, what to charge Medicare, etc.

-Also PAYGO issues.
-Also shift of $ from Medicare to VA (Medicare trust fund in trouble; and VA has more clout with Hill appropriations)

Concept good, particularly in context of health reform; but not for this year (Medicare budget cuts and TF).

Medicare Reimbursement Pilots
Department of Veterans Affairs (VA) and Health Care Financing Administration (HCFA)

Veterans with service-connected disabilities or who qualify because their income falls below a minimum threshold are given priority in VA Medical Centers. All other veterans (Category C veterans) are generally not treated because of budget constraints.

A VA initiative implemented as a result of the second National Performance Review called for a study to develop a range of VA Medicare pilot options. The pilots would test the feasibility of using Medicare reimbursement to cover the cost of expanding VA health care to Medicare-eligible Category C veterans.

The Study Group includes representatives from VA, HCFA and OMB and has been meeting since June 1995. It is supported by three work groups of technical and program experts from these agencies, with each work group assigned to one of the pilot models being considered:

- Under the ***centers of excellence*** model the VA pilot location would function as a Medicare referral center for certain procedures in which the VA has a reputation for high quality and low cost.

- Under the ***fee-for-service*** model, patients have the option of selecting from among many providers. Patients may continually change providers at their own discretion. If an eligible veteran chooses to receive care from the VA for a certain procedure, the pilot location would be reimbursed by Medicare for that episode of care.

- Under the ***capitation*** model a VA medical center would operate its own health maintenance organization (HMO) for Medicare-eligible "Category C" veterans. Patients would be required to enroll in a VA plan, and receive all of their care from the plan.

The work groups were formed in August 1995. Since the work groups must resolve issues of access, cost, eligibility, benefits design, quality, delivery systems, and pilot evaluation; they include physicians and experts in the areas of VA and Medicare programs, finance, budget, quality assurance and management.

Under existing budget authority, VA currently treats approximately 37,000 of the estimated four million Category C veterans who are Medicare-eligible. VA would continue to fund health care for these veterans so as to insure that the liability is not transferred to the Medicare Trust Fund.

The Study Group expects to submit a draft report and recommendations to VA, HCFA and OMB policy officials in mid-February 1996. The report is meant to give policy makers the protocols necessary to administer pilots they choose to implement.

= pros & cons of full proposal + cost

EXECUTIVE OFFICE OF THE PRESIDENT

25-May-1995 09:51am

TO: Molly Brostrom

FROM: Toni S. Hustead
Office of Mgmt and Budget, VAPD

SUBJECT: RE: medicare/va

Molly,

The NPR proposal on Medicare has to be taken very delicately. The proposal calls for a 3 month study (with OMB, HCFA, and VA experts on the study group) that will produce a report that will contain a range of options that might be used as pilots in selected VA hospitals. These options will have defined parameters and cost impacts which will play a big role in the selection and definition of any pilot that is finally implimented. There are numerous ways to define such a pilot - the most problematic thing here is that the VA has never had a managed care system. It is unable to tell us what is costs to produce any service like managed care systems in the private sector. With no ability to determine the cost of a medical procedure, it is unclear whether they do it cheaper, what to charge medicare, etc. Also there are tremendous PAYGO issues here. We are committed to try to figure out how to do this - but not in a hurry, hence the study. It is key not to speed this process up. Our official language here:

"VA will work with HCFA and OMB to develop Medicare reimbursement demonstration project alternatives. Currently, veterans who may wish to choose VA as their health care provider do not have that option because VA's medical care appropriation is insufficient to allow the VA health care delivery system to provide services to all veterans. Only those with service-connencted disabilitis and low-income veterans are generally covered by the appropriation. Higher-income, non-service connected veterans with MEdicare eligibiltiy should be able to choose VA and bring their Medicare reimbursement to VA to cover the cost of their care. To ensure that these veterans have this choice available to them, VA proposes to recover and retain revenues from Medicare for designated categories of veterans. By permitting VA access to these revenues, VA will be able to expand the choices of veterans and potentially offer some savings to Medicare which is now paying for the health care needs of these veterans in what VA believes are more expensive settings. The study will serve to identify a range of detailed pilot options with defined parameters and cost impacts for consideration."

Status Report on Medicare Subvention for VA

- VA Medicare subvention will test the feasibility of VA as a Medicare provider. They will also test its ability to integrate its core mission -- caring for Category A veterans -- with competition with the private sector to provide care to Medicare-eligible Category C veterans. The decision to expand the pilots nationally will be made after the evaluation demonstrates VA's ability to meet the cost, quality and access standards.

- The importance of the evaluation was demonstrated recently when CBO scored the DoD Medicare subvention demonstration at a cost of $1.5 billion over six years (FYs 1997-2002). CBO based its scoring on uncertainties about how DoD and beneficiary behavior would affect Medicare costs in a demonstration. The same uncertainties cited by CBO in its DoD scoring also exist in the VA. Like DoD,
  - -- VA cannot accurately estimate the current level of services it now provides to dually eligible beneficiaries.
  - -- VA pilot sites may have incentive to shift costs to Medicare.
  - -- a VA capitation pilot (the option VA appears to be most in favor of) could attract relatively healthy beneficiaries that currently receive care in the private sector on a fee-for-service basis. If this occurs, Medicare could end up paying more to VA for the care of these patients than it now pays the private sector.

- We expect CBO to score any VA proposal similarly due to the difficulty in addressing these issues prior to the pilot's start. Consequently, the evaluation must address these questions before a decision to expand subvention nationally can be considered to avoid paygo costs and a drain on the Medicare Trust Fund.

- Three work groups were established late last summer to develop working models for the capitation, fee-for-service, and bundled payment pilot options. The work groups report to the study team, which has overall responsibility for creating a final report for policy-makers at all three agencies.

- The workgroups have developed interim reports, but several cross cutting decisions needed to be addressed before final reports could be prepared. Work was temporarily halted during the winter as the study team struggled to develop a common set of overriding principals to guide work team efforts.

- At this time, all issues have essentially been settled. The final issue, the evaluation, was resolved in early April when the study team agreed that the pilots will be subject to a comprehensive evaluation that considers the full range of cost, quality and access issues.

- We expect the work groups to submit final reports to the study team in early June. The study team plans to present its report and recommendations to policy officials in July.