106TH CONGRESS
1st Session
HOUSE OF REPRESENTATIVES
REPT. 106–436
Part 1

MEDICARE BALANCED BUDGET REFINEMENT ACT OF 1999

NOVEMBER 2, 1999.—Ordered to be printed

Mr. ARCHER, from the Committee on Ways and Means, submitted the following

R E P O R T

together with

ADDITIONAL VIEWS

[To accompany H.R. 3075]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 3075) To amend title XVIII of the Social Security Act to make corrections and refinements in the Medicare Program as revised by the Balanced Budget Act of 1997, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

CONTENTS

The amendment is as follows:

Strike out all after the enacting clause and insert in lieu thereof the following:

SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; REFERENCES TO BBA; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Medicare Balanced Budget Refinement Act of 1999".

(b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this title an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) REFERENCES TO BALANCED BUDGET ACT OF 1997.—In this Act, the term "BBA" means the Balanced Budget Act of 1997 (Public Law 105–33).

(d) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—PROVISIONS RELATING TO PART A

Subtitle A—PPS Hospitals

SEC. 101. ONE-YEAR DELAY IN TRANSITION FOR INDIRECT MEDICAL EDUCATION (IME) PERCENTAGE ADJUSTMENT.

(a) IN GENERAL.—Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)), as amended by section 4621(a)(1) of BBA, is amended—

(1) in subclause (IV), by inserting "and 2001" after "2000"; and

(2) by striking "2000" in subclause (V) and inserting "2001".

(b) CONFORMING AMENDMENT RELATING TO DETERMINATION OF STANDARDIZED AMOUNT.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)), as amended by section 4621(a)(2) of BBA, is amended by inserting "or any additional payments under such paragraph resulting from the amendment made by section 101(a) of Medicare Balanced Budget Refinement Act of 1999" after "Balanced Budget Act of 1997".

SEC. 102. DECREASE IN REDUCTIONS FOR DISPROPORTIONATE SHARE HOSPITALS; DATA COLLECTION REQUIREMENTS.

(a) IN GENERAL.—Section 1886(d)(5)(F)(ix) (42 U.S.C. 1395ww(d)(5)(F)(ix)), as added by section 4403(a) of BBA, is amended—

(1) in subclause (III), by striking "during fiscal year 2000" and inserting "during each of fiscal years 2000 and 2001";

(2) by striking subclause (IV);

(3) by redesignating subclauses (V) and (VI) and subclauses (IV) and (V), respectively; and

(4) in subclause (IV), as so redesignated, by striking "reduced by 5 percent" and inserting "reduced by 4 percent".

(b) DATA COLLECTION.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall require any subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)) to submit to the Secretary, in the cost reports submitted to the Secretary by such hospital for discharges occurring during a fiscal year, data on the costs incurred by the hospital for providing inpatient and outpatient hospital services for which the hospital is not compensated, including bad debt and charity care.

(2) EFFECTIVE DATE.—The Secretary shall require the submission of the data described in paragraph (1) in cost reports for cost reporting periods beginning on or after the date of the enactment of this Act.

Subtitle B—PPS Exempt Hospitals

SEC. 111. WAGE ADJUSTMENT OF PERCENTILE CAP FOR PPS-EXEMPT HOSPITALS.

(a) IN GENERAL.—Section 1886(b)(3)(H) (42 U.S.C. 1395ww(b)(3)(H)), as amended by section 4414 of BBA, is amended—

(1) in clause (i), by inserting ", as adjusted under clause (iii)" before the period,

(2) in clause (ii), by striking "clause (i)" and "such clause" and inserting "subclause (I)" and "such subclause" respectively,

(3) by striking "(H)(i)" and inserting "(ii)(I)",

(4) by redesignating clauses (ii) and (iii) as subclauses (II) and (III),

(5) by inserting after clause (ii), as so redesignated, the following new clause:

"(iii) In applying clause (ii)(I) in the case of a hospital or unit, the Secretary shall provide for an appropriate adjustment to the labor-related portion of the amount determined under such subparagraph to take into account differences between average wage-related costs in the area of the hospital and the national average of such costs within the same class of hospital.", and

(6) by inserting before clause (ii), as so redesignated, the following new clause:

"(H)(i) In the case of a hospital or unit that is within a class of hospital described in clause (iv), for a cost reporting period beginning during fiscal years 1998 through 2002, the target amount for such a hospital or unit may not exceed the amount as updated up to or for such cost reporting period under clause (ii).".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to cost reporting periods beginning on or after October 1, 1999.

SEC. 112. ENHANCED PAYMENTS FOR LONG-TERM CARE AND PSYCHIATRIC HOSPITALS UNTIL DEVELOPMENT OF PROSPECTIVE PAYMENT SYSTEMS FOR THOSE HOSPITALS.

Section 1886(b)(2) (42 U.S.C. 1395ww(b)(2)), as added by section 4415(b) of BBA, is amended—

(1) in subparagraph (A), by striking "In addition to" and inserting "Except as provided in subparagraph (E), in addition to"; and

(2) by adding at the end the following new subparagraph:

"(E)(i) In the case of an eligible hospital that is a hospital or unit that is within a class of hospital described in clause (ii) with a 12-month cost reporting period beginning before the enactment of this subparagraph, in determining the amount of the increase under subparagraph (A), the Secretary shall substitute for the percentage of the target amount applicable under subparagraph (A)(ii)—

"(I) for a cost reporting period beginning on or after October 1, 2000, and before September 30, 2001, 1.5 percent; and

"(II) for a cost reporting period beginning on or after October 1, 2001, and before September 30, 2002, 2 percent.

"(ii) For purposes of clause (i), each of the following shall be treated as a separate class of hospital:

"(I) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

"(II) Hospitals described in clause (iv) of such subsection.".

SEC. 113. PER DISCHARGE PROSPECTIVE PAYMENT SYSTEM FOR LONG-TERM CARE HOSPITALS.

(a) DEVELOPMENT OF SYSTEM.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall develop a per discharge prospective payment system for payment for inpatient hospital services of long-term care hospitals described in section 1886(d)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(iv)) under the medicare program. Such system shall include an adequate patient classification system that is based on diagnosis-related groups (DRGs) and that reflects the differences in patient resource use and costs, and shall maintain budget neutrality.

(2) COLLECTION OF DATA AND EVALUATION.—In developing the system described in paragraph (1), the Secretary may require such long-term care hospitals to submit such information to the Secretary as the Secretary may require to develop the system.

(b) REPORT.—Not later than October 1, 2001, the Secretary shall submit to the appropriate committees of Congress a report that includes a description of the system developed under subsection (a)(1).

(c) IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.—Notwithstanding section 1886(b)(3) of the Social Security Act (42 U.S.C. 1395ww(b)(3)), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 2002, for payments for inpatient hospital services furnished by long-term care hospitals under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) in accordance with the system described in subsection (a).

SEC. 114. PER DIEM PROSPECTIVE PAYMENT SYSTEM FOR PSYCHIATRIC HOSPITALS.

(a) DEVELOPMENT OF SYSTEM.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall develop a per diem prospective payment system for payment for inpatient hospital services of psychiatric hospitals and units (as defined in paragraph (3)) under the medicare program. Such system shall include an adequate patient classification system that reflects the differences in patient resource use and costs among such hospitals and shall maintain budget neutrality.

(2) COLLECTION OF DATA AND EVALUATION.—In developing the system described in paragraph (1), the Secretary may require such psychiatric hospitals and units to submit such information to the Secretary as the Secretary may require to develop the system.

(3) DEFINITION.—In this section, the term "psychiatric hospitals and units" means a psychiatric hospital described in clause (i) of section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)) and psychiatric units described in the matter following clause (v) of such section.

(b) REPORT.—Not later than October 1, 2001, the Secretary shall submit to the appropriate committees of Congress a report that includes a description of the system developed under subsection (a)(1).

(c) IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.—Notwithstanding section 1886(b)(3) of the Social Security Act (42 U.S.C. 1395ww(b)(3)), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 2002, for payments for inpatient hospital services furnished by psychiatric hospitals and units under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) in accordance with the prospective payment system established by the Secretary under this section.

SEC. 115. REFINEMENT OF PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT REHABILITATION SERVICES.

(a) ELECTION TO APPLY FULL PROSPECTIVE PAYMENT RATE WITHOUT PHASE-IN.—

(1) IN GENERAL.—Paragraph (1) of section 1886(j) (42 U.S.C. 1395ww(j)), as added by section 4421(a) of BBA, is amended—

(A) in subparagraph (C), by inserting "subject to subparagraph (E)," after "subparagraph (A),"; and

(B) by adding at the end the following new subparagraph:

"(E) ELECTION TO APPLY FULL PROSPECTIVE PAYMENT SYSTEM.—A rehabilitation facility may elect for either or both cost reporting periods described in subparagraph (C) to have the TEFRA percentage and prospective payment percentage set at 0 percent and 100 percent, respectively, for the facility.".

(2) BUDGET NEUTRALITY IN APPLICATION.—Paragraph (3)(B) of such section is amended by inserting "and taking into account the election permitted under paragraph (1)(E)" after "in the Secretary's estimation".

(3) TRANSITIONAL ADJUSTMENT AND IMPLEMENTATION.—In order to implement the amendments made by this subsection on a budget neutral basis—

(A) the Secretary of Health and Human Services shall decrease the prospective payment rate otherwise established for fiscal year 2001 by 10 percent, and shall adjust such rate for subsequent years to reflect the extent to which such 10 percent payment adjustment was inappropriate, as determined by the Secretary based upon an analysis that takes into account utilization and payments made during fiscal year 2001; and

(B) the Secretary shall provide for the computation of such rate in an iterative manner to take into account the effect of permitting an election under section 1886(j)(1)(E) of the Social Security Act, under the amendment made by paragraph (1).

(b) USE OF DISCHARGE AS PAYMENT UNIT.—

(1) IN GENERAL.—Paragraph (1)(D) of such section is amended by striking ", day of inpatient hospital services, or other unit of payment defined by the Secretary".

(2) CONFORMING AMENDMENT TO CLASSIFICATION.—Paragraph (2)(A) of such section is amended by amending clause (i) of to read as follows:

"(i) classes of patient discharges of rehabilitation facilities (each in this subsection referred to as a 'case mix group'), based on impairment, age, comorbidities, and functional capability of the patient and such other factors as the Secretary deems appropriate to improve the explanatory power of functional independence measure-function related groups; and".

(3) CONSTRUCTION RELATING TO TRANSFER AUTHORITY.—Paragraph (1) of such section, as amended by subsection (a)(1), is further amended by adding at the end the following new subparagraph:

"(F) CONSTRUCTION RELATING TRANSFER AUTHORITY.—Nothing in this subsection shall be construed as preventing the Secretary from providing for an adjustment to payments to take into account the early transfer of a patient from a rehabilitation facility to another site of care.".

(c) STUDY ON IMPACT OF IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study of the impact on utilization and beneficiary access to services of the implementation of the medicare prospective payment system for inpatient hospital services or rehabilitation facilities under section 1886(j) of the Social Security Act (as added by section 4421(a) of BBA).

(2) REPORT.—Not later than 3 years after the date such system is first implemented, the Secretary shall submit to Congress a report on such study.

(d) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) are effective as if included in the enactment of section 4421(a) of BBA.

Subtitle C—Adjustments to PPS Payments for Skilled Nursing Facilities

SEC. 121. TEMPORARY INCREASE IN PAYMENT FOR CERTAIN HIGH COST PATIENTS.

(a) ADJUSTMENT FOR MEDICALLY COMPLEX PATIENTS UNTIL ESTABLISHMENT OF REFINED CASE-MIX ADJUSTMENT.—For purposes of computing payments for covered skilled nursing facility payments under paragraph (1) of section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)), as added by section 4432(a) of BBA, for such services furnished on or after April 1, 2000, and before October 1, 2000, the Secretary of Health and Human Services shall increase by 10 percent the adjusted Federal per diem rate otherwise determined under paragraph (4) of such section (but for this section) for covered skilled nursing facility services for RUG–III groups described in subsection (b) furnished to an individual entitled to benefits under part A of title XVIII of such Act during the period in which such individual is classified in such a RUG–III category.

(b) GROUPS DESCRIBED.—The RUG–III groups for which the adjustment described in subsection (a) applies are SE3, SE2, SE1, SSC, SSB, SSA, CC2, CC1, CB2, CB1, CA2, and CA1, as specified in Tables 3 and 4 of the final rule published in the Federal Register by the Health Care Financing Administration on July 30, 1999 (64 FR 41684).

SEC. 122. MARKET BASKET INCREASE.

Section 1888(e)(4)(E)(ii) (42 U.S.C. 1395yy(e)(4)(E)(ii)) is amended—

(1) by redesignating subclause (III) as subclause (IV); and

(2) by striking subclause (II) and inserting after subclause (I) the following:

"(II) for fiscal year 2001, the rate computed for fiscal year 2000 (determined without regard to section 121 of the Medicare Balanced Budget Refinement Act of 1999) increased by the skilled nursing facility market basket percentage change for the fiscal year involved plus 0.8 percentage point;

"(III) for fiscal year 2002, the rate computed for the previous fiscal year increased by the skilled nursing facility market basket percentage change for the fiscal year involved minus 1 percentage point; and".

SEC. 123. AUTHORIZING FACILITIES TO ELECT IMMEDIATE TRANSITION TO FEDERAL RATE.

(a) IN GENERAL.—Section 1888(e) (42 U.S.C. 1395yy(e)), as added by section 4432(a) of BBA, is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by striking "paragraph (7)" and inserting "paragraphs (7) and (11)"; and

(2) by adding at the end the following new paragraph:

"(11) PERMITTING FACILITIES TO WAIVE 3-YEAR TRANSITION.—Notwithstanding paragraph (1)(A), a facility may elect to have the amount of the payment for all costs of covered skilled nursing facility services for each day of such services furnished in cost reporting periods beginning after the date of such election determined pursuant to subparagraph (B) of paragraph (1).".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to elections made more than 60 days after the date of enactment of this Act.

SEC. 124. PART A PASS-THROUGH PAYMENT FOR CERTAIN AMBULANCE SERVICES, PROSTHESES, AND CHEMOTHERAPY DRUGS.

(a) IN GENERAL.—Section 1888(e) (42 U.S.C. 1395yy(e)), as added by section 4432(a) of BBA, is amended—

(1) in paragraph (2)(A)(i)(II), by striking "services described in clause (ii)" and inserting "items and services described in clauses (ii) and (iii)";

(2) by adding at the end of paragraph (2)(A) the following new clause:

"(iii) EXCLUSION OF CERTAIN ADDITIONAL ITEMS.—Items described in this clause are the following:

"(I) Ambulance services furnished to an individual in conjunction with renal dialysis services described in section 1861(s)(2)(F).

"(II) Chemotherapy items (identified as of July 1, 1999, by HCPCS codes J9000–J9020; J9040–J9151; J9170–J9185; J9200–J9201; J9206–J9208; J9211; J9230–J9245; and J9265–J9600 (and as subsequently modified by the Secretary)).

"(III) Chemotherapy administration services (identified as of July 1, 1999, by HCPCS codes 36260–36262; 36489; 36530–36535; 36640; 36823; and 96405–96542 (and as subsequently modified by the Secretary)).

"(IV) Radioisotope services (identified as of July 1, 1999, by HCPCS codes 79030–79440 (and as subsequently modified by the Secretary)).

"(V) Customized prosthetic devices (commonly known as artificial limbs or components or artifical limbs) under the following HCPCS codes (as of July 1, 1999 (and as subsequently modified by the Secretary)) if delivered to an inpatient for use during the stay in the extended care facility and intended to be used by the patient after discharge from the facility: L5050–L5340; L5500–L5610; L5613–L5986; L5988; L6050–L6370; L6400–L6880; L6920–L7274; and L7362–7366."; and

(3) by adding at the end of paragraph (9) the following: "In the case of an item or service described in clause (iii) of paragraph (2)(A) that would be payable under part A but for the exclusion of such item or service under such clause, payment shall be made for the item or service, in an amount otherwise determined under part B of this title for such item or service, from the Federal Hospital Insurance Trust Fund under section 1817 (rather than from the Federal Supplementary Medical Insurance Trust Fund under section 1841).".

(b) CONFORMING FOR BUDGET NEUTRALITY FOR FISCAL YEAR 2001.—Section 1888(e)(4)(G) (42 U.S.C. 1395yy(e)(4)(G)) is amended by adding at the end the following new clause:

"(iii) ADJUSTMENT FOR EXCLUSION OF CERTAIN ADDITIONAL ITEMS.—The Secretary shall provide for an appropriate proportional reduction in payments so that beginning with fiscal year 2001, the aggregate amount of such reductions is equal to the aggregate increase in payments attributable to the exclusion effected under clause (iii) of paragraph (2)(A).".

(c) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to payments made for items furnished on or after April 1, 2000.

SEC. 125. PROVISION FOR PART B ADD-ONS FOR FACILITIES PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT.

(a) IN GENERAL.—Section 1888(e)(3) (42 U.S.C. 1395yy(e)(3)), as added by section 4432(a) of BBA, is amended—

(1) in subparagraph (A)—

(A) in clause (i), by inserting "or, in the case of a facility participating in the Nursing Home Case-Mix and Quality Demonstration (RUGS–III), the RUGS–III rate received by the facility during the cost reporting period beginning in 1997" after "to nonsettled cost reports"; and

(B) in clause (ii), by striking "furnished during such period" and inserting "furnished during the applicable cost reporting period described in clause (i)".

(2) in subparagraph (B), to read as follows:

"(B) UPDATE TO FIRST COST REPORTING PERIOD.—The Secretary shall update the amount determined under subparagraph (A), for each cost reporting period after the applicable cost reporting period described in subparagraph (A)(i) and up to the first cost reporting period by a factor equal to the skilled nursing facility market basket percentage increase minus 1 percentage point (except that for the cost reporting period beginning in fiscal year 2001, the factor shall be equal to such market basket percentage plus 0.8 percentage point).".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall be effective as if included in the enactment of section 4432(a) of BBA.

SEC. 126. SPECIAL CONSIDERATION FOR FACILITIES SERVING SPECIALIZED PATIENT POPULATIONS.

(a) IN GENERAL.—Section 1888(e) (42 U.S.C. 1395yy(e)), as amended by section 123(a)(1), is further amended—

(1) in paragraph (1), by striking "subject to paragraphs (7) and (11)" and inserting "subject to paragraphs (7), (11), and (12)"; and

(2) by adding at the end the following new paragraph:

"(12) PAYMENT RULE FOR CERTAIN FACILITIES.—

"(A) IN GENERAL.—In the case of a qualified acute skilled nursing facility described in subparagraph (B), the per diem amount of payment shall be determined by applying the non-Federal percentage and Federal percentage specified in paragraph (2)(C)(ii).

"(B) FACILITY DESCRIBED.—For purposes of subparagraph (A), a qualified acute skilled nursing facility is a facility that—

"(i) was certified by the Secretary as a skilled nursing facility eligible to furnish services under this title before July 1, 1992;

"(ii) is a hospital-based facility; and

"(iii) for the cost reporting period beginning in fiscal year 1998, the facility had more than 60 percent of total patient days comprised of patients who are described in subparagraph (C).

"(C) DESCRIPTION OF PATIENTS.—For purposes of subparagraph (B), a patient described in this subparagraph is an individual who—

"(i) is entitled to benefits under part A; and

"(ii) is immuno-compromised secondary to an infectious disease, with specific diagnoses as specified by the Secretary.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply for the period beginning on the date on which after the date of the enactment of this Act the first cost reporting period of the facility begins and ending on September 30, 2001, and applies to skilled nursing facilities furnishing covered skilled nursing facility services on the date of the enactment of this Act for which payment is made under title XVIII of the Social Security Act.

(c) REPORT TO CONGRESS.—By not later than one year after the date of the enactment of this Act, the Secretary of Health and Human Services shall assess the resource use of patients of skilled nursing facilities furnishing services under the medicare program who are immuno-compromised secondary to an infectious disease, with specific diagnoses as specified by the Secretary (under paragraph (12)(C), as added by subsection (a), of section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e))) to determine whether any permanent adjustments are needed to the RUGs to take into account the resource uses and costs of these patients.

SEC. 127. MEDPAC STUDY ON SPECIAL PAYMENT FOR FACILITIES LOCATED IN HAWAII AND ALASKA.

(a) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study on skilled nursing facilities furnishing covered skilled nursing facility services (as defined in section 1888(e)(2)(A) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)) to determine the need for an additional payment amount under section 1888(e)(4)(G) of such Act (42 U.S.C. 1395yy(e)(4)(G)) to take into account the unique circumstances of skilled nursing facilities located in Alaska and Hawaii.

(b) REPORT.—By not later than 18 months after the date of the enactment of this Act, the Medicare Payment Advisory Commission shall submit a report to Congress on the study conducted under subsection (a).

Subtitle D—Other

SEC. 131. PART A BBA TECHNICAL CORRECTIONS.

(a) SECTION 4201.—Section 1820(c)(2)(B)(i) (42 U.S.C. 1395i–4(c)(2)(B)(i)), as amended by section 4201(a) of BBA, is amended by striking "and is located in a county (or equivalent unit of local government) in a rural area (as defined in section 1886(d)(2)(D)) that" and inserting "that is located in a county (or equivalent unit of local government) in a rural area (as defined in section 1886(d)(2)(D)), and that".

(b) SECTION 4204.—(1) Section 1886(d)(5)(G) (42 U.S.C. 1395ww(d)(5)(G)), as amended by section 4204(a)(1) of BBA, is amended—

(A) in clause (i), by striking "or beginning on or after October 1, 1997, and before October 1, 2001," and inserting "or discharges on or after October 1, 1997, and before October 1, 2001,"; and

(B) in clause (ii)(II), by striking "or beginning on or after October 1, 1997, and before October 1, 2001," and inserting "or discharges on or after October 1, 1997, and before October 1, 2001,".

(2) Section 1886(b)(3)(D) (42 U.S.C. 1395ww(b)(3)(D)), as amended by section 4204(a)(2) of BBA, is amended in the matter preceding clause (i) by striking "and for cost reporting periods beginning on or after October 1, 1997, and before October 1, 2001," and inserting "and for discharges beginning on or after October 1, 1997, and before October 1, 2001,".

(c) SECTION 4205.—Section 4205(a)(1)(B) of BBA (42 U.S.C. 1395l note) is amended by striking "services furnished" and inserting "cost reporting periods beginning".

(d) SECTION 4319.—Section 1847(b)(2) (42 U.S.C. 1395w–3(b)(2)), as added by section 4319 of BBA, is amended by inserting "and" after "specified by the Secretary".

(e) SECTION 4401.—Section 4401(b)(1)(B) of BBA (42 U.S.C. 1395ww note) is amended by striking "section 1886(b)(3)(B)(i)(XIII) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)(XIII))" and inserting "section 1886(b)(3)(B)(i)(XIV) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)(XIV))".

(f) SECTION 4402.—The last sentence of section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)), as added by section 4402 of BBA, is amended by striking "September 30, 2002," and inserting "October 1, 2002,".

(g) SECTION 4419.—The first sentence of section 1886(b)(4)(A)(i) (42 U.S.C. 1395ww(b)(4)(A)(i)), as amended by section 4419(a)(1) of BBA, by striking "or unit".

(h) SECTION 4442.—Section 4442(b) of BBA (42 U.S.C. 1395f note) is amended by striking "applies to cost reporting periods beginning" and inserting "applies to items and services furnished".

(i) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of BBA.

TITLE II—PROVISIONS RELATING TO PART B

Subtitle A—Adjustments to Physician Payment Updates

SEC. 201. MODIFICATION OF UPDATE ADJUSTMENT FACTOR PROVISIONS TO REDUCE UPDATE OSCILLATIONS AND REQUIRE ESTIMATE REVISIONS.

(a) UPDATE ADJUSTMENT FACTOR.—

(1) IN GENERAL.—Section 1848(d) (42 U.S.C. 1395w–4(d)) is amended—

(A) in paragraph (3)—

(i) in the heading, by inserting "FOR 1999 AND 2000" after "UPDATE";

(ii) in subparagraph (A), by striking "a year beginning with 1999" and inserting "1999 and 2000"; and

(iii) in subparagraph (C), by inserting "and paragraph (4)" after "For purposes of this paragraph"; and

(B) by adding at the end the following new paragraph:

"(4) UPDATE FOR YEARS BEGINNING WITH 2001.—

"(A) IN GENERAL.—Unless otherwise provided by law, subject to the budget-neutrality factor determined by the Secretary under subsection (c)(2)(B)(ii) and subject to adjustment under subparagraph (F), the update to the single conversion factor established in paragraph (1)(C) for a year beginning with 2001 is equal to the product of—

"(i) 1 plus the Secretary's estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year (divided by 100), and

"(ii) 1 plus the Secretary's estimate of the update adjustment factor under subparagraph (B) for the year.

"(B) UPDATE ADJUSTMENT FACTOR.—For purposes of subparagraph (A)(ii), subject to subparagraph (D), the 'update adjustment factor' for a year is equal (as estimated by the Secretary) to the sum of the following:

"(i) PRIOR YEAR ADJUSTMENT COMPONENT.—An amount determined by—

"(I) computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services for the prior year (as determined under subparagraph (C)) and the amount of the actual expenditures for such services for that year;

"(II) dividing that difference by the amount of the actual expenditures for such services for that year; and

"(III) multiplying that quotient by 0.75.

"(ii) CUMULATIVE ADJUSTMENT COMPONENT.—An amount determined by—

"(I) computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services (as determined under subparagraph (C)) from April 1, 1996, through the end of the prior year and the amount of the actual expenditures for such services during that period;

"(II) dividing that difference by actual expenditures for such services for the prior year as increased by the sustainable growth rate under subsection (f) for the year for which the update adjustment factor is to be determined; and

"(III) multiplying that quotient by 0.33.

"(C) DETERMINATION OF ALLOWED EXPENDITURES.—For purposes of this paragraph:

"(i) PERIOD UP TO APRIL 1, 1999.—The allowed expenditures for physicians' services for a period before April 1, 1999, shall be the amount of the allowed expenditures for such period as determined under paragraph (3)(C).

"(ii) TRANSITION TO CALENDAR YEAR ALLOWED EXPENDITURES.—Subject to subparagraph (E), the allowed expenditures for—

"(I) the 9-month period beginning April 1, 1999, shall be the Secretary's estimate of the amount of the allowed expenditures that would be permitted under paragraph (3)(C) for such period; and

"(II) the year of 1999, shall be the Secretary's estimate of the amount of the allowed expenditures that would be permitted under paragraph (3)(C) for such year.

"(iii) YEARS BEGINNING WITH 2000.—The allowed expenditures for a year (beginning with 2000) is equal to the allowed expenditures for physicians' services for the previous year, increased by the sustainable growth rate under subsection (f) for the year involved.

"(D) RESTRICTION ON UPDATE ADJUSTMENT FACTOR.—The update adjustment factor determined under subparagraph (B) for a year may not be less than -0.07 or greater than 0.03.

"(E) RECALCULATION OF ALLOWED EXPENDITURES FOR UPDATES BEGINNING WITH 2001.—For purposes of determining the update adjustment factor for a year beginning with 2001, the Secretary shall recompute the allowed expenditures for previous periods beginning on or after April 1, 1999, consistent with subsection (f)(3).

"(F) TRANSITIONAL ADJUSTMENT DESIGNED TO PROVIDE FOR BUDGET NEUTRALITY.—Under this subparagraph the Secretary shall provide for an adjustment to the update under subparagraph (A)—

"(i) for each of 2001, 2002, 2003, and 2004, of -0.2 percent; and

"(ii) for 2005 of +0.8 percent.".

(2) PUBLICATION CHANGE.—

(A) IN GENERAL.—Section 1848(d)(1)(E) (42 U.S.C. 1395w–4(d)(1)(E)) is amended to read as follows:

"(E) PUBLICATION AND DISSEMINATION OF INFORMATION.—The Secretary shall—

"(i) cause to have published in the Federal Register not later than November 1 of each year (beginning with 2000) the conversion factor which will apply to physicians' services for the succeeding year, the update determined under paragraph (4) for such succeeding year, and the

allowed expenditures under such paragraph for such succeeding year; and

"(ii) make available to the Medicare Payment Advisory Commission and the public by March 1 of each year (beginning with 2000) an estimate of the conversion factor which will apply to physicians' services for the succeeding year and data used in making such estimate.".

(B) MEDPAC REVIEW OF CONVERSION FACTOR ESTIMATES.—Section 1805(b)(1)(D) (42 U.S.C. 1395b–6(b)(1)(D)) is amended by inserting "and including a review of the estimate of the conversion factor submitted under section 1848(d)(1)(E)(ii)" before the period at the end.

(C) 1-TIME PUBLICATION OF INFORMATION ON TRANSITION.—The Secretary of Health and Human Services shall cause to have published in the Federal Register, not later than 90 days after the date of the enactment of this section, the Secretary's determination, based upon the best available data, of—

(i) the allowed expenditures under subclauses (I) and (II) of section 1848(d)(4)(C)(ii) of the Social Security Act, as added by subsection (a)(1)(B), for the 9-month period beginning on April 1, 1999, and for 1999;

(ii) the estimated actual expenditures described in section 1848(d) of such Act for 1999; and

(iii) the sustainable growth rate under section 1848(f) of such Act (42 U.S.C. 1395w–4(f)) for 2000.

(3) CONFORMING AMENDMENTS.—

(A) Section 1848 (42 U.S.C. 1395w–4) is amended—

(i) in subsection (d)(1)(A), by inserting "(for years before 2001) and, for years beginning with 2001, multiplied by the update (established under paragraph (4)) for the year involved" after "for the year involved"; and

(ii) in subsection (f)(2)(D), by inserting "or (d)(4)(B), as the case may be" after "(d)(3)(B)".

(B) Section 1833(l)(4)(A)(i)(VII) (42 U.S.C. 1395l(l)(4)(A)(i)(VII)) is amended by striking "1848(d)(3)" and inserting "1848(d)".

(b) SUSTAINABLE GROWTH RATES.—Section 1848(f) (42 U.S.C. 1395w–4(f)) is amended—

(1) by amending paragraph (1) to read as follows:

"(1) PUBLICATION.—The Secretary shall cause to have published in the Federal Register not later than—

"(A) November 1, 2000, the sustainable growth rate for 2000 and 2001; and

"(B) November 1 of each succeeding year the sustainable growth rate for such succeeding year and each of the preceding 2 years.";

(2) in paragraph (2)—

(A) in the matter before subparagraph (A), by striking "fiscal year 1998)" and inserting "fiscal year 1998 and ending with fiscal year 2000) and a year beginning with 2000"; and

(B) in subparagraphs (A) through (D), by striking "fiscal year" and inserting "applicable period" each place it appears;

(3) in paragraph (3), by adding at the end the following new subparagraph:

"(C) APPLICABLE PERIOD.—The term 'applicable period' means—

"(i) a fiscal year, in the case of fiscal year 1998, fiscal year 1999, and fiscal year 2000; or

"(ii) a calendar year with respect to a year beginning with 2000;

as the case may be.";

(4) by redesignating paragraph (3) as paragraph (4); and

(5) by inserting after paragraph (2) the following new paragraph:

"(3) DATA TO BE USED.—For purposes of determining the update adjustment factor under subsection (d)(4)(B) for a year beginning with 2001, the sustainable growth rates taken into consideration in the determination under paragraph (2) shall be determined as follows:

"(A) FOR 2001.—For purposes of such calculations for 2001, the sustainable growth rates for fiscal year 2000 and the years 2000 and 2001 shall be determined on the basis of the best data available to the Secretary as of September 1, 2000.

"(B) FOR 2002.—For purposes of such calculations for 2002, the sustainable growth rates for fiscal year 2000 and for years 2000, 2001, and 2002 shall be determined on the basis of the best data available to the Secretary as of September 1, 2001.

"(C) FOR 2003 AND SUCCEEDING YEARS.—For purposes of such calculations for a year after 2002—

"(i) the sustainable growth rates for that year and the preceding 2 years shall be determined on the basis of the best data available to the Secretary as of September 1 of the year preceding the year for which the calculation is made; and

"(ii) the sustainable growth rate for any year before a year described in clause (i) shall be the rate as most recently determined for that year under this subsection.

Nothing in this paragraph shall be construed as affecting the sustainable growth rates established for fiscal year 1998 or fiscal year 1999.".

(c) EFFECTIVE DATE.—The amendments made by this section shall be effective in determining the conversion factor under section 1848(d) of the Social Security Act (42 U.S.C. 1395w–4(d)) for years beginning with 2001 and shall not apply to or affect any update (or any update adjustment factor) for any year before 2001.

Subtitle B—Hospital Outpatient Services

SEC. 211. OUTLIER ADJUSTMENT AND TRANSITIONAL PASS-THROUGH FOR CERTAIN MEDICAL DEVICES, DRUGS, AND BIOLOGICALS.

(a) OUTLIER ADJUSTMENT.—Section 1833(t) (42 U.S.C. 1395l(t)), as added by section 4523(a) of BBA, is amended—

(1) by redesignating paragraphs (5) through (9) as paragraphs (7) through (11), respectively; and

(2) by inserting after paragraph (4) the following new paragraph:

"(5) OUTLIER ADJUSTMENT.—

"(A) IN GENERAL.—The Secretary shall provide for an additional payment for each covered OPD service (or group of services) for which a hospital's charges, adjusted to cost, exceed—

"(i) a fixed multiple of the sum of—

"(I) the applicable Medicare OPD fee schedule amount determined under paragraph (3)(D), as adjusted under paragraph (4)(A) (other than for adjustments under this paragraph or paragraph (6)); and

"(II) any transitional pass-through payment under paragraph (6); and

"(ii) at the option of the Secretary, such fixed dollar amount as the Secretary may establish.

"(B) AMOUNT OF ADJUSTMENT.—The amount of the additional payment under subparagraph (A) shall be determined by the Secretary and shall approximate the marginal cost of care beyond the applicable cutoff point under such subparagraph.

"(C) LIMIT ON AGGREGATE OUTLIER ADJUSTMENTS.—

"(i) IN GENERAL.—The total of the additional payments made under this paragraph for covered OPD services furnished in a year (as projected or estimated by the Secretary before the beginning of the year) may not exceed the applicable percentage (specified in clause (ii)) of the total program payments projected or estimated to be made under this subsection for all covered OPD services furnished in that year. If this paragraph is first applied to less than a full year, the previous sentence shall apply only to the portion of such year.

"(ii) APPLICABLE PERCENTAGE.—For purposes of clause (i), the term 'applicable percentage' means a percentage specified by the Secretary up to (but not to exceed)—

"(I) for a year (or portion of a year) before 2004, 2.5 percent; and

"(II) for 2004 and thereafter, 3.0 percent.".

(b) TRANSITIONAL PASS-THROUGH FOR ADDITIONAL COSTS OF INNOVATIVE MEDICAL DEVICES, DRUGS, AND BIOLOGICALS.—Such section is further amended by inserting after paragraph (5) the following new paragraph:

"(6) TRANSITIONAL PASS-THROUGH FOR ADDITIONAL COSTS OF INNOVATIVE MEDICAL DEVICES, DRUGS, AND BIOLOGICALS.—

"(A) IN GENERAL.—The Secretary shall provide for an additional payment under this paragraph for any of the following that are provided as part of a covered OPD service (or group of services):

"(i) CURRENT ORPHAN DRUGS.—A drug or biological that is used for a rare disease or condition with respect to which the drug or biological

has been designated as an orphan drug under section 526 of the Federal Food, Drug and Cosmetic Act if payment for the drug or biological as an outpatient hospital service under this part was being made on the first date that the system under this subsection is implemented.

"(ii) CURRENT CANCER THERAPY DRUGS AND BIOLOGICALS.—A drug or biological that is used in cancer therapy if payment for the drug or biological as an outpatient hospital service under this part was being made on such first date.

"(iii) NEW MEDICAL DEVICES, DRUGS, AND BIOLOGICALS.—A medical device, drug, or biological not described in clause (i) or (ii) if—

"(I) payment for the device, drug, or biological as an outpatient hospital service under this part was not being made as of December 31, 1996; and

"(II) the cost of the device, drug, or biological is not insignificant in relation to the OPD fee schedule amount (as calculated under paragraph (3)(D)) payable for the service (or group of services) involved.

"(B) LIMITED PERIOD OF PAYMENT.—The payment under this paragraph with respect to a medical device, drug, or biological shall only apply during a period of at least 2 years, but not more than 3 years, that begins—

"(i) on the first date this subsection is implemented in the case of a drug or biological described in clause (i) or (ii) of subparagraph (A) and in the case of a device, drug, or biological described in subparagraph (A)(iii) for which payment under this part is made as an outpatient hospital service before such first date; or

"(ii) in the case of a device, drug, or biological described in subparagraph (A)(iii) not described in clause (i), on the first date on which payment is made under this part for the device, drug, or biological as an outpatient hospital service.

"(C) AMOUNT OF ADDITIONAL PAYMENT.—Subject to subparagraph (D)(iii), the amount of the payment under this paragraph with respect to a device, drug, or biological provided as part of a covered OPD service is—

"(i) in the case of a drug or biological, the amount by which the amount determined under section 1842(o) for the drug or biological exceeds the portion of the otherwise applicable medicare OPD fee schedule that the Secretary determines is associated with the drug or biological; or

"(ii) in the case of a medical device, the amount by which the hospital's charges for the device, adjusted to cost, exceeds the portion of the otherwise applicable medicare OPD fee schedule that the Secretary determines is associated with the device.

"(D) LIMIT ON AGGREGATE ANNUAL ADJUSTMENT.—

"(i) IN GENERAL.—The total of the additional payments made under this paragraph for covered OPD services furnished in a year (as projected or estimated by the Secretary before the beginning of the year) may not exceed the applicable percentage (specified in clause (ii)) of the total program payments projected or estimated to be made under this subsection for all covered OPD services furnished in that year. If this paragraph is first applied to less than a full year, the previous sentence shall apply only to the portion of such year.

"(ii) APPLICABLE PERCENTAGE.—For purposes of clause (i), the term 'applicable percentage' means—

"(I) for a year (or portion of a year) before 2004, 2.5 percent; and

"(II) for 2004 and thereafter, a percentage specified by the Secretary up to (but not to exceed) 2.0 percent.

"(iii) UNIFORM PROSPECTIVE REDUCTION IF AGGREGATE LIMIT PROJECTED TO BE EXCEEDED.—If the Secretary projects or estimates before the beginning of a year that the amount of the additional payments under this paragraph for the year (or portion thereof) as determined under clause (i) without regard to this clause) will exceed the limit established under such clause, the Secretary shall reduce pro rata the amount of each of the additional payments under this paragraph for that year (or portion thereof) in order to ensure that the aggregate additional payments under this paragraph (as so projected or estimated) do not exceed such limit.".

(c) APPLICATION OF NEW ADJUSTMENTS ON A BUDGET NEUTRAL BASIS.—Section 1833(t)(2)(E) (42 U.S.C. 1395l(t)(2)(E)) is amended by striking "other adjustments, in a budget neutral manner, as determined to be necessary to ensure equitable pay-

ments, such a outlier adjustments or" and inserting ", in a budget neutral manner, outlier adjustments under paragraph (5) and transitional pass-through payments under paragraph (6) and other adjustments as determined to be necessary to ensure equitable payments, such as".

(d) LIMITATION ON JUDICIAL REVIEW FOR NEW ADJUSTMENTS.—Section 1833(t)(11), as redesignated by subsection (a)(1), is amended—

(1) by striking "and" at the end of subparagraph (C);

(2) by striking the period at the end of subparagraph (D) and inserting "; and"; and

(3) by adding at the end the following:

"(E) the determination of the fixed multiple, or a fixed dollar cutoff amount, the marginal cost of care, or applicable percentage under paragraph (5) or the determination of insignificance of cost, the duration of the additional payments (consistent with paragraph (6)(B)), the portion of the Medicare OPD fee schedule amount associated with particular devices, drugs, or biologicals, and the application of any pro rata reduction under paragraph (6).".

(e) INCLUSION OF MEDICAL DEVICES UNDER SYSTEM.—Section 1833(t) (42 U.S.C. 1395l(t)) is amended—

(1) in paragraph (1)(B)(ii), by striking "clause (iii)" and inserting "clause (iv)" and by striking "but";

(2) by redesignating clause (iii) of paragraph (1)(B) as clause (iv) and inserting after clause (ii) of such paragraph the following new clause:

"(iii) includes medical devices (such as implantable medical devices); but"; and

(3) in paragraph (2)(B), by inserting after "resources" the following: "and so that a device is classified to the group that includes the service to which the device relates".

(f) AUTHORIZING PAYMENT WEIGHTS BASED ON MEAN HOSPITAL COSTS.—Section 1833(t)(2)(C) (42 U.S.C. 1395l(t)(2)(C)) is amended by inserting "(or, at the election of the Secretary, mean)" after "median".

(g) LIMITING VARIATION OF COSTS OF SERVICES CLASSIFIED WITH A GROUP.—Section 1833(t)(2) (42 U.S.C. 1395l(t)(2)) is amended by adding at the end the following new flush sentence:

"For purposes of subparagraph (B), items and services within a group shall not be treated as 'comparable with respect to the use of resources' if the highest median cost (or mean cost, if elected by the Secretary under subparagraph (C)) for an item or service within the group is more than 2 times greater than the lowest median cost (or mean cost, if so elected) for an item or service within the group; except that the Secretary may make exceptions in unusual cases, such as low volume items and services.".

(h) ANNUAL REVIEW OF OPD PPS COMPONENTS.—

(1) IN GENERAL.—Section 1833(t)(8)(A) (42 U.S.C. 1395l(t)(8)(A)) as redesignated by subsection (a), is amended by striking "may periodically review" and inserting "shall review not less often than annually".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) applies beginning with 2002.

(i) NO IMPACT ON COPAYMENT.—Section 1833(t)(7) (42 U.S.C. 1395l(t)(7)), as redesignated by subsection (a), is amended by adding at the end the following new subparagraph:

"(D) COMPUTATION IGNORING OUTLIER AND PASS-THROUGH ADJUSTMENTS.—The copayment amount shall be computed under subparagraph (A) as if the adjustments under paragraphs (5) and (6) (and any adjustment made under paragraph (2)(E) in relation to such adjustments) had not occurred.".

(j) TECHNICAL CORRECTION IN REFERENCE RELATING TO HOSPITAL-BASED AMBULANCE SERVICES.—Section 1833(t)(9) (42 U.S.C. 1395l(t)(9)), as redesignated by subsection (a), is amended by striking "the matter in subsection (a)(1) preceding subparagraph (A)" and inserting "section 1861(v)(1)(U)".

(k) EFFECTIVE DATE.—Except as provided in this section, the amendments made by this section shall be effective as if included in the enactment of BBA.

(l) STUDY OF DELIVERY OF INTRAVENOUS IMMUNE GLOBULIN (IVIG) OUTSIDE HOSPITALS AND PHYSICIANS' OFFICES.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study of the extent to which intravenous immune globulin (IVIG) could be delivered and reimbursed under the medicare program outside of a hospital or physician's office. In conducting the study, the Secretary shall—

(A) consider the sites of service that other payors, including Medicare+Choice plans, use for these drugs and biologicals;

(B) determine whether covering the delivery of these drugs and biologicals in a medicare patient's home raises any additional safety and health concerns for the patient;

(C) determine whether covering the delivery of these drugs and biologicals in a patient's home can reduce overall spending under the medicare program; and

(D) determine whether changing the site of setting for these services would affect beneficiary access to care.

(2) REPORT.—The Secretary shall submit a report on such study to the Committees on Way and Means and Commerce of the House of Representatives and the Committee on Finance of the Senate within 1 year after the date of the enactment of this Act. The Secretary shall include in the report recommendations regarding on the appropriate manner and settings under which the medicare program should pay for these drugs and biologicals delivered outside of a hospital or physician's office.

SEC. 212. ESTABLISHING A TRANSITIONAL CORRIDOR FOR APPLICATION OF OPD PPS.

(a) IN GENERAL.—Section 1833(t) (42 U.S.C. 1395l(t)), as amended by section 211(a), is further amended—

(1) in paragraph (4), in the matter before subparagraph (A), by inserting ", subject to paragraph (7)," after "is determined"; and

(2) by redesignating paragraphs (7) through (11) as paragraphs (8) through (12), respectively; and

(3) by inserting after paragraph (6), as inserted by section 211(b), the following new paragraph:

"(7) TRANSITIONAL ADJUSTMENT TO LIMIT DECLINE IN PAYMENT.—

"(A) BEFORE 2002.—For covered OPD services furnished before January 1, 2002, for which the PPS amount (as defined in subparagraph (D)(i)) is—

"(i) at least 90 percent, but less than 100 percent, of the pre-BBA amount (as defined in subparagraph (D)(ii)), the amount of payment under this subsection shall be increased by 80 percent of the amount of such difference;

"(ii) at least 80 percent, but less than 90 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount by which (I) the product of 0.71 and the pre-BBA amount, exceeds (II) the product of 0.70 and the PPS amount;

"(iii) at least 70 percent, but less than 80 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount by which (I) the product of 0.63 and the pre-BBA amount, exceeds (II) the product of 0.60 and the PPS amount;

"(iv) less than 70 percent of the pre-BBA amount, the amount of payment under this subsection shall be increased by 21 percent of the pre-BBA amount.

"(B) 2002.—For covered OPD services furnished during 2002, for which the PPS amount is—

"(i) at least 90 percent, but less than 100 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by 70 percent of the amount of such difference;

"(ii) at least 80 percent, but less than 90 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount by which (I) the product of 0.61 and the pre-BBA amount, exceeds (II) the product of 0.60 and the PPS amount;

"(iii) less than 80 percent of the pre-BBA amount, the amount of payment under this subsection shall be increased by 13 percent of the pre-BBA amount.

"(C) 2003.—For covered OPD services furnished during 2003, for which the PPS amount is—

"(i) at least 90 percent, but less than 100 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by 60 percent of the amount of such difference; or

"(ii) less than 90 percent of the pre-BBA amount, the amount of payment under this subsection shall be increased by 6 percent of the pre-BBA amount.

"(D) DEFINITIONS.—For purposes of this subparagraph:

"(i) PPS AMOUNT.—The term 'PPS amount' means, with respect to a covered OPD service, the amount of payment under this title for such service (determined without regard to this paragraph).

"(ii) PRE-BBA AMOUNT.—The term 'pre-BBA amount' means, with respect to a covered OPD service, the amount that would have been paid under this title for such service if this subsection did not apply.

"(E) CONSTRUCTION.—Nothing in this paragraph shall be construed to affect the copayment amount under paragraph (8).".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall be effective as if included in the enactment of BBA.

(c) REPORT ON RURAL HOSPITALS.—Not later than July 1, 2002, the Secretary of Health and Human Services shall submit to Congress a report and recommendations on whether the prospective payment system for covered outpatient services furnished under title XVIII of the Social Security Act should apply to the following providers of services furnishing outpatient items and services for which payment is made under such title:

(1) Medicare-dependent, small rural hospitals (as defined in section 1886(d)(5)(G)(iv) of such Act (42 U.S.C. 1395ww(d)(5)(G)(iv))).

(2) Sole community hospitals (as defined in section 1886(d)(5)(D)(iii) of such Act (42 U.S.C. 1395ww(d)(5)(D)(iii)).

(3) Rural health clinics (as defined in section 1861(aa)(2) of such Act (42 U.S.C. 1395x(aa)(2)).

(4) Rural referral centers (as so classified under section 1886(d)(5)(C) of such Act (42 U.S.C. 1395ww(d)(5)(C)).

(5) Any other rural hospital that the Secretary determines appropriate.

SEC. 213. DELAY IN APPLICATION OF PROSPECTIVE PAYMENT SYSTEM TO CANCER CENTER HOSPITALS.

Section 1833(t)(11)(A) (42 U.S.C. 1395l(t)(11)(A)), as redesignated by section 212(a), is amended by striking "January 1, 2000" and inserting "the first day of the first year that begins 2 years after the date the prospective payment system under this section is first implemented".

SEC. 214. LIMITATION ON OUTPATIENT HOSPITAL COPAYMENT FOR A PROCEDURE TO THE HOSPITAL DEDUCTIBLE AMOUNT.

(a) IN GENERAL.—Section 1833(t)(8) (42 U.S.C. 1395l(t)(8)) as redesignated by section 212(a), is amended—

(1) in subparagraph (A), by striking "subparagraph (B)" and inserting "subparagraphs (B) and (C)";

(2) by redesignating subparagraphs (C) and (D) as subparagraphs (D) and (E), respectively; and

(3) by inserting after subparagraph (B) the following new subparagraph:

"(C) LIMITING COPAYMENT AMOUNT TO INPATIENT HOSPITAL DEDUCTIBLE AMOUNT.—In no case shall the copayment amount for a procedure performed in a year exceed the amount of the inpatient hospital deductible established under section 1813(b) for that year.".

(b) INCREASE IN PAYMENT TO REFLECT REDUCTION IN COPAYMENT.—Section 1833(t)(4)(C) (42 U.S.C. 1395l(t)(4)(C)) is amended by inserting ", plus the amount of any reduction in the copayment amount attributable to paragraph (5)(C)" before the period at the end.

(c) EFFECTIVE DATE.—The amendments made by this section apply as if included in the enactment of BBA and shall only apply to procedures performed for which payment is made on the basis of the prospective payment system under section 1833(t) of the Social Security Act.

Subtitle C—Other

SEC. 221. APPLICATION OF SEPARATE CAPS TO PHYSICAL AND SPEECH THERAPY SERVICES.

(a) IN GENERAL.—Section 1833(g) (42 U.S.C. 1395l(g)) is amended—

(1) in paragraph (1)—

(A) by inserting "(A)" after "(g)(1)"; and

(B) by adding at the end the following new subparagraph:

"(B) Subparagraph (A) shall be applied separately for speech-language pathology services described in the fourth sentence of section 1861(p) and for other outpatient physical therapy services."; and

(2) by adding at the end the following new paragraph:

"(4) The limitations of this subsection apply to the services involved on a per beneficiary, per facility (or provider) basis.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to services furnished on or after January 1, 2000.

SEC. 222. TRANSITIONAL OUTLIER PAYMENTS FOR THERAPY SERVICES FOR CERTAIN HIGH ACUITY PATIENTS.

Section 1833(g) (42 U.S.C. 1395l(g)), as amended by section 221, is further amended by adding at the end the following new paragraph:

"(5)(A) The Secretary shall establish a process under which a facility or provider that is providing therapy services to which the limitation of this subsection applies to a beneficiary may apply to the Secretary for an increase in such limitation under this paragraph for services furnished in 2000 or in 2001.

"(B) Such process shall take into account the clinical diagnosis and shall provide that the aggregate amount of additional payments resulting from the application of this paragraph—

"(i) during fiscal year 2000 may not exceed $40,000,000;

"(ii) during fiscal year 2001 may not exceed $60,000,000; and

"(iii) during fiscal year 2002 may not exceed $20,000,000.".

SEC. 223. UPDATE IN RENAL DIALYSIS COMPOSITE RATE.

(a) IN GENERAL.—Section 1881(b)(7) (42 U.S.C. 1395rr(b)(7)) is amended by adding at the end the following new flush sentence:

"The Secretary shall increase the amount of each composite rate payment for dialysis services furnished on or after January 1, 2000, and on or before December 31, 2000, by 1.2 percent above such composite rate payment amounts for such services furnished on December 31, 1999, and for such services furnished on or after January 1, 2001, by 1.2 percent above such composite rate payment amounts for such services furnished on December 31, 2000.".

(b) CONFORMING AMENDMENT.—

(1) IN GENERAL.—Section 9335(a) of the Omnibus Budget Reconciliation Act of 1986 (42 U.S.C. 1395rr note) is amended by striking paragraph (1).

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on January 1, 2000.

(c) STUDY ON PAYMENT LEVEL FOR HOME HEMODIALYSIS.—The Medicare Payment Advisory Commission shall conduct a study on the appropriateness of the differential in payment under the medicare program for hemodialysis services furnished in a facility and such services furnished in a home. Not later than 1 year after the date of the enactment of this Act, the Commission shall submit to Congress a report on such study and shall include recommendations regarding changes in medicare payment policy in response to the study.

SEC. 224. TEMPORARY UPDATE IN DURABLE MEDICAL EQUIPMENT AND OXYGEN RATES.

(a) DURABLE MEDICAL EQUIPMENT AND OXYGEN.—Section 1834(a)(14) (42 U.S.C. 1395m(a)(14)), as amended by section 4551(a)(1) of BBA, is amended —

(1) by redesignating subparagraph (D) as subparagraph (E); and

(2) by striking subparagraph (C) and inserting the following:

"(C) for each of the years 1998 through 2000, 0 percentage points;

"(D) for each of the years 2001 and 2002, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year minus 2 percentage points; and".

(b) CONFORMING AMENDMENTS.—Section 1834(a)(9)(B) (42 U.S.C. 1395m(a)(9)(B)), as amended by section 4552(a) of BBA, is amended—

(1) by striking "and" at the end of clause (v);

(2) in clause (vi), by striking "and each subsequent year" and inserting "and 2000" and by striking the period at the end and inserting "; and"; and

(3) by adding at the end the following new clause:

"(vii) for 2001 and each subsequent year, the amount determined under this subparagraph for the preceding year increased by the covered item update for such subsequent year.".

SEC. 225. REQUIREMENT FOR NEW PROPOSED RULEMAKING FOR IMPLEMENTATION OF INHERENT REASONABLENESS POLICY.

The Secretary of Health and Human Services shall not exercise inherent reasonableness authority provided under section 1842(b)(8) of the Social Security Act (42 U.S.C. 1395u(b)(8)) before such time as—

(1) the Secretary has published in the Federal Register a new notice of proposed rulemaking to implement subparagraph (A) of such section;

(2) has provided for a period of not less than 60 days for public comment on such proposed rule; and

(3) the Secretary has published in the Federal Register a final rule which takes into account comments received during such period.

SEC. 226. INCREASE IN REIMBURSEMENT FOR PAP SMEARS.

(a) PAP SMEAR PAYMENT INCREASE.—Section 1833(h) (42 U.S.C. 1395l(h)) is amended by adding at the end the following new paragraph:

"(7) Notwithstanding paragraphs (1) and (4), the Secretary shall establish a minimum payment amount under this subsection for all areas for a diagnostic or screening pap smear laboratory test (including all cervical cancer screening technologies that have been approved by the Food and Drug Administration) of not less than $14.60.".

(b) SENSE OF CONGRESS.—It is the sense of the Congress that—

(1) the Health Care Financing Administration has been slow to incorporate or provide incentives for providers to use new screening diagnostic health care technologies in the area of cervical cancer;

(2) some new technologies have been developed which optimize the effectiveness of pap smear screening; and

(3) the Health Care Financing Administration should institute an appropriate increase in the payment rate for new cervical cancer screening technologies that have been approved by the Food and Drug Administration as significantly more effective than a conventional pap smear.

(c) EFFECTIVE DATE.—The amendments made by subsection (a) apply to services items and furnished on or after January 1, 2000.

SEC. 227. REFINEMENT OF AMBULANCE SERVICES DEMONSTRATION PROJECT.

Effective as if included in the enactment of BBA, section 4532 of BBA is amended—

(1) in subsection (a), by adding at the end the following: "The Secretary shall publish by not later than July 1, 2000, a request for proposals for such projects."; and

(2) by amending paragraph (2) of subsection (b) to read as follows:

"(2) CAPITATED PAYMENT RATE DEFINED.—In this subsection, the 'capitated payment rate' means, with respect to a demonstration project—

"(A) in its first year, a rate established for the project by the Secretary, using the most current available data, in a manner that ensures that aggregate payments under the project will not exceed the aggregate payment that would have been made for ambulance services under part B of title XVIII of the Social Security Act in the local area of government's jurisdiction; and

"(B) in a subsequent year, the capitated payment rate established for the previous year increased by an appropriate inflation adjustment factor.".

SEC. 228. ADDITIONAL PROVISIONS.

(a) MEDPAC STUDY ON POSTSURGICAL RECOVERY CARE CENTER SERVICES.—

(1) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study on the cost-effectiveness and efficacy of covering under the medicare program services of a post-surgical recovery care center (that provides an intermediate level of recovery care following surgery). In conducting such study, the Commission shall consider data on these centers gathered in demonstration projects.

(2) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Commission shall submit to Congress a report on such study and shall include in the report recommendations on the feasibility, costs, and savings of covering such services under the medicare program.

TITLE III—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

SEC. 301. ADJUSTMENT TO REFLECT ADMINISTRATIVE COSTS NOT INCLUDED IN THE INTERIM PAYMENT SYSTEM.

(a) IN GENERAL.—In the case of a home health agency that furnishes home health services to a medicare beneficiary, for each such beneficiary to whom the agency fur-

nished such services during the agency's cost reporting period beginning in fiscal year 2000, the Secretary of Health Services shall pay the agency, in addition to any amount of payment made under subsection (v)(1)(L) of such section for the beneficiary and only for such cost reporting period, an aggregate amount of $10 to defray costs incurred by the agency attributable to data collection and reporting requirements under the Outcome and Assessment Information Set (OASIS) required by reason of section 4602(e) of the Balanced Budget Act of 1997 (42 U.S.C. 1395fff note).

(b) PAYMENT SCHEDULE.—

(1) MIDYEAR PAYMENT.—By not later than April 1 2000, the Secretary shall pay to a home health agency an amount that the Secretary estimates to be 50 percent of the aggregate amount payable to the agency by reason of this section.

(2) UPON SETTLED COST REPORT.—The Secretary shall pay the balance of amounts payable to an agency under this section on the date that the cost report submitted by the agency for the cost reporting period beginning in fiscal year 2000 is settled.

(c) PAYMENT FROM TRUST FUNDS.—Payments under this section shall be made, in appropriate part as specified by the Secretary, from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund.

(d) DEFINITIONS.—In this section:

(1) HOME HEALTH AGENCY.—The term "home health agency" has the meaning given that term under section 1861(o) of the Social Security Act (42 U.S.C. 1395x(o)).

(2) HOME HEALTH SERVICES.—The term "home health services" has the meaning given that term under section 1861(m) of such Act (42 U.S.C. 1395x(m)).

(3) MEDICARE BENEFICIARY.—The term "medicare beneficiary" means a beneficiary described in section 1861(v)(1)(L)(vi)(II) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)(vi)(II)).

SEC. 302. DELAY IN APPLICATION OF 15 PERCENT REDUCTION IN PAYMENT RATES FOR HOME HEALTH SERVICES UNTIL 1 YEAR AFTER IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.

(a) CONTINGENCY REDUCTION.—Section 4603(e) of the Balanced Budget Act of 1997 (42 U.S.C. 1395fff note) (as amended by section 5101(c)(3) of the Tax and Trade Relief Extension Act of 1998 (contained in division J of Public Law 105–277)) is amended by striking "September 30, 2000" and inserting "on the date that is 12 months after the date the Secretary implements such system".

(b) PROSPECTIVE PAYMENT SYSTEM.—Section 1895(b)(3)(A)(i) (42 U.S.C. 1395fff(b)(3)(A)(i)) (as amended by section 5101 of the Tax and Trade Relief Extension Act of 1998 (contained in division J of Public Law 105–277)) is amended to read as follows:

"(i) IN GENERAL.—Under such system the Secretary shall provide for computation of a standard prospective payment amount (or amounts). Such amount (or amounts) shall initially be based on the most current audited cost report data available to the Secretary and shall be computed in a manner so that the total amounts payable under the system—

"(I) for the 12-month period beginning on the date the Secretary implements the system, shall be equal to the total amount that would have been made if the system had not been in effect; and

"(II) for periods beginning after the period described in subclause (I), shall be equal to the total amount that would have been made for fiscal year 2001 if the system had not been in effect but if the reduction in limits described in clause (ii) had been in effect, and updated under subparagraph (B).

Each such amount shall be standardized in a manner that eliminates the effect of variations in relative case mix and wage levels among different home health agencies in a budget neutral manner consistent with the case mix and wage level adjustments provided under paragraph (4)(A). Under the system, the Secretary may recognize regional differences or differences based upon whether or not the services or agency are in an urbanized area.".

(c) REPORT.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall submit to Congress a report analyzing the need for the 15 percent reduction under section 1895(b)(3)(A)(ii) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(A)(ii)), or for any reduction, in the computation of the base payment amounts under the

prospective payment system for home health services under section 1895 of such Act (42 U.S.C. 1395w–29).

(2) DEADLINE.—The Secretary shall submit to Congress the report described in paragraph (1) by not later than the date that is six months after the date the Secretary implements the prospective payment system for home health services under such section 1895.

SEC. 303. CLARIFICATION OF SURETY BOND REQUIREMENTS.

(a) HOME HEALTH AGENCIES.—Section 1861(o)(7) (42 U.S.C. 1395x(o)(7)) is amended to read as follows:

"(7) provides the Secretary with a surety bond—

"(A) effective for a period of 4 years (as specified by the Secretary) or in the case of a change in the ownership or control of the agency (as determined by the Secretary) during or after such 4-year period, an additional period of time that the Secretary determines appropriate, such additional period not to exceed 4 years from the date of such change in ownership or control;

"(B) in a form specified by the Secretary; and

"(C) for a year in the period described in subparagraph (A) in an amount that is equal to the lesser of $50,000 or 10 percent of the aggregate amount of payments to the agency under this title and title XIX for that year, as estimated by the Secretary; and".

(b) COORDINATION OF SURETY BONDS.—Part A of title XI is amended by adding at the end the following new section:

"COORDINATION OF MEDICARE AND MEDICAID SURETY BOND PROVISIONS

"SEC. 1148. In the case of a home health agency that is subject to a surety bond under title XVIII and title XIX, the surety bond provided to satisfy the requirement under one such title shall satisfy the requirement under the other such title so long as the bond applies to guarantee return of overpayments under both such titles.".

(c) EFFECTIVE DATE.—The amendments made by this section take effect on the date of the enactment of this Act and in applying section 1861(o)(7) of the Social Security Act, as amended by subsection (a), the Secretary of Health and Human Services may take into account the previous period for which a home health agency had a surety bond in effect under such section before such date.

SEC. 304. TECHNICAL AMENDMENT CLARIFYING APPLICABLE MARKET BASKET INCREASE FOR PPS.

Section 1895(b)(3)(B)(ii)(I) (42 U.S.C. 1395fff(b)(3)(B)(ii)(I)), as added by section 4603 of BBA (as amended by section 5101(d)(2) of the Tax and Trade Relief Extension Act of 1998 (contained in division J of Public Law 105–277)) is amended by striking "fiscal year 2002 or 2003" and inserting "each of fiscal years 2002 and 2003".

Subtitle B—Direct Graduate Medical Education

SEC. 311. USE OF NATIONAL AVERAGE PAYMENT METHODOLOGY IN COMPUTING DIRECT GRADUATE MEDICAL EDUCATION (DGME) PAYMENTS.

Section 1886(h) (42 U.S.C. 1395ww(h)) is amended—

(1) by amending clause (i) of paragraph (3)(B) to read as follows:

"(i)(I) for a cost reporting period beginning before October 1, 2000, the hospital's approved FTE resident amount (determined under paragraph (2)) for that period;

"(II) for a cost reporting period beginning on or after October 1, 2000, and before October 1, 2004, the national average per resident amount determined under paragraph (7) or, if greater, the sum of the hospital-specific percentage (as defined in subparagraph (E)) of the hospital's approved FTE resident amount (determined under paragraph (2)) for the period and the national percentage (as defined in such subparagraph) of the national average per resident amount determined under paragraph (7); and

"(III) for a cost reporting period beginning on or after October 1, 2004, the national average per resident amount determined under paragraph (7); and";

(2) in paragraph (3), by adding at the end the following new subparagraph:

"(E) TRANSITION TO NATIONAL AVERAGE PER RESIDENT PAYMENT SYSTEM.—For purposes of subparagraph (B)(i)(II), for the cost reporting period of a hospital beginning—

"(i) during fiscal year 2001, the hospital-specific percentage is 80 percent and the national percentage is 20 percent;

"(ii) during fiscal year 2002, the hospital-specific percentage is 60 percent and the national percentage is 40 percent;

"(iii) during fiscal year 2003, the hospital-specific percentage is 40 percent and the national percentage is 60 percent; and

"(iv) during fiscal year 2004, the hospital-specific percentage is 20 percent and the national percentage is 80 percent."; and

(3) by adding at the end the following new paragraph:

"(7) NATIONAL AVERAGE PER RESIDENT AMOUNT.—The national average per resident amount for a hospital for a cost reporting period beginning in a fiscal year is an amount determined as follows:

"(A) DETERMINATION OF HOSPITAL SINGLE PER RESIDENT AMOUNT.—The Secretary shall compute for each hospital operating an approved graduate medical education program a single per resident amount equal to the average (weighted by number of full-time equivalent residents) of the primary care per resident amount and the non-primary care per resident amount computed under paragraph (2) for cost reporting periods ending during fiscal year 1997.

"(B) DETERMINATION OF WAGE AND NON-WAGE-RELATED PROPORTION OF THE SINGLE PER RESIDENT AMOUNT.—The Secretary shall estimate the average proportion of the single per resident amounts computed under subparagraph (A) that is attributable to wages and wage-related costs.

"(C) STANDARDIZING PER RESIDENT AMOUNTS.—The Secretary shall establish a standardized per resident amount for each such hospital—

"(i) by dividing the single per resident amount computed under subparagraph (A) into a wage-related portion and a non-wage-related portion by applying the proportion determined under subparagraph (B);

"(ii) by dividing the wage-related portion by the factor applied under subsection (d)(3)(E) for discharges occurring during fiscal year 1999 for the hospital's area; and

"(iii) by adding the non-wage-related portion to the amount computed under clause (ii).

"(D) DETERMINATION OF NATIONAL AVERAGE.—The Secretary shall compute a national average per resident amount equal to the average of the standardized per resident amounts computed under subparagraph (C) for such hospitals, with the amount for each hospital weighted by the average number of full-time equivalent residents at such hospital.

"(E) APPLICATION TO INDIVIDUAL HOSPITALS.—The Secretary shall compute for each such hospital a per resident amount—

"(i) by dividing the national average per resident amount computed under subparagraph (D) into a wage-related portion and a non-wage-related portion by applying the proportion determined under subparagraph (B);

"(ii) by multiplying the wage-related portion by the factor described in subparagraph (C)(ii) for the hospital's area; and

"(iii) by adding the non-wage-related portion to the amount computed under clause (ii).

"(F) INITIAL UPDATING RATE.—The Secretary shall update such per resident amount for the hospital's cost reporting period that begins during fiscal year 2001 for each such hospital by the estimated percentage increase in the consumer price index for all urban consumers during the period beginning October 1997 and ending with the midpoint of the hospital's cost reporting period that begins during fiscal year 2001.

"(G) SUBSEQUENT UPDATING.—For each subsequent cost reporting period, subject to subparagraph (H), the national average per resident amount for a hospital is equal to the amount determined under this paragraph for the previous cost reporting period updated, through the midpoint of the period, by projecting the estimated percentage change in the consumer price index during the 12-month period ending at that midpoint, with appropriate adjustments to reflect previous under- or over-estimations under this subparagraph in the projected percentage change in the consumer price index.

"(H) TRANSITIONAL BUDGET NEUTRALITY ADJUSTMENT.—

"(i) IN GENERAL.—If the Secretary estimates that, as a result of the amendments made by section 311 of the Medicare Balanced Budget Re-

finement Act of 1999, the post-MBBRA expenditures for fiscal year 2005 will be greater or less than the pre-MBBRA expenditures for that fiscal year—

"(I) the Secretary shall adjust the update applied under subparagraph (G) in determining the national average per resident amount for cost reporting periods beginning during fiscal year 2005 so that the amount of the post-MBBRA expenditures for those cost reporting periods is equal to the amount of the pre-MBBRA expenditures for such periods; and

"(II) the Secretary shall, taking into account the adjustment made under subclause (I), adjust the national average per resident amount, as applied for the portion of a cost reporting period beginning during fiscal year 2004 that occur in fiscal year 2005, so that the amount of the post-MBBRA expenditures made during fiscal year 2005 is equal to the amount of the pre-MBBRA expenditures during such fiscal year.

"(ii) DEFINITIONS.—In this subparagraph:

"(I) AGGREGATE SUBSECTION (h)-RELATED EXPENDITURES.—The term 'aggregate subsection (h)-related expenditures' means, with respect to cost reporting periods beginning during a fiscal year or with respect to a fiscal year, the aggregate expenditures under this title for such periods or fiscal year, respectively, which are attributable to the operation of this subsection.

"(II) PRE-MBBRA EXPENDITURES.—The term 'pre-MBBRA expenditures' means aggregate subsection (h)-related expenditures determined as if the amendments made by section 311 of the Medicare Balanced Budget Refinement Act of 1999 had not been enacted.

"(III) POST-MBBRA EXPENDITURES.—The term 'post-MBBRA expenditures' means aggregate subsection (h)-related expenditures determined taking into account the amendments made by section 311 of the Medicare Balanced Budget Refinement Act of 1999.".

Subtitle C—Other

SEC. 321. GAO STUDY ON GEOGRAPHIC RECLASSIFICATION.

(a) IN GENERAL.—The Comptroller General of the United States shall conduct a study of the current laws and regulations for geographic reclassification of hospitals under the medicare program. Such study shall examine data on the number of hospitals that are reclassified and their special designation status in determining payments under the medicare program. The study shall evaluate—

(1) the magnitude of the effect of geographic reclassification on rural hospitals that do not reclassify;

(2) whether the current thresholds used in geographic reclassification reclassify hospitals to the appropriate labor markets;

(3) the effect of eliminating geographic reclassification through use of the occupational mix data;

(4) the group reclassification policy;

(5) changes in the number of reclassifications and the compositions of the groups;

(6) the effect of State-specific budget neutrality compared to national budget neutrality; and

(7) whether there are sufficient controls over the intermediary evaluation of the wage data reported by hospitals.

(b) REPORT.—Not later than 18 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a).

SEC. 322. MEDPAC STUDY ON MEDICARE PAYMENT FOR NON-PHYSICIAN HEALTH PROFESSIONAL CLINICAL TRAINING IN HOSPITALS.

(a) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study on medicare payment policy with respect to professional clinical training of different classes of non-physician health care professionals (such as nurses, allied health professionals, physician assistants, and psychologists) and the basis for any differences in treatment among such classes.

(b) REPORT.—The Commission shall submit a report to Congress on the study conducted under subsection (a) not later than 18 months after the date of the enactment of this Act.

TITLE IV—RURAL PROVIDER PROVISIONS

SEC. 401. PERMITTING RECLASSIFICATION OF CERTAIN URBAN HOSPITALS AS RURAL HOSPITALS.

(a) IN GENERAL.—Section 1886(d)(8) (42 U.S.C. 1395ww(d)(8)) is amended by adding at the end the following new subparagraph:

"(E)(i) For purposes of this subsection, not later than 60 days after the receipt of an application from a subsection (d) hospital described in clause (ii), the Secretary shall treat the hospital as being located in the rural area (as defined in such paragraph (2)(D)) of the State in which the hospital is located.

"(ii) For purposes of clause (i), a subsection (d) hospital described in this clause is a subsection (d) hospital that is located in an urban area (as defined in paragraph (2)(D)) and satisfies any of the following criteria:

"(I) The hospital is located in a rural census tract of a metropolitan statistical area (as determined under the Goldsmith Modification, as published in the Federal Register on February 27, 1992 (57 FR 6725)).

"(II) The hospital is located in an area designated by any law or regulation of such State as a rural area (or is designated by such State as a rural hospital).

"(III) The hospital would qualify as a sole community hospital under paragraph (5)(D) if the hospital were located in a rural area.

"(IV) The hospital meets such other criteria as the Secretary may specify.".

(b) CONFORMING CHANGES.—(1) Section 1833(t) (42 U.S.C. 1395l(t)), as amended by sections 211 and 212, is further amended by adding at the end the following new paragraph:

"(13) MISCELLANEOUS PROVISIONS.—

"(A) APPLICATION OF RECLASSIFICATION OF CERTAIN HOSPITALS.—If a hospital is being treated as being located a rural under section 1886(d)(8)(E), that hospital shall be treated under this subsection as being located in that rural area.".

(2) Section 1820(c)(2)(B)(i) (42 U.S.C. 1395i–4(c)(2)(B)(i)) is amended by inserting "or is treated as being located in a rural area pursuant to section 1886(d)(8)(E)" after "section 1886(d)(2)(D))".

(c) EFFECTIVE DATE.—The amendments made by this section shall become effective on January 1, 2000.

SEC. 402. UPDATE OF STANDARDS APPLIED FOR GEOGRAPHIC RECLASSIFICATION FOR CERTAIN HOSPITALS.

(a) IN GENERAL.—Section 1886(d)(8)(B) (42 U.S.C. 1395ww(d)(8)(B)) is amended—

(1) by inserting "(i)" after "(B)";

(2) by striking "published in the Federal Register on January 3, 1980" and inserting "described in clause (ii)"; and

(3) by adding at the end the following new clause:

"(ii) The standards described in this clause for cost reporting periods beginning in a fiscal year—

"(I) before fiscal year 2003, are the standards published in the Federal Register on January 3, 1980, or, at the election of the hospital with respect to fiscal years 2001 and 2002, standards so published on March 30, 1990; and

"(II) after fiscal year 2002, are the standards published in the Federal Register by the Director of the Office of Management and Budget based on the most recent available decennial population data.

Subparagraphs (C) and (D) shall not apply with respect to the application of subclause (I).".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply with respect to discharges occurring during cost reporting periods beginning on or after October 1, 1999.

SEC. 403. IMPROVEMENTS IN THE CRITICAL ACCESS HOSPITAL (CAH) PROGRAM.

(a) APPLYING 96-HOUR LIMIT ON AN AVERAGE ANNUAL BASIS.—

(1) IN GENERAL.—Section 1820(c)(2)(B)(iii) (42 U.S.C. 1395i–4(c)(2)(B)(iii)), as added by section 4201(a) of BBA, is amended by striking "for a period not to exceed 96 hours" and all that follows and inserting "for a period that does not exceed, as determined on an annual, average basis, 96 hours per patient;".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) takes effect on the date of the enactment of this Act.

(b) PERMITTING FOR-PROFIT HOSPITALS TO QUALIFY FOR DESIGNATION AS A CRITICAL ACCESS HOSPITAL.—Section 1820(c)(2)(B)(i) (42 U.S.C. 1395i–4(c)(2)(B)(i)), as added by section 4201(a) of BBA, is amended in the matter preceding subclause (I), by striking "nonprofit or public hospital" and inserting "hospital".

(c) ALLOWING CLOSED OR DOWNSIZED HOSPITALS TO CONVERT TO CRITICAL ACCESS HOSPITALS.—Section 1820(c)(2) (42 U.S.C. 1395i–4(c)(2)), as added by section 4201(a) of BBA, is amended—

(1) in subparagraph (A), by striking "subparagraph (B)" and inserting "subparagraphs (B), (C), and (D)"; and

(2) by adding at the end the following new subparagraphs:

"(C) RECENTLY CLOSED FACILITIES.—A State may designate a facility as a critical access hospital if the facility—

"(i) was a hospital that ceased operations on or after the date that is 10 years before the date of enactment of this subparagraph; and

"(ii) as of the effective date of such designation, meets the criteria for designation under subparagraph (B).

"(D) DOWNSIZED FACILITIES.—A State may designate a health clinic or a health center (as defined by the State) as a critical access hospital if such clinic or center—

"(i) is licensed by the State as a health clinic or a health center;

"(ii) was a hospital that was downsized to a health clinic or health center; and

"(iii) as of the effective date of such designation, meets the criteria for designation under subparagraph (B).".

(d) ALL-INCLUSIVE PAYMENT OPTION FOR OUTPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—

(1) IN GENERAL.—Section 1834(g) (42 U.S.C. 1395m(g)), as added by section 4201(c)(5) of BBA, is amended to read as follows:

"(g) PAYMENT FOR OUTPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—

"(1) ELECTION OF CAH.—At the election of a critical access hospital, the amount of payment for outpatient critical access hospital services under this part shall be determined under paragraph (2) or (3), such amount determined under either paragraph without regard to the amount of the customary or other charge.

"(2) COST-BASED HOSPITAL OUTPATIENT SERVICE PAYMENT PLUS FEE SCHEDULE FOR PROFESSIONAL SERVICES.—If a hospital elects this paragraph to apply, there shall be paid amounts equal to the sum of the following, less the amount that such hospital may charge as described in section 1866(a)(2)(A):

"(A) FACILITY FEE.—With respect to facility services, not including any services for which payment may be made under subparagraph (B), the reasonable costs of the critical access hospital in providing such services.

"(B) FEE SCHEDULE FOR PROFESSIONAL SERVICES.—With respect to professional services otherwise included within outpatient critical access hospital services, such amounts as would otherwise be paid under this part if such services were not included in outpatient critical access hospital services.

"(3) ALL-INCLUSIVE RATE.—If a hospital elects this paragraph to apply, with respect to both facility services and professional services, there shall be paid amounts equal to the reasonable costs of the critical access hospital in providing such services, less the amount that such hospital may charge as described in section 1866(a)(2)(A).".

(2) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply for cost reporting periods beginning on or after October 1, 1999.

(e) ELIMINATION OF COINSURANCE FOR CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED BY A CRITICAL ACCESS HOSPITAL ON AN OUTPATIENT BASIS.—

(1) IN GENERAL.—Section 1833(a)(1)(D) (42 U.S.C. 1395l(a)(1)(D)) is amended by inserting "or which are furnished on an outpatient basis by a critical access hospital" after "on an assignment-related basis".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services furnished on or after the date of the enactment of this Act.

(f) PARTICIPATION IN SWING BED PROGRAM.—Section 1883 (42 U.S.C. 1395tt) is amended—

(1) in subsection (a)(1), by striking "(other than a hospital which has in effect a waiver under subparagraph (A) of the last sentence of section 1861(e))"; and

(2) in subsection (c), by striking ", or during which there is in effect for the hospital a waiver under subparagraph (A) of the last sentence of section 1861(e)".

SEC. 404. 5-YEAR EXTENSION OF MEDICARE DEPENDENT HOSPITAL (MDH) PROGRAM.

(a) EXTENSION OF PAYMENT METHODOLOGY.—Section 1886(d)(5)(G) (42 U.S.C. 1395ww(d)(5)(G)), as amended by section 4204(a)(1) of BBA, is amended—

(1) in clause (i), by striking "and before October 1, 2001," and inserting "and before October 1, 2006"; and

(2) in clause (ii)(II), by striking "and before October 1, 2001," and inserting "and before October 1, 2006".

(b) CONFORMING AMENDMENTS.—

(1) EXTENSION OF TARGET AMOUNT.—Section 1886(b)(3)(D) (42 U.S.C. 1395ww(b)(3)(D)), as amended by section 4204(a)(2) of BBA, is amended—

(A) in the matter preceding clause (i), by striking "and before October 1, 2001," and inserting "and before October 1, 2006"; and

(B) in clause (iv), by striking "during fiscal year 1998 through fiscal year 2000" and inserting "during fiscal year 1998 through fiscal year 2005".

(2) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—Section 13501(e)(2) of Omnibus Budget Reconciliation Act of 1993 (42 U.S.C. 1395ww note), as amended by section 4204(a)(3) of BBA, is amended by striking "or fiscal year 2000" and inserting "or fiscal year 2000 through fiscal year 2005".

SEC. 405. REBASING FOR CERTAIN SOLE COMMUNITY HOSPITALS.

Section 1886(b)(3) (42 U.S.C. 1395ww(b)(3)), as amended by sections 4413 and 4414 of BBA, is amended—

(1) in subparagraph (C), by inserting "subject to subparagraph (I)" before "the term 'target amount' means"; and

(2) by adding at the end the following new subparagraph:

"(I)(i) For cost reporting periods beginning on or after October 1, 2000, in the case of a sole community hospital that for its cost reporting period beginning during 1999 is paid on the basis of the target amount applicable to the hospital under subparagraph (C) and that elects (in a form and manner determined by the Secretary) this subparagraph to apply to the hospital, there shall be substituted for the base cost reporting period described in subparagraph (C) the rebased target amount determined under this subparagraph.

"(ii) For purposes of clause (i), the rebased target amount applicable to a hospital making an election under this subparagraph is equal to the sum of the following:

"(I) With respect to discharges occurring in fiscal year 2001, 75 percent of the target amount applicable to the hospital under subparagraph (C) (hereinafter in this subparagraph referred to as the 'subparagraph (C) target amount') and 25 percent of the amount of the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital for the 12-month cost reporting period beginning during fiscal year 1996 (hereinafter in this subparagraph referred to as the 'rebased target amount'), increased by the applicable percentage increase under subparagraph (B)(iv).

"(II) With respect to discharges occurring in fiscal year 2002, 50 percent of the subparagraph (C) target amount and 50 percent of the rebased target amount, increased by the applicable percentage increase under subparagraph (B)(iv).

"(III) With respect to discharges occurring in fiscal year 2003, 25 percent of the subparagraph (C) target amount and 75 percent of the rebased target amount, increased by the applicable percentage increase under subparagraph (B)(iv).

"(IV) With respect to discharges occurring in fiscal year 2003 or any subsequent fiscal year, 100 percent of the rebased target amount, increased by the applicable percentage increase under subparagraph (B)(iv).".

SEC. 406. INCREASED FLEXIBILITY IN PROVIDING GRADUATE PHYSICIAN TRAINING IN RURAL AREAS.

(a) PERMITTING 30 PERCENT EXPANSION IN CURRENT GME TRAINING PROGRAMS FOR HOSPITALS LOCATED IN RURAL AREAS.—

(1) PAYMENT FOR DIRECT GRADUATE MEDICAL EDUCATION COSTS.—Section 1886(h)(4)(F) (42 U.S.C. 1395ww(h)(4)(F)), as added by section 4623 of BBA, is amended by inserting "(or, 130 percent of such number in the case of a hospital located in a rural area)" after "may not exceed the number".

(2) PAYMENT FOR INDIRECT GRADUATE MEDICAL EDUCATION COSTS.—Section 1886(d)(5)(B)(v) (42 U.S.C. 1395ww(d)(5)(B)(v)), as added by section 4621(b)(1) of BBA, is amended by inserting "(or, 130 percent of such number in the case of a hospital located in a rural area)" after "may not exceed the number".

(3) EFFECTIVE DATES.—(A) The amendment made by paragraph (1) applies to cost reporting periods beginning on or after October 1, 1999.

(B) The amendment made by paragraph (2) applies to discharges occurring during cost reporting periods beginning on or after October 1, 1999.

(b) SPECIAL RULE FOR NON-RURAL FACILITIES SERVING RURAL AREAS.—

(1) IN GENERAL.—Section 1886(h)(4)(H) (42 U.S.C. 1395ww(h)(4)(H)), as added by section 4623 of BBA, is amended by adding at the end the following new clause:

"(iv) NON-RURAL HOSPITALS OPERATING TRAINING PROGRAMS IN UNDERSERVED RURAL AREAS.—In the case of a hospital that is not located in a rural area but establishes separately accredited approved medical residency training programs (or rural tracks) in an underserved rural area or has an accredited training program with an integrated rural track, the Secretary shall adjust the limitation under subparagraph (F) in an appropriate manner insofar as it applies to such programs in such underserved rural areas in order to encourage the training of physicians in underserved rural areas.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) applies with respect to payments to hospitals for cost reporting periods beginning on or after October 1, 1999.

SEC. 407. ELIMINATION OF CERTAIN RESTRICTIONS WITH RESPECT TO HOSPITAL SWING BED PROGRAM.

(a) ELIMINATION OF REQUIREMENT FOR STATE CERTIFICATE OF NEED.—Section 1883(b) (42 U.S.C. 1395tt(b)) is amended to read as follows:

"(b) The Secretary may not enter into an agreement under this section with any hospital unless, except as provided under subsection (g), the hospital is located in a rural area and has less than 100 beds.".

(b) ELIMINATION OF SWING BED RESTRICTIONS ON CERTAIN HOSPITALS WITH MORE THAN 49 BEDS.—Section 1883(d) (42 U.S.C. 1395tt(d)) is amended—

(1) by striking paragraphs (2) and (3); and

(2) by striking "(d)(1)" and inserting "(d)".

(c) EFFECTIVE DATE.—The amendments made by this section take effect on the date that is the first day after the expiration of the transition period under section 1888(e)(2)(E) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(E)), as added by section 4432(a) of BBA, for payments for covered skilled nursing facility services under the medicare program.

SEC. 408. GRANT PROGRAM FOR RURAL HOSPITAL TRANSITION TO PROSPECTIVE PAYMENT.

Section 1820(g) (42 U.S.C. 1395i–4(g)), as added by section 4201(a) of BBA, is amended by adding at the end the following new paragraph:

"(3) UPGRADING DATA SYSTEMS.—

"(A) GRANTS TO HOSPITALS.—The Secretary may award grants to hospitals that have submitted applications in accordance with subparagraph (C) to assist eligible small rural hospitals in meeting the costs of implementing data systems required to meet requirements established under the medicare program pursuant to amendments made by the Balanced Budget Act of 1997.

"(B) ELIGIBLE SMALL RURAL HOSPITAL DEFINED.—For purposes of this paragraph, the term 'eligible small rural hospital' means a non-Federal, short-term general acute care hospital that—

"(i) is located in a rural area (as defined for purposes of section 1886(d)); and

"(ii) has less than 50 beds.

"(C) APPLICATION.—A hospital seeking a grant under this paragraph shall submit an application to the Secretary on or before such date and in such form and manner as the Secretary specifies.

"(D) AMOUNT OF GRANT.—A grant to a hospital under this paragraph may not exceed $50,000.

"(E) USE OF FUNDS.—A hospital receiving a grant under this paragraph may use the funds for the purchase of computer software and hardware and for the education and training of hospital staff on computer information systems and costs related to the implementation of prospective payment systems.

"(F) REPORT.—

"(i) INFORMATION.—A hospital receiving a grant under this section shall furnish the Secretary with such information as the Secretary may require to evaluate the project for which the grant is made and to ensure that the grant is expended for the purposes for which it is made.

"(ii) REPORTING.—

"(I) INTERIM REPORTS.—The Secretary shall report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate at least annually on the grant program established under this section, including in such report information on the number of grants made, the nature of the projects involved, the geographic distribution of grant recipients, and such other matters as the Secretary deems appropriate.

"(II) FINAL REPORT.—The Secretary shall submit a final report to such committees not later than 180 days after the completion of all of the projects for which a grant is made under this section.".

SEC. 409. MEDPAC STUDY OF RURAL PROVIDERS.

(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on rural providers furnishing items and services for which payment is made under title XVIII of the Social Security Act. Such study shall examine and evaluate the adequacy and appropriateness of the categories of special payments (and payment methodologies) established for rural hospitals under the medicare program, and their impact on beneficiary access and quality of health care services.

(b) REPORT.—By not later than 18 months after the date of the enactment of this Act, the Medicare Payment Advisory Commission shall submit to Congress a report on the study conducted under subsection (a).

SEC. 410. EXPANSION OF ACCESS TO PARAMEDIC INTERCEPT SERVICES IN RURAL AREAS.

(a) EXPANSION OF PAYMENT AREAS.—Section 4531(c) of BBA (42 U.S.C. 1395x(s)(7) note, 111 Stat. 452) is amended by adding at the end the following flush sentence: "For purposes of this subsection, an area shall be treated as a rural area if it is designated as a rural area by any law or regulation of the State or if it is located in a rural census tract of a metropolitan statistical area (as determined under the Goldsmith Modification, as published in the Federal Register on February 27, 1992 (57 FR 6725)).".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) takes effect on January 1, 2000, and applies to paramedic intercept services furnished on or after such date.

TITLE V—PROVISIONS RELATING TO PART C (MEDICARE+CHOICE PROGRAM)

Subtitle A—Medicare+Choice

SEC. 501. PHASE-IN OF NEW RISK ADJUSTMENT METHODOLOGY.

Section 1853(a)(3)(C) (42 U.S.C. 1395w–23(a)(3)(C)) is amended—

(1) by redesignating the first sentence as clause (i) with the heading "IN GENERAL.—" and appropriate indentation; and

(2) by adding at the end the following new clause:

"(ii) PHASE-IN.—Such risk adjustment methodology shall be implemented in a phased-in manner so that the new methodology applies only to—

"(I) 10 percent of the payment amount in 2000 and 2001;

"(II) 20 percent of such amount in 2002;

"(III) 30 percent of such amount in 2003; and

"(IV) 100 percent of such amount in any subsequent year (at which time the risk adjustment methodology should reflect data from multiple settings).".

SEC. 502. ENCOURAGING OFFERING OF MEDICARE+CHOICE PLANS IN AREAS WITHOUT PLANS.

Section 1853 (42 U.S.C. 1395w–23) is amended—

(1) in subsection (a)(1), by striking "subsections (e) and (f)" and inserting "subsections (e), (g), and (i)";

(2) in subsection (c)(5), by inserting "(other than those attributable to subsection (i))" after "payments under this part"; and

(3) by adding at the end the following new subsection:

"(i) NEW ENTRY BONUS.—

"(1) IN GENERAL.—Subject to paragraphs (2) and (3), in the case of Medicare+Choice payment area in which a Medicare+Choice plan has not been offered since 1997 (or in which any organization that offered a plan since such date has announced, as of October 13, 1999, that it will not be offering such plan as of January 1, 2000), the amount of the monthly payment otherwise made under this subsection shall be increased—

"(A) only for the first 12 months in which any Medicare+Choice plan is offered in the area, by 5 percent of the payment rate otherwise computed; and

"(B) only for the subsequent 12 months, by 3 percent of the payment rate otherwise computed.

If such 12 months are not a calendar year, the Secretary shall provide for an appropriate blend of such percentage increases for the second and third calendar years in which months described in subparagraph (B) occur to reflect the proportion of such months in each such year.

"(2) PERIOD OF APPLICATION.—Paragraph (1) shall only apply to payment for Medicare+Choice plans which are first offered in a Medicare+Choice payment area during the 2-year period beginning with January 1, 2000.

"(3) LIMITATION TO ORGANIZATION OFFERING FIRST PLAN IN AN AREA.—Paragraph (1) shall only apply to payment to the first Medicare+Choice organization that offers a Medicare+Choice plan in each Medicare+Choice payment area, except that if more than one such organization first offers such a plan in an area on the same date, paragraph (1) shall apply to payment for such organizations.

"(4) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as affecting the Medicare+Choice capitation rate for any area or as applying to payment for any period not described in such paragraph.

"(5) OFFERED DEFINED.—In this subsection, the term 'offered' means, with respect to a Medicare+Choice plan as of a date, that a Medicare+Choice eligible individual may enroll with the plan on that date, regardless of when the enrollment takes effect or the individual obtain benefits under the plan.".

SEC. 503. MODIFICATION OF 5-YEAR RE-ENTRY RULE FOR CONTRACT TERMINATIONS.

(a) IN GENERAL.—Section 1857(c)(4) (42 U.S.C. 1395w–27(c)(4)) is amended—

(1) by inserting "as provided in paragraph (2) and except" after "except";

(2) by redesignating the first sentence as a subparagraph (A) with an appropriate indentation and the heading "IN GENERAL.—"; and

(3) by adding at the end the following new subparagraph:

"(B) EARLIER RE-ENTRY PERMITTED WHERE CHANGE IN PAYMENT POLICY AND NO MORE THAN ONE OTHER PLAN AVAILABLE.—Subparagraph (A) shall not apply with respect to the offering by a Medicare+Choice organization of a Medicare+Choice plan in a Medicare+Choice payment area if—

"(i) during the 6-month period beginning on the date the organization notified the Secretary of the intention to terminate the most recent previous contract, there was a legislative change enacted (or a regulatory change adopted) that has the effect of increasing payment rates under section 1853 for that Medicare+Choice payment area; and

"(ii) at the time the organization notifies the Secretary of its intent to enter into a contract to offer such a plan in the area, there is no more than one Medicare+Choice plan offered in the area.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to contract terminations occurring before, on, or after the date of the enactment of this Act.

SEC. 504. CONTINUED COMPUTATION AND PUBLICATION OF AAPCC DATA.

(a) IN GENERAL.—Section 1853(b) (42 U.S.C. 1395w–23(b)) is amended by adding at the end the following new paragraph:

"(4) CONTINUED COMPUTATION AND PUBLICATION OF COUNTY-SPECIFIC PER CAPITA FEE-FOR-SERVICE EXPENDITURE INFORMATION.—The Secretary, through the Chief Actuary of the Health Care Financing Administration, shall provide for the computation and publication, on an annual basis at the time of publication of the annual Medicare+Choice capitation rates, of information on the level of the average annual per capita costs (described in section 1876(a)(4)) for each Medicare+Choice payment area.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act and apply to publications of the annual Medicare+Choice capitation rates made on or after such date.

SEC. 505. CHANGES IN MEDICARE+CHOICE ENROLLMENT RULES.

(a) PERMITTING ENROLLMENT IN ALTERNATIVE MEDICARE+CHOICE PLANS AND MEDIGAP COVERAGE IN CASE OF INVOLUNTARY TERMINATION OF MEDICARE+CHOICE ENROLLMENT.—

(1) IN GENERAL.—Section 1851(e)(4) (42 U.S.C. 1395w–21(e)(4)) is amended by striking subparagraph (A) and inserting the following:

"(A)(i) the certification of the organization or plan under this part has been terminated, or the organization or plan has notified the individual or the Secretary of an impending termination of such certification; or

"(ii) the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides, or has notified the in-

dividual or Secretary of an impending termination or discontinuation of such plan;".

(2) CONFORMING MEDIGAP AMENDMENT.—Section 1882(s)(3)(A) (42 U.S.C. 1395ss(s)(3)(A)) is amended, in the matter following clause (iii)—

(A) by inserting "(or, if elected by the individual, the date of notification of the individual or the Secretary by the plan or organization of the impending termination or discontinuance of the plan in the area in which the individual resides)" after "the date of the termination of enrollment described in such subparagraph"; and

(B) by inserting "(or the date of such notification)" after "the date of termination or disenrollment".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to notices of impending terminations or discontinuances made before, on, or after the date of the enactment of this Act, except that, for purposes of applying such amendments with respect to a notice of a termination or discontinuance that was made before such date and for which the termination or discontinuance occurs after such date, such notice shall be treated as having occurred on the date of the enactment of this Act.

(b) CONTINUOUS OPEN ENROLLMENT FOR INSTITUTIONALIZED INDIVIDUALS.—Section 1851(e)(2) (42 U.S.C. 1395w–21(e)(2)) is amended—

(1) in subparagraph (B)(i), by inserting "and subparagraph (D)" after "clause (ii)";

(2) in subparagraph (C)(i), by inserting "and subparagraph (D)" after "clause (ii)"; and

(3) by adding at the end the following new subparagraph:

"(D) CONTINUOUS OPEN ENROLLMENT FOR INSTITUTIONALIZED INDIVIDUALS.—At any time after 2001 in the case of a Medicare+Choice eligible individual who is institutionalized, the individual may change the election under subsection (a)(1).".

(c) CONTINUING ENROLLMENT FOR CERTAIN ENROLLEES.—Section 1851(b)(1) (42 U.S.C. 1395w–21(b)(1)) is amended—

(1) in subparagraph (A), by inserting "and except as provided in subparagraph (C)" after "may otherwise provide"; and

(2) by adding at the end the following new subparagraph:

"(C) CONTINUATION OF ENROLLMENT PERMITTED WHERE SERVICE CHANGED.—Notwithstanding subparagraph (B), if a Medicare+Choice organization eliminates from its service area a geographic area that was previously within its service area, the organization may elect to offer individuals residing in the affected geographic area who would otherwise be ineligible to continue enrollment the option to continue enrollment in a Medicare+Choice plan it offers so long as—

"(i) the enrollee agrees to receive the full range of basic benefits (excluding emergency and urgently needed care) exclusively at facilities designated by the organization within the plan service area; and

"(ii) there is no other Medicare+Choice plan offered in the area in which the enrollee resides at the time of the organization's election.".

(d) EFFECTIVE DATE.—The amendments made by subsections (b) and (c) apply as if included in the enactment of BBA.

SEC. 506. ALLOWING VARIATION IN PREMIUM WAIVERS WITHIN A SERVICE AREA IF MEDICARE+CHOICE PAYMENT RATES VARY WITHIN THE AREA.

(a) IN GENERAL.—Section 1854(c) (42 U.S.C. 1395w–24(c)) is amended—

(1) by striking "The" and inserting "Subject to paragraph (2), the";

(2) by redesignating the first sentence as a paragraph (1) with an appropriate indentation and the heading "IN GENERAL.—"; and

(3) by adding at the end the following new paragraph:

"(2) VARIATION IN PREMIUM WAIVER PERMITTED.—A Medicare+Choice organization may waive part or all of a premium described in paragraph (1) for one or more Medicare+Choice payment areas within its service area if the annual Medicare+Choice capitation rates under section 1853(c) vary between such payment area and other payment areas within such service area.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to premiums for contract years beginning on or after January 1, 2001.

SEC. 507. DELAY IN DEADLINE FOR SUBMISSION OF ADJUSTED COMMUNITY RATES AND RELATED INFORMATION.

(a) DELAY IN DEADLINE FOR SUBMISSION OF ADJUSTED COMMUNITY RATES AND RELATED INFORMATION.—Section 1854(a)(1) (42 U.S.C. 1395w–24(a)(1)) is amended by striking "May 1" and inserting "July 1".

(b) ADJUSTMENT IN INFORMATION DISCLOSURE PROVISIONS.—Section 1851(d)(2)(A)(ii) (42 U.S.C. 1395w–21(d)(2)(A)(ii)) is amended by inserting after "information described in paragraph (4) concerning such plans" the following: ", to the extent such information is available at the time of preparation of the material for mailing".

SEC. 508. 2 YEAR EXTENSION OF MEDICARE COST CONTRACTS.

Section 1876(h)(5)(B) (42 U.S.C. 1395mm(h)(5)(B)) is amended by striking "2002" and inserting "2004".

SEC. 509. MEDICARE+CHOICE NURSING AND ALLIED HEALTH PROFESSIONAL EDUCATION AND EARMARK.

Section 1886(d)(11) (42 U.S.C. 1395ww(d)(11)) is amended—

(1) in subparagraph (A)—

(A) by inserting "(i)" after ".—", and

(B) by adding at the end the following new clause:

"(ii) For portions of cost reporting periods occurring on or after January 1, 2000, the Secretary shall provide for an additional payment amount for each applicable discharge of any subsection (d) hospital that has direct costs of approved education activities for nurse and allied health professional training.";

(2) in subparagraph (C)—

(A) by inserting "(i)" after ".—";

(B) by striking "under this paragraph" and inserting "under subparagraph (A)(i)";

(C) by inserting "the DGME portion of" after "shall be equal to"; and

(D) by adding at the end the following new clauses:

"(ii) The amount of the payment under subparagraph (A)(ii) with respect to any applicable discharge shall be equal to an amount, specified by the Secretary, in a manner consistent with the following:

"(I) The total payments under such subparagraph in a year are equal to $60,000,000.

"(II) The payments to different hospitals are proportional to the direct costs of each hospital described in such subparagraph.

"(iii) For purposes of this subparagraph, the 'DGME portion' means, for a year, the ratio of—

"(I) the amount by which (aa) the Secretary's estimate of the total additional payments that would be payable under this paragraph for the year if subparagraph (A)(ii) and clause (ii) of this subparagraph did not apply, exceeds (bb) $60,000,000; to

"(II) the total additional payments estimated under subclause (I)(aa) for the year.".

SEC. 510. MISCELLANEOUS CHANGES AND STUDIES.

(a) PERMITTING RELIGIOUS FRATERNAL BENEFIT SOCIETIES TO OFFER A RANGE OF MEDICARE+CHOICE PLANS.—Section 1859(e)(2) (42 U.S.C. 1395w–29(e)(2)) is amended in the matter preceding subparagraph (A) by striking "section 1851(a)(2)(A)" and inserting "section 1851(a)(2)".

(b) STUDY OF ACCOUNTING FOR VA AND DOD EXPENDITURES FOR MEDICARE+CHOICE ENROLLEES.—The Secretary of Health and Human Services, jointly with the Secretaries of Defense and of Veterans Affairs, shall submit to Congress not later than 1 year after the date of the enactment of this Act a report on the estimated use of health care services furnished by the Departments of Defense and of Veterans Affairs to medicare beneficiaries including enrollees in Medicare+Choice plans. The report shall include an analysis of how best to properly account for expenditures for such services in the computation of Medicare+Choice capitation rates.

(c) PROMOTING PROMPT IMPLEMENTATION OF INFORMATICS, TELEMEDICINE, AND EDUCATION DEMONSTRATION PROJECT.—Section 4207 of BBA is amended—

(1) in subsection (a)(1), by adding at the end the following: "The Secretary shall make an award for such project not later than 3 months after the date of the enactment of the Medicare Balanced Budget Refinement Act of 1999. The Secretary shall accept the proposal adjudged to be the best technical proposal as of such date of enactment without the need for additional review or resubmission of proposals.";

(2) in subsection (a)(2)(A), by inserting before the period at the end the following: "that qualify as Federally designated medically underserved areas or health professional shortage areas at the time of enrollment of beneficiaries under the project";

(3) in subsection (c)(2), by striking "and the source and amount of non-Federal funds used in the project";

(4) in subsection (d)(2)(A), by striking "at a rate of 50 percent of the costs that are reasonable and" and inserting "for the costs that are related";

(5) in subsection (d)(2)(B)(i), by striking "(but only in the case of patients located in medically underserved areas)" and inserting "or at sites providing health care to patients located in medically underserved areas";

(6) in subsection (d)(2)(C)(i), by striking "to deliver medical informatics services under" and inserting "for activities related to"; and

(7) by amending paragraph (4) of subsection (d) to read as follows:

"(4) COST-SHARING.—The project may not impose cost sharing on a medicare beneficiary for the receipt of services under the project. Project costs will cover all costs to patients and providers related to participation in the project.".

SEC. 511. MEDPAC REPORT ON MEDICARE MSA (MEDICAL SAVINGS ACCOUNT) PLANS.

Not later than 1 year after the date of the enactment of this Act, the Medicare Payment Advisory Commission shall submit to Congress a report on specific legislative changes that should be made to make MSA plans a viable option under the Medicare+Choice program.

SEC. 512. CLARIFICATION OF NONAPPLICABILITY OF CERTAIN PROVISIONS OF DISCHARGE PLANNING PROCESS TO MEDICARE+CHOICE PLANS.

(a) IN GENERAL.—Section 1861(ee)(2)(H) (42 U.S.C. 1395x(ee)(2)(H)), as added by section 4431 of BBA, is amended—

(1) in clause (i)—

(A) by striking "not specify" and inserting "subject to clause (iii), not specify"; and

(B) by striking "and" at the end; and

(2) in clause (ii), by striking the period at the end and inserting ", and"; and

(3) by adding at the end the following new clause:

"(iii) for individuals enrolled under a Medicare+Choice plan, under a contract with the Secretary under section 1857, for whom a hospital furnishes inpatient hospital services, the hospital may specify with respect to such individual the provider of post-hospital home health services or other post-hospital services under the plan.".

Subtitle B—Managed Care Demonstration Projects

SEC. 521. EXTENSION OF SOCIAL HEALTH MAINTENANCE ORGANIZATION DEMONSTRATION (SHMO) PROJECT AUTHORITY.

(a) EXTENSION.—Section 4018(b) of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203), as amended by section 4014(a)(1) of BBA, is amended—

(1) in paragraph (1), by striking "December 31, 2000" and inserting "the date that is 18 months after the date that the Secretary submits to Congress the report described in section 4014(c) of the Balanced Budget Act of 1997"; and

(2) by adding at the end of paragraph (4) the following: "Not later than 6 months after the date the Secretary submits such final report, the Medicare Payment Advisory Commission shall submit to Congress a report containing recommendations regarding such project.".

(b) SUBSTITUTION OF AGGREGATE CAP.—Section 13567(c) of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66), as amended by section 4014(b) of BBA, is amended to read as follows:

"(c) AGGREGATE LIMIT ON NUMBER OF MEMBERS.—The Secretary of Health and Human Services may not impose a limit on the number of individuals that may participate in a project conducted under section 2355 of the Deficit Reduction Act of 1984, other than an aggregate limit of not less than 324,000 for all sites.".

SEC. 522. EXTENSION OF MEDICARE COMMUNITY NURSING ORGANIZATION DEMONSTRATION PROJECT.

(a) EXTENSION.—Notwithstanding any other provision of law, any demonstration project conducted under section 4079 of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–123) and conducted for the additional period of 2 years as provided for under section 4019 of BBA, shall be conducted for an additional period of 2 years.

(b) REPORT.—By not later than July 1, 2001, the Secretary of Health and Human Services shall submit to Congress a report describing the results of any demonstra-

tion project conducted under section 4079 of the Omnibus Budget Reconciliation Act of 1987, and describing the data collected by the Secretary relevant to the analysis of the results of such project, including the most recently available data through the end of 2000.

SEC. 523. MEDICARE+CHOICE COMPETITIVE BIDDING DEMONSTRATION PROJECT.

Section 4011 of BBA is amended—

(1) in subsection (a)—

(A) by striking "The Secretary" and inserting the following:

"(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary"; and

(B) by adding at the end the following:

"(2) DELAY IN IMPLEMENTATION.—The Secretary shall not implement the project until January 1, 2002, or, if later, 6 months after the date the Competitive Pricing Advisory Committee has submitted to Congress a report on each of the following topics:

"(A) INCORPORATION OF ORIGINAL FEE-FOR-SERVICE MEDICARE PROGRAM INTO PROJECT.—What changes would be required in the project to feasibly incorporate the original fee-for-service medicare program into the project in the areas in which the project is operational.

"(B) QUALITY ACTIVITIES.—The nature and extent of the quality reporting and monitoring activities that should be required of plans participating in the project, the estimated costs that plans will incur as a result of these requirements, and the current ability of the Health Care Financing Administration to collect and report comparable data, sufficient to support comparable quality reporting and monitoring activities with respect to beneficiaries enrolled in the original fee-for-service medicare program generally.

"(C) RURAL PROJECT.—The current viability of initiating a project site in a rural area, given the site specific budget neutrality requirements of the project, and insofar as the Committee decides that the addition of such a site is not viable, recommendations on how the project might best be changed so that such a site is viable.

"(D) BENEFIT STRUCTURE.—The nature and extent of the benefit structure that should be required of plans participating in the project, the rationale for such benefit structure, the potential implications that any benefit standardization requirement may have on the number of plan choices available to a beneficiary in an area designated under the project, the potential implications of requiring participating plans to offer variations on any standardized benefit package the committee might recommend, such that a beneficiary could elect to pay a higher percentage of out-of-pocket costs in exchange for a lower premium (or premium rebate as the case may be), and the potential implications of expanding the project (in conjunction with the potential inclusion of the original fee-for-service medicare program) to require medicare supplemental insurance plans operating in an area designated under the project to offer a coordinated and comparable standardized benefit package.

"(3) CONFORMING DEADLINES.—Any dates specified in the succeeding provisions of this section shall be delayed (as specified by the Secretary) in a manner consistent with the delay effected under paragraph (2).."; and

(2) in subsection (c)(1)(A)—

(A) by striking "and" at the end of clause (i); and

(B) by adding at the end the following new clause:

"(iii) establish beneficiary premiums for plans offered in such area in a manner such that a beneficiary who enrolls in an offered plan with a below average price (as established by the competitive pricing methodology established for such area) may, at the plan's election, be offered a rebate of some or all of the medicare part B premium that such individual must otherwise pay in order to participate in a Medicare+Choice plan under the Medicare+Choice program; and".

I. INTRODUCTION

A. PURPOSE AND SUMMARY

The Balanced Budget Act of 1997 (P.L. 105–33) contained more than 300 Medicare provisions and represented the most extensive reforms since the enactment of the program in 1965. Among the

changes were Medicare's expanded coverage of preventive benefits, additional choices for seniors through the new Medicare+Choice program, new tools to combat health care waste, fraud and abuse, and many initiatives to modernize and strengthen Medicare fee-for-service payment systems. New payment methodologies were established affecting virtually every segment of the health care industry including managed care plans, hospitals, skilled nursing facilities, and home health agencies.

H.R. 3075, the "Medicare Balanced Budget Refinement Act of 1999," makes necessary refinements to many of the complex program changes enacted in the Balanced Budget Act of 1997 (BBA). The provisions of H.R. 3075 are designed to strengthen and improve the Medicare program for current and future generations by addressing concerns about BBA policies that have been raised by Medicare's 39 million beneficiaries and the providers who deliver care to them.

Coupled with the legislative measures contained in H.R. 3075, the Committee believes very strongly that there are several administrative steps that the Health Care Financing Administration (HCFA) must take to ensure that the policies enacted in the BBA are implemented in a manner that reflects Congressional intent in 1997. The Committee feels very strongly that prompt attention to these administrative issues is critical in addressing the concerns that have arisen since the passage of the BBA.

H.R. 3075 was developed after receiving input from public hearings before the Committee on Ways and Means Subcommittee on Health. During these hearings, the Subcommittee received testimony from many witnesses, including representatives of beneficiary organizations, medical providers, actuaries, health economists, health plan professionals, and other experts in Medicare and healthcare policy.

B. Background and Need for the Legislation

In the years ahead, the Medicare program will face serious challenges brought on by rapid changes in the aging of the population and increasing medical costs. The ability of Medicare's current financing structure to adequately fund program growth has been a concern for many years. Since 1970, the Medicare Trustees have been predicting the imminent insolvency of the Part A Trust Fund. Not until 1995, however, did Medicare insolvency become a substantial part of the budget debate. The Balanced Budget Act of 1997 contains major revisions in Medicare payment policies designed to modernize Medicare so as to provide mechanisms to ensure quality care while slowing the rate of growth of payments to hospitals, physicians, and other providers.

When the Balanced Budget Act of 1997 was adopted, Congress utilized the data and estimates available at the time, and relied upon the Administration's representations that it could successfully implement, in a timely manner, the many programmatic changes required to curb unnecessary growth. During enactment, the Congressional Budget Office (CBO) estimated that, because of the changes initiated by the BBA, Medicare spending would be reduced by $116 billion over five years (FY 1998–FY 2002) and $393 billion over ten years. The BBA was expected to achieve the target savings

both by slowing the rate of payment growth to hospitals, physicians, and other providers and by establishing new prospective payment systems (PPS) for the reimbursement of skilled nursing facilities, hospital outpatient departments, home health agencies, and other providers. Additionally, the establishment of the Medicare+Choice program expanded coverage options for beneficiaries.

Actual Medicare spending since BBA enactment is even lower than was anticipated. For the ten-year period for which the original CBO estimates were done, the agency now expects spending to be billions of dollars less in each year. As recently as March of 1999, CBO lowered its Medicare spending estimates for the FY 1998–FY 2007 period by $229 billion. Between 1980 and 1997, Medicare spending increased at an average rate of 11% per year. In 1998, however, total Medicare outlays rose by only 1.5%. The CBO has stated that the program may experience an even smaller percentage growth increase in 1999. Commentators have attributed a portion of these changes to BBA policies, but have also recognized that other factors have played a part as well. In any event, the change in annual growth rates and the disparity between projected and realized savings since the enactment of the BBA have given the Committee, participating providers, and affected beneficiaries reason for concern.

The BBA changes had varying effects on different sectors of the health care delivery system. Similarly, within these sectors, the changes in policy have raised some specific concerns that vary accordingly. The provisions of H.R. 3075 are intended to address each of these concerns.

The Committee has heard many concerns about the effects of Medicare payment changes on the financial stability of the inpatient hospital sector. Many provisions of the BBA had an impact on inpatient facility revenues. While testimony presented to the Subcommittee on Health indicated that it has been difficult to determine the precise effects of the BBA on the hospital sector, commentators agreed that many hospital margins are in decline and under increasing pressure from both the payment reductions made in 1997 and similar payment pressures from private sector payors. With this in mind, the Committee bill seeks to provide some targeted relief with respect to particular BBA policies. Among other things, the bill provides a one-year delay in the phase-in of the indirect medical education (IME) percentage adjustment, reduces the reduction in the disproportionate share adjustment that was established by the BBA, and includes various refinements to the new payment methodologies proposed for long-term care and psychiatric hospitals and inpatient rehabilitation providers. In response to criticisms of HCFA's prospective payment system (PPS) for skilled nursing facilities (SNFs), provisions are included to provide additional payments to facilities that care for high acuity nursing patients. This is done in the form of special payment adjustments and pass-through payments for patients with specific needs. In addition, general assistance for SNFs is provided through an increase in the market basket update.

Targeted refinements in the Part B program are also included. Recommendations of the current sustainable growth rate (SGR)

system by the Medicare Payment Advisory Commission (MedPAC) prompted the Committee to include technical changes to the physician payment update mechanism, so that future updates will be more accurate and updates will not oscillate severely, as experts now predict will be the case under current law. In addition, revisions to the proposed prospective payment system for hospital outpatient services are included to help ensure that appropriate payments are made for all patients, including those whose treatment requires the utilization of costly drugs or devices. In addition, provisions implementing payment corridors are included to help hospitals with above average operating costs manage the transition to the PPS system.

In response to expressed concerns about the potential effect of BBA caps on physical therapy, occupational therapy and speech pathology services on patient access to care, the bill amends this provision to expand physical therapy and speech pathology benefits, and provides for an outlier poll to fund the inordinate therapy costs that can be incurred by high acuity patients. The bill also provides minor adjustments to ease the effects of the BBA on durable medical equipment suppliers and increases the reimbursement rate for pap smears, so as to ensure continuing access to this important preventive care benefit.

Although the Committee worked hard to address concerns about the BBA's effects on the supply of home health care agencies last year [with the passage of the Omnibus Consolidated and Emergency Supplemental Appropriations Act for Fiscal year 1999 (P.L. 105–277)], continuing concerns about instability in this area prompted the inclusion of several additional provisions designed to provide assistance to these providers so as to ensure beneficiary access to these services. The bill includes special payments to help offset the administrative costs of conducting the OASIS patient survey, delays the 15% reduction in payment rates for one year after the implementation of the PPS, and makes modifications to the surety bond requirements.

Title III also includes revisions to Medicare Direct Graduate Medical Education (DGME) payments and requires several studies, including one on geographic reclassification methodologies, that are intended to help the Committee consider the need for additional revisions to make payments more accurate in the future.

The impact of the policy changes made by the BBA on rural health care providers has been of particular concern to the Committee. Rural hospitals are often the only available medical care facility capable of serving the health care needs of a rural community's Medicare population. Yet, while critical to the region's public health, these facilities often have low volume, few resources, and have experienced the most trouble adapting to broad changes in payment methodologies initiated by the BBA. The bill seeks to address this concern by including various provisions in Title IV that are designed to help rural providers, and the beneficiaries they serve, make the transition to the post-BBA environment. Included are provisions extending the Medicare Dependent Hospital Program, several sections allowing for greater flexibility in the geographic and categorical designations of rural health facilities, augmented payments for certain non-PPS facilities, and a grant pro-

gram designed to help rural hospitals transition to Medicare's newly-required prospective payment systems.

Problems in the Medicare+Choice market have also been evident since enacted BBA policies have begun to be implemented by the Administration. Many plans have announced that they are withdrawing from the program, thus reducing the choices available to seniors. These disruptions have been compounded by wide-scale reductions in benefits by some of the plans that have decided to remain in the program. Testimony received by the Subcommittee has indicated that these changes are due to many factors, including changes made in both the payment and regulation of Medicare managed care plans. The transition to a new risk adjustment methodology, particularly the system proposed by HCA, has been of special concern.

The bill seeks to address the concerns that have arisen in the Medicare+Choice market, by including several provisions in Title V that are designed to stabilize the system. Among other things, these provisions would slow down the phase-in of HCFA's new risk adjuster, offer incentives to plans to enter markets where no Medicare+Choice plans now exist, and provide increased flexibility in several enrollment and participation rules so that beneficiaries would be more likely to retain access to Medicare+Choice plan options in the future.

C. Legislative History

Committee bill

H.R. 3075 was introduced on October 14, 1999 by Chairman Bill Thomas and was referred to the Committee on Ways and Means Subcommittee on Health and, in addition, the Committee on Commerce. The Subcommittee on Health ordered favorably reported the bill on October 15, 1999 to the full Ways and Means Committee by voice vote with no amendments. On October 21, 1999, H.R. 3075 was taken up for consideration by the full Committee. The bill was amended by an amendment in the nature of a substitute offered by Representative Thomas and reported to the House of Representatives by a roll call vote of 26 ayes and 11 nays.

The bill contains five main titles. Title I contains provisions relating to Medicare Part A and is divided into four subtitles. Subtitle A applies to acute care hospitals that are paid under the prospective payment system (PPS) and includes a one-year delay in the application of the indirect medical education (IME) adjustment and a decrease in scheduled reductions for disproportionate share hospitals. Subtitle B addresses PPS-exempt hospitals and provides enhanced payments for long-term care and psychiatric hospitals until the development of the PPS system for those facilities. It also specifies certain design components of these PPS systems and specifies certain refinements in the prospective payment system for inpatient rehabilitation services. Subtitle C addresses payments for skilled nursing facilities and includes a temporary increase in payment for certain high cost patients, an increase in payments to account for inflation, authorization for facilities to elect immediate transition to the federal rate, payment adjustments for certain ambulance services, prostheses, and chemotherapy drugs, and provi-

sions for Part B add-ons for facilities participating in the Nursing Home Case-Mix and Quality (NHCMQ) demonstration project. Subtitle D includes various technical corrections to Part A policies included in the BBA.

Title II contains provisions relating to Medicare Part B and is divided into three subtitles. Subtitle A provides for technical adjustments to the physician payment update system, so as to improve the accuracy and reduce oscillations in future payment updates. Subtitle B applies to hospital outpatient services and allows for outlier adjustments and transitional pass-through payments for certain medical devices, drugs, and biologicals. It also establishes a transitional corridor to help hospitals with above-average costs adjust to the new prospective payment system for outpatient services (OPD PPS). Subtitle C relates to other Part B issues and provides for the application of separate benefit caps to physical and speech therapy services, an outlier pool for high-cost therapy patients, an update in the renal dialysis composite rate, a temporary update in durable medical equipment and oxygen rates, an increase in the reimbursement rate for pap smear tests, and refinements in the ambulance services demonstration project.

Title III contains provisions relating to Medicare Parts A and B and is divided into three subtitles. Subtitle A applies to home health services. It provides for special payments to reflect administrative costs not included in the interim payment system (IPS) and a delay in the application of a 15 percent reduction in payment rates for home health services. In addition, it modifies current surety bond requirements for home health agencies (HHAs). Subtitle B would provide for a transition to a national average payment methodology in computing DGME payments. Subtitle C requires a study by the General Accounting Office (GAO) which would focus on refining geographic reclassification methodologies, and one by MedPAC, which would study Medicare payment policies with respect to non-physician clinical training programs.

Title IV contains provisions relating to rural providers. It includes provisions to permit the reclassification of certain urban hospitals as rural hospitals, update the standards applied for the geographic reclassification for certain hospitals, and improve the Critical Access Hospital (CAH) program. In addition, it provides for a five-year extension of the Medicare Dependent Hospital (MDH) program, allows for the re-basing of certain Sole Community Hospitals, increases flexibility in providing graduate physician training in rural areas, eliminates certain restrictions with respect to the hospital swing bed program, establishes a grant program to assist rural hospitals in the transition to prospective payment, requires a MedPAC study of rural providers, and expands access to paramedic intercept services in rural areas.

Title V contains provisions relating to Medicare Part C and is divided into two subtitles. Subtitle A applies to the Medicare+Choice program. Various provisions would restructure the phase-in of a new risk adjustment methodology, encourage the offering of Medicare+Choice plans in areas without plans, modify the five-year reentry rule for contract terminations, require the continued computation and publication of average adjusted per capita costs (AAPCC) data for each county, modify several current

Medicare+Choice enrollment rules, allow for the variation in Medicare+Choice plan premium waivers within a contractor's service area, delay the deadline for submission of adjusted community rates (ACR) proposals, extend for two years the Medicare+Choice cost contracting program, and request a MedPAC report on Medicare+Choice Medical Savings Account (MSA) plans. Subtitle B addresses several managed care demonstration projects. It would extend the Social Health Maintenance Organizations (SHMOs) and Community Nursing Organizations (CNOs) demonstration projects, and delay the Medicare+Choice competitive pricing demonstration project until 2002 or until such time as several specified reports are submitted to Congress by the Competitive Pricing Advisory Committee (CPAC).

Legislative hearings

The Committee on Ways and Means Subcommittee on Health held several hearings focusing on various Medicare payment policy issues in 1999. On February 11, 1999, the Subcommittee examined HCFA's ability to administer the current Medicare program and to manage the future needs of the program's growing number of beneficiaries. More specifically, the Subcommittee examined HCFA's inability to implement many aspects of the Balanced Budget Act within the time-frames specified in law. Some of the BBA requirements discussed were the proposed prospective payment systems for skilled nursing, hospital outpatient and home health services.

On March 2, 1999, the Subcommittee held a hearing on the annual MedPAC Report to the Congress on Medicare Payment Policy. The Subcommittee examined MedPAC's recommendations regarding Medicare Parts A and B which specifically addressed factors affecting hospitals, skilled nursing facilities, physicians and other providers. The Subcommittee also analyzed Medicare+Choice payment calculations, risk selection, and quality assurance mechanisms. In addition, on March 18, 1999, the Subcommittee held a hearing on the Medicare+Choice program to examine the Administration's proposed new risk adjustment method, dissemination of health plan information to seniors, and new plan requirements for quality measurement.

On October 1, 1999, the Subcommittee held a hearing on Medicare Balanced Budget Act refinements. The hearing provided the opportunity to hear from the Administration, Congressional advisory bodies, and providers about the implementation and impact of policy changes included in the BBA, including changes in various payment methodologies. The Subcommittee also sought input regarding a variety of potential refinements to these BBA policies.

II. EXPLANATION OF PROVISIONS

SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; REFERENCES TO BBA; TABLE OF CONTENTS

The Act may be cited as the "Medicare Balanced Budget Refinement Act of 1999."

TITLE I. PROVISIONS RELATING TO PART A

Subtitle A—PPS Hospitals

SECTION 101. ONE YEAR DELAY IN TRANSITION FOR INDIRECT MEDICAL EDUCATION (IME) PERCENTAGE ADJUSTMENT

Current law

The Balanced Budget Act of 1997 (hereafter referred to as "BBA") reduced the indirect medical education adjustment from the existing 7.7% in FY 1997 to 7.0% in FY 1998; to 6.5% in FY 1999; to 6.0% in FY 2000; and to 5.5% in FY 2001 and subsequent years.

Explanation of provisions

This provision would freeze the indirect medical education (IME) adjustment at its current FY 2000 level of 6.0% for one year (FY 2001). The IME adjustment would be decreased to 5.5% in FY 2002 and for subsequent years.

Effective date

Upon enactment.

Reason for change

This provision eases the transition to a level of the IME adjustment that is closer to its empirical estimate of approximately 4.1 percent as calculated by the Prospective Payment Assessment Commission (ProPAC) in 1997. A delay in the reduction of the IME adjustment is warranted so that teaching hospitals can adjust to the impact of the Balanced Budget Act of 1997.

SECTION 102. DECREASE IN REDUCTIONS FOR DISPROPORTIONATE SHARE HOSPITALS; DATA COLLECTION REQUIREMENTS

Current law

The BBA reduced the disproportionate share adjustment for hospitals by one percentage point each year starting in FY 1998 and continuing through FY 2002. The Secretary of Health and Human Services (hereafter referred to as "Secretary") is required to submit a report to Congress that contains a formula for a new disproportionate share adjustment.

Explanation of provision

This provision would freeze the reduction in the disproportionate share (DSH) adjustment at its current FY 2000 level of 3% for one year (FY 2001). The DSH adjustment would be reduced by 4% in FY 2002 and for subsequent years the reduction would be 0 percent. The Secretary would be required to collect data on the costs incurred in providing inpatient and outpatient uncompensated care, including bad debt and charity care.

Effective date

Upon enactment.

Reason for change

This provision eases the financial impact on hospitals for caring for a disproportionate share of low-income individuals. In addition, the Secretary is required to collect additional data necessary to develop a DSH payment methodology that takes into account the cost of serving uninsured and underinsured patients, as recommended by MedPAC. Presently, the DSH formula is based only on the costs associated with Medicaid patients and Medicare patients eligible for Supplementary Security Income (SSI). MedPAC has recommended that the formula be amended to include inpatient and outpatient costs associated with services provided to low-income patients, defined broadly to include all care to the poor. In order to develop such a revised formula, it is necessary first to collect additional data. MedPAC recommends that data be collected on patients enrolled in state and local indigent care programs, as well as uncompensated care associated with uninsured or underinsured patients. State and local indigent care programs would include nonfederally financed programs with specific eligibility criteria for specified health care services. Financial data on state and local appropriations that offset uncompensated care expenses should also be collected. Uncompensated care costs and charges are those identified more typically as bad debt and charity care. While the Committee recognizes that there may be problems in defining and appropriately measuring such costs and charges in a way that avoids duplication, such problems can best be overcome by developing standard definitions at the national level. The Committee expects the Secretary to report on the financial interactions and potential for shifts between Federal and State governments.

Subtitle B—PPS Exempt Hospitals

SECTION 111. WAGE ADJUSTMENT TO PERCENTILE CAP FOR PPS—EXEMPT HOSPITALS

Current law

Psychiatric, rehabilitation, and long-term care providers, including separate facilities and qualified distinct part units in acute general hospitals, were excluded from the Medicare inpatient prospective payment system (PPS) when the system was implemented in FY 1984. These Medicare providers are subject to the payment limitations and incentives established by the Tax Equity and Fiscal Responsibility of 1982 (TEFRA) as modified by the BBA.

Generally speaking, these PPS-exempt providers are paid based on their costs per discharge, subject to provider-specific limits established by TEFRA and to national limits established by the BBA. The provider's target amount is based on its Medicare allowable costs per discharge in a base year, inflated to the current year by an annual update factor. A national limit or cap amount is calculated for these 3 classes of PPS-exempt providers. Each provider's limit is the lesser of its target or cap amount. Generally, a provider with costs per discharge under its limit is rewarded with a bonus payment while a provider with costs per discharge above its limit receives a relief payment.

The BBA established a national cap on the TEFRA limits for PPS-exempt hospitals and units in cost reporting periods, beginning on or after October 1, 1997 and before October 1, 2002. The cap is set at the 75th percentile of the target amount for each class of provider in FY 1996, updated each year by the increase in the hospital market basket. There is currently no provision for a wage adjustment of the percentile cap used to set limits for established PPS-exempt providers.

Explanation of provision

The provision would require the Secretary to recalculate the 75th percentile cap to reflect differences in wage-related costs across geographic areas and also to adjust the cap for differences in wage-related costs when applied to new TEFRA hospitals.

Effective date

The provision would be effective for cost reporting periods beginning on or after October 1, 1999.

Reason for change

This provision makes the appropriate adjustment to recognize differences in wage-related costs across geographic areas for TEFRA hospitals.

SECTION 112. ENHANCED PAYMENTS FOR LONG-TERM CARE AND PSYCHIATRIC HOSPITALS UNTIL DEVELOPMENT OF PROSPECTIVE PAYMENT SYSTEMS FOR THOSE HOSPITALS

Current law

The BBA established the amount of bonus and relief payments payable to eligible PPS-exempt providers. A provider with costs under its limit is rewarded with a bonus payment that is equal to the lesser of: (1) 15% of the amount by which the target amount exceeds the amount of operating costs; or (2) 2% of the target amount. In addition, eligible hospitals could also receive an increased bonus payment (called a continuous improvement payment) equal to the lesser of: (1) 50% of the amount by which the eligible hospital's operating costs are less than those expected for the period; or (2) 1% of the target amount of the period.

Explanation of provision

The provision would increase the continuous improvement bonus payments from 1% to 1.5% for cost reporting periods beginning on or after October 1, 2000 and before September 30, 2001, and to 2% for cost reporting periods beginning on or after October 1, 2001 and before September 30, 2002. Only psychiatric hospitals, psychiatric units exempt from the PPS and long-term care hospitals would be eligible for these payments.

Effective date

The provision would be effective for cost reporting periods beginning on or after October 1, 2000.

Reason for change

This provision would provide temporary relief to eligible PPS-exempt hospitals and units until a prospective payment system is implemented for these providers.

SECTION 113. PER DISCHARGE PROSPECTIVE PAYMENT SYSTEM FOR LONG-TERM CARE HOSPITALS

Current law

The BBA requires the Secretary to collect data to develop, establish, administer, and evaluate a case-mix adjusted prospective payment system (PPS) for long-term care hospitals. The Secretary is required to develop a legislative proposal for establishing and administering a payment system that includes an adequate patient classification system that reflects differences in patient resource use. The Secretary may require these hospitals to submit necessary data to develop this proposal. The Secretary is instructed to consider several payment methodologies including the feasibility of expanding the diagnosis-related groups (DRGs) and inpatient PPS for acute hospitals established under section 1886(d) of the Social Security Act. The Secretary's legislative proposal is due to the appropriate Congressional committees no later than October 1, 1999.

Explanation of provision

The provision would require the Secretary to report to Congress by October 1, 2001 on a prospective payment system (PPS) for long-term care hospitals, based on DRGs, per discharge payment. The PPS would then be implemented in a budget neutral manner beginning October 1, 2002.

Effective date

Upon enactment.

Reason for change

This provision clarifies the type of prospective payment system, a per discharge system based on DRGs, that should be designed for long-term care hospitals. It also specifies budget neutrality and the time frame for implementation. In developing and evaluating the new PPS system, the Committee encourages the Secretary to measure the quality of outcomes.

SECTION 114. PER DIEM PROSPECTIVE PAYMENT SYSTEM FOR PSYCHIATRIC HOSPITALS

Current law

There is currently no provision for a prospective payment system for psychiatric hospitals.

Explanation of provision

The provision would require the Secretary to report to Congress by October 1, 2001 on a prospective payment system (PPS) for psychiatric hospitals and distinct part units, based on a per diem payment. The PPS would then be implemented in a budget neutral manner beginning October 1, 2002.

Effective date

Upon enactment.

Reason for change

This provision clarifies the type of prospective payment system, a per diem system, that should be designed for psychiatric hospitals and PPS-exempt psychiatric units. It also specifies budget neutrality and the time frame for implementation. In developing and evaluating the new PPS system, the Committee encourages the Secretary to measure the quality of outcomes. The Committee notes a recent GAO report ("Mental Health: Improper Restraint or Seclusion Use Places People at Risk") concerning unnecessary deaths and lack of reporting by institutions on death and injury from the use of restraints and seclusion. The Committee urges the Secretary to examine the cause of these unnecessary deaths.

SECTION 115. REFINEMENT OF PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT REHABILITATION SERVICES

Current law

The BBA requires the Secretary to establish a case-mix adjusted prospective payment system (PPS) for rehabilitation hospitals and distinct part units, effective October 1, 2000. The system is designed to be phased-in over a three-year period with an increasing percentage of the base amount based on the PPS amount. Total payments are to be set to equal 98% of the amount that would have been paid if the PPS had not been enacted.

Explanation of provision

This provision would allow rehabilitation facilities to elect the full national prospective rate upon implementation of the prospective payment system instead of a gradual transition. The rates are adjusted in each year to ensure that aggregate payments do not increase. The Secretary is also directed to use discharges as the payment unit for the new PPS to improve the Functional Independence Measure-Function-Related Groups. Within three years of implementation, the Secretary is required to report to Congress on the impact of the prospective payment system on utilization and access to services.

Effective date

Upon enactment.

Reason for change

This provision would allow rehabilitation facilities increased flexibility in adjusting to the new prospective payment system.

Subtitle C—Adjustments to PPS Payments for Skilled Nursing Facilities

SECTION 121. TEMPORARY INCREASE IN PAYMENT FOR CERTAIN HIGH COST PATIENTS

Current law

The BBA required the Secretary to implement a prospective payment system for skilled nursing facility care starting in July 1998. The prospective payment system outlined in the BBA is based on the Resource Utilization Group (RUG) design that HCFA developed over several years and tested on a demonstration project basis. The RUG system requires skilled nursing facilities (SNFs) to categorize their Medicare patients according to 44 hierarchical groups based on the kinds and intensities of care and services they need. For example, patients needing mostly physical therapy or speech therapy of different intensities use different kinds and amounts of resources than patients needing such things as skilled nursing care, intravenous feeding or medications, extensive laboratory testing, or use of a respirator, and such patients would be assigned to different groups. The SNF prospective payment system provides facilities a fixed amount per day per patient (a "per diem" payment), with the amount of the payment determined by the RUG into which the patient is classified. This RUG classification system serves as the case-mix adjustment that is used to relate program payment to individual patient characteristics and resource use.

The BBA instructed the Secretary how to: (a) compute average per diem payment rates using Medicare-approved SNF costs in 1995 as the base year; (b) adjust the average rates for facility case-mix and geographic differences; and (c) update the per diem rates for years after 1995. This methodology aims at setting the prospective payment system per diem amounts in a budget neutral manner relative to payments that would have been made before the PPS. The law specifies limited updates to payments under the RUG system in future years.

Explanation of provision

This provision would temporarily increase the Federal portion of the rates by 10 percent for 12 RUGs in the "Extensive Services," "Special Care" and "Clinically Complex" categories to adjust for the costs of medically complex patients. Payments would be increased from April 1, 2000 through September 30, 2000 at which time the Secretary is expected to make refinements to the case-mix measure and adjust the average rates for case-mix with more refined data on intensity than had been available at the inception of the PPS.

Effective date

Upon enactment.

Reason for change

Independent research has demonstrated that the RUG categories containing medically complex patients have higher average per diem costs than the average per diem payment rates. The Committee has proposed increases in payments for certain RUG cat-

egories so that access to SNF services is not impaired. This provision temporarily increases payments for certain medically complex patients in specified RUG categories for a 6-month period until the Secretary can implement a case-mix adjustment based on refined data.

SECTION 122. MARKET BASKET INCREASE

Current law

The BBA requires the Secretary to update the Federal per diem for skilled nursing facilities by the skilled nursing facility market basket minus one percentage point in FY 2000. In FY 2001 and 2002, the rate would be updated by market basket minus one percentage point.

Explanation of provision

The provision would increase the update for FY 2001 to the skilled nursing facility market basket plus 0.8 percentage points. For FY 2002 and subsequent years, the update would remain as specified by the BBA.

Effective date

Upon enactment.

Reason for change

This provision would provide a greater-than-market basket increase because aggregate payments to skilled nursing facilities have been significantly lower than anticipated. The Committee encourages the Secretary to determine the cost and utilization of new technologies and medications that are used in the treatment of SNF patients.

SECTION 123. AUTHORIZING FACILITIES TO ELECT IMMEDIATE TRANSITION TO FEDERAL RULE

Current law

The BBA requires that the SNF prospective payment system be phased in over 3 years starting July 1, 1998 (or the first date thereafter on which a SNF started a new annual cost reporting period). During this phase-in period, the per diem payment to each SNF is based part on the facility's Medicare-covered costs in 1995 with certain updates (the "facility-specific" component of the prospective payment system), and in part of the new federal per diem prospective payment. During the 3-year phase-in period starting in 1998, a SNF receives per diem rates that are a "blend" of 75% of the facility-specific rate and 25% of the federal per diem rate, and the proportions of facility-specific rates to federal per diem rates shift annually by 25 percentage points until the federal prospective payment system rate equals the full payment.

Explanation of provision

This provision would permit skilled nursing facilities to choose to receive the full Federal rate.

Effective date

Skilled nursing facilities could elect the full Federal rate 60 days after enactment.

Reason for change

This provision allows those skilled nursing facilities that have experienced increases in volume or case mix since the 1995 base year to choose the Federal rate instead of a facility-specific and Federal blended rate, thus providing them with increased flexibility.

SECTION 124. PART A PASS-THROUGH PAYMENT FOR CERTAIN AMBULANCE SERVICES, PROSTHESES AND CHEMOTHERAPY DRUGS

Current law

The per diem amounts Medicare pays SNFs under the prospective payment system include the costs of "ancillary services" needed by Medicare patients. These services include restorative therapies, laboratory services, drugs, supplies, prosthetic devices, and equipment. Thus, SNFs do not receive separate payments for these services and items in addition to the per diem payment.

Explanation of provision

This provision would exclude certain services and items from the per diem amounts that Medicare pays to SNFs because of their relatively rate occurrence and high cost. They would be paid for separately starting April 1, 2000. These services include ambulance services furnished in conjunction with renal dialysis services, specific chemotherapy items, chemotherapy services, radioisotopes services, and customized prosthetic devices, such as artificial limbs. Base payment rates would not be adjusted to account for the exclusion of these services and items in FY 2000, but beginning in FY 2001, the Secretary would provide for an appropriate reduction in payments so that the exclusion of the above items would be budget neutral.

Effective date

April 1, 2000.

Reason for change

Some services and items furnished in SNFs are very high cost but very infrequent events. This provision would exclude certain specified services and items from the per diem amounts that Medicare pays to SNFs and pay for them separately. While the bill exempts ambulance services for ESRD patients, the Committee notes that, in many cases, regularly scheduled trips may be made in vehicles that are less costly than an Advanced or Basic Life Support ambulance, and the Committee urges that SNFs use these cost-saving services appropriately.

SECTION 125. PROVISION FOR PART B ADD-ONS FOR FACILITIES PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT

Current law

A demonstration project known as the Nursing Home Case Mix and Quality (NHCMQ) demonstration project preceded implementation of the SNF prospective payment system. Skilled nursing facilities that participated in that demonstration project do not have the cost of Medicare Part B services to SNF patients accounted for under the facility-specific component of the prospective payment system during the transition period as do other SNFs, although their federal per diem amounts are higher than those for other SNFs.

Explanation of provision

This provision would treat skilled nursing facilities that participated in the demonstration project in the same way as other skilled nursing facilities by accounting for the cost of Medicare Part B services to SNF patients under the facility-specific component of the prospective payment system during the transition period to a prospective payment system.

Effective date

This provision would become effective as if it were included in the BBA.

Reason for change

HCFA has interpreted inadvertent placement of the Part B provisions in the BBA as Congressional intent that these facilities should not receive payments for Part B services to facility-specific rates for participants in the RUG III demonstration project. This provision would clarify that these facilities should be treated as other SNFs in receiving payment for Part B services under the facility-specific component.

SECTION 126. SPECIAL CONSIDERATION FOR FACILITIES SERVICING SPECIALIZED PATIENT POPULATIONS

Current law

The SNF prospective payment system provides facilities a fixed amount per day per patient (a "per diem" payment), with the amount of the payment determined by the Resource Utilization Group (RUG) into which the patient is classified. This RUG classification system serves as the case-mix adjustment that is used to relate program payment to individual patient characteristics and resource use, but the RUG system is not diagnosis-based. As a result, certain types of patients may not be classified accurately for payment purposes.

Explanation of provision

This provision would allow for payments based on costs for certain skilled nursing facilities that threat very specialized patients, who are immuno-compromised secondary to an infectious disease with specific diagnoses. These payments would be made for a lim-

ited time until the Secretary reports no later than within one year of enactment on the resource use of these patients and whether any permanent adjustment is necessary.

Effective date

This provision applies beginning on the date of the first cost reporting period that begins after enactment and ends on September 30, 2001.

Reason for change

This provision would adjust payment for certain patients whose medical conditions are not well-accounted for in the RUG classification system.

SECTION 127. MEDPAC STUDY ON SPECIAL PAYMENT FOR FACILITIES LOCATED IN HAWAII AND ALASKA

Current law

Skilled nursing facility payments are adjusted by a wage index, but no adjustment is made for the special circumstances of skilled nursing facilities in Alaska and Hawaii.

Explanation of provision

This provision would require the Medicare Payment Advisory Commission (MedPAC) to study the need for a special adjustment for Alaska and Hawaii and submit a report to Congress within 18 months of enactment.

Effective date

Upon enactment.

Reason for change

This provision would assist the Congress in determining whether a special adjustment for skilled nursing facilities in Alaska and Hawaii is necessary.

Subtitle D—Other

SECTION 313. PART A TECHNICAL CORRECTIONS

Current law

Part A of Medicare law was amended by various provisions in the BBA.

Explanation of provision

This provision makes miscellaneous grammatical, cross-reference, or similar technical changes in parts of the BBA relating to Part A of the Medicare program.

Effective date

As if included in enactment of the BBA.

Reason for change

This provision would make technical corrections.

TITLE II. PROVISIONS RELATING TO PART B

Subtitle A—Adjustments to Physician Payment Updates

SECTION 201. MODIFICATION OF UPDATE ADJUSTMENT FACTOR PROVISIONS TO REDUCE UPDATE OSCILLATIONS AND REQUIRE ESTIMATE REVISIONS

Current law

The conversion factor is a dollar figure that converts the geographically adjusted relative value into a dollar payment amount. This amount is updated each year according to a formula established in law. Beginning in 1999, the update percentage equals the Medicare Economic Index (MEI), subject to an adjustment to match target spending for physician services under the sustainable growth rate (SGR) system. In no case can the adjustment be more than three percentage points above or seven percentage points below the MEI.

Four factors make up the SGR: (1) changes in spending due to fee increases; (2) fee-for-service enrollment; (3) gross domestic product (GDP) growth per capita, and; (4) laws and regulations. Data from various measurement periods are used for the SGR calculation. Time lags between these measurement periods can lead to oscillation in conversion factor updates.

Explanation of provision

Subsection (a) provides for technical changes to limit oscillations in the annual update to the conversion factor used to determine physician payment rates beginning in CY 2001. This is accomplished in three ways. First, the provision requires that future update adjustment factors be calculated using data measured on a calendar year basis. This will ensure that the time periods used in the update adjustment formula conforms to the calendar system, which is used for actually updating payments. In addition, the provision modifies the formula for determining the update adjustment factor. In adds a new component to the formula to measure past year variances from allowed spending growth. This measure is to be used in conjunction with the existing fomular component that measures cumulative spending variances from the sustainable physician payment baseline established in 1997. In addition, the impact of these measures on the update formula is mitigated by the addition of dampening multipliers. Both formula changes are designed to lessen oscillations in the annual update adjustment factor and will make annual adjustments in the conversion factor less severe.

The subsection includes language requiring the Secretary to develop CY 1999 allowed expenditure targets based on current law so that a budget neutral transition to the calendar year system can begin with CY 2000. Similarly, provisions for special adjustments to the payment updates for CY 2001 to CY 2005 are specified so as to make the transition to the revised updated adjustment factor formula budget neutral. The subsection also clarifies that the Secretary make available annual updates to the conversion factor on November 1, while adding a new requirement that the Secretary make available an early estimate of such conversion factor by

March 1 each year. In addition, MedPAC is instructed to review this early estimate and comment on it in its annual report to Congress. The subsection also includes conforming technical amendments.

Subsection (b) includes related changes to the existing sustainable growth rate provision in Section 1848(f) of the Social Security Act. These provisions clarify that starting in CY 2000 the sustainable growth rate is also to be determined on a calendar year basis. The date for publishing applicable rates is moved to November 1, and the Secretary is required to begin using the best available data to revise prior estimations of the sustainable growth rate for up to two years after such an estimate is first published. This provision is phased in on a prospective basis to ensure budget neutrality.

Effective date

The changes made by this section are to be effective in determining the conversion factor for physician services for years beginning with 2001.

Reason for change

MedPAC recommended these changes to improve the accuracy of physician payment updates, and to reduce the magnitude of future oscillations in the update factor.

The Committee is also concerned about other physician payment issues. The BBA instructed the Secretary to develop resource-based practice expense relative to value units (RVUs) to use in calculating relative payment values under the Medicare physician fee schedule. The Committee agrees with recent observations made by MedPAC and the General Accounting Office that these practice expense RVUs may require refinement during the transition period. Thus, the Committee urges the Secretary to work with all interested parties to develop and implement appropriate procedures to ensure the accuracy of the practice expense RVUs as the transition to the resource-based fee schedule continues. The Committee also notes that it will continue to examine these activities to ensure that HCFA's actions are consistent with the provision of high quality medical care in all settings.

With regard to physician supervision of anesthesia services under Medicare's Conditions of Participation, if the Secretary determines that there is insufficient current scientific data comparing mortality and adverse outcome rates in the provision of anesthesia services to Medicare patients, the Secretary should conduct a comparative outcome study and report back to the Committee.

If the Secretary believes that she has sufficient mortality and quality information regarding the provision of anesthesia services by nurse anesthetists and anesthesiologists, then she should make appropriate regulatory changes to ensure access to quality care for Medicare beneficiaries.

Subtitle B—Hospital Outpatient Services

SECTION 211. OUTLIER ADJUSTMENT AND TRANSITIONAL PASS-THROUGH FOR CERTAIN MEDICAL DEVICES, DRUGS, AND BIOLOGICALS

Current law

The BBA directed the Secretary to implement a prospective payment system for hospital outpatient departments in 1999. However, HCFA delayed implementation of the new system until after the start of CY 2000 in order to ensure that "year 2000" data processing problems are fully resolved before the new system is implemented. HCFA currently estimates that the outpatient department prospective payment system will be implemented in July 2000.

The BBA required that the outpatient prospective payment system be designated so that the payments to hospital outpatient departments would equal the aggregate amount that would have been paid to hospitals in 1999 under old law, prior to the prospective payment system. The law also changes the coinsurnace amounts that beneficiaries would be required to pay for hospital outpatient services.

Explanation of provision

The provision would create an outlier adjustment and a transitional pass-through for certain medical devices, drugs, and biologicals. The policy would be implemented on a budget neutral basis. The outlier payments would be made for exceptionally high cost cases. The variation in costs of services within a group would be limited to no more than two times greater than the lowest median cost (or mean cost, if the Secretary chooses) for an item or service within a group. From implementation until 2004, the outlier pool would be up to 2.5 percent of aggregate payment. For 2004 and beyond, the outlier pool would be up to 3 percent.

The transitional pass-through would allow for additional payments for orphan drugs, cancer therapy drugs and biologicals, and new medical devices, drugs, and biologicals. The Committee intends for the Secretary to include in the definition of cancer therapy products anti-cancer chemotherapeutic agents, as well as supportive care drugs and biologicals (including, but not limited to, antiemetics, hematopoietic growth factors, colony stimulating factors, bisphosphonates, and biological response modifiers) used to treat cancer and the symptoms and side-effects of cancer and chemotherapy. A medical device, drug or biological would be considered "new" if payments were not made for these items before December 31, 1996. Any individual device, drug, or biological would be given the pass-through for a period of at least two, but not more than three years. The transitional pass-through pool would be 2.5 percent from implementation until 2003. For years 2004 and beyond, the pool would be 2 percent.

The Secretary is required to conduct a study of intravenous immune globulin (IVIG) services in setting other than hospital outpatient departments and physicians' offices to be completed within one year of the date of enactment. The Secretary should make recommendations on the appropriate manner and settings under

which Medicare should pay for these services delivered outside a hospital or physician's office.

Effective date

Upon implementation of the hospital outpatient prospective payment system. The report on IVIG should be submitted to Congress within one year of enactment.

Reason for change

The Committee believes that HCFA plans for implementing the outpatient prospective payment system (PPS), as described in HCFA's September 7, 1998 proposed regulation, raise many concerns. The proposal: (1) fails to provide adjustments for high cost care; (2) does not adequately provide a transition to include medical devices, drugs and biologicals in the system, and; (3) will not be updated annually to keep pace with changes in technology and medical practice. The Committee is making several structural changes to improve the design of the outpatient PPS and to assure that patients are not denied access to needed care.

In the proposed regulation, HCFA classified many different services with varying costs into a single payment group. In one example, brachytherapy has been placed in a group with other procedures that are much less costly. This could provide disincentives to use this technology. The Committee believes that while some level of variation is unavoidable, there should not be wide variation that could potentially restrict access to the most costly services. To address this problem, that provision would place an upper limit on the variation of costs among services included in the same group. The most costly item or service in a group could not have a mean or median cost that was more than twice the mean or median cost of the least costly item or service in the group. To provide additional flexibility, the Committee gives the Secretary the option to base the relative payment weights on either the mean or median cost of the items and services in a group.

The Committee recognizes that there may be unusual cases, such as low volume items and services, and the Secretary is given discretion to exempt these exceptional cases from the limitation. The Committee expects that the Secretary would not use this exception to include orphan drugs in a group that contains very different resources.

In the proposed regulation, HCFA stated its intention not to update the payment groups and rates annually. This is different from the agency's process of annually updating the inpatient prospective payment system. Given the rapid pace of technological change as well as changes in medical practice, the Committee requires the Secretary to review the outpatient payment groups and amounts annually and to update them as necessary.

The BBA gave the Secretary the discretion to make additional payments (called outlier payments) to hospitals for particularly costly costs. The Committee would require the Secretary to make outlier payments in a budget neutral manner and in a similar way as is currently done in the inpatient PPS. The outlier pool would be established at any level up to 2.5 percent of total payments for

the first three years under the new system. After the third year, the pool could be set at any level up to 3 percent of total payments.

While the statutory provisions for the inpatient PPS require an outlier pool equal to a level between 5 and 6 percent of total inpatient PPS payments, the Committee believes that the lower levels of 2.5 and 3.0 percent are more appropriate for the outpatient PPS because the outpatient PPS will make separate payments for most individual services performed during an outpatient encounter. The allowed upper limit on the size of the pool is increased after the third year because the need for outlier payments may increase after the temporary add-on payments for drugs and biologicals, described below, are replaced with a transitional provision that applies only to new products.

The Committee is concerned that HCFA's proposed payment system does not adequately address issues pertaining to the treatment of drugs, biologicals and new technology. The Committee believes that these oversights could lead to restricted beneficiary access to drugs, biologicals and new technology. The provisions would establish transitional payments to cover the added costs of certain services involving the use of medical devices, drugs and biologicals. Hospitals using these drugs, biologicals and devices would be eligible for additional payments.

The duration of the transitional payment would be for a period of at least two years but not more than three years. For drugs and biologicals used in cancer therapy and orphan drugs, the period would begin with the implementation date of the outpatient PPS. This also would be the period applicable to medical devices first paid as an outpatient hospital service after 1996 but before implementation of the outpatient PPS (as well as for any other item or service eligible for the additional payments at the inception of the outpatient PPS because of insufficient data or use of the Secretary's discretion). For products first paid as an outpatient service after implementation of the outpatient PPS, the transitional payment would begin with the first date on which payment is made for the device, drug or biological as an outpatient hospital service and continue for at least two, but no more than three, years.

The Committee expects the Secretary to develop a process to deal with new devices, drugs and biologicals introduced after the outpatient fee schedule for a particular year has been set. This process should include assigning an appropriate code (or codes) to the product and establishing the amount of the add-on payment. New codes and add-on payment amounts should be made effective quarterly.

The amount of the additional payment to hospitals, before applying the limitation described below, should equal the amount specified for the new technology less the average cost included in the outpatient payment schedule for the existing technology. Specifically, for drugs and biologicals, the amount of the additional payment is the amount by which 95 percent of the Average Wholesale Price (AWP) exceeds the portion of the applicable outpatient fee schedule amount that the Secretary determines is associated with the drug or biological. Similarly, for new medical devices, the add-on payment is the amount by which the hospital's charges for the device, adjusted to cost, exceed the outpatient fee schedule amount associated with the device.

The total amount of additional payments in a year should not exceed a prescribed percentage of total projected payments under the outpatient prospective payment system. The applicable percentages are: (1) 2.5 percent for the first three years after implementation of the new outpatient payment system; and (2) up to 2.0 percent in subsequent years. In setting the hospital outpatient department (OPD) rates and add-on amounts for a particular year, the Secretary will estimate the total amount of additional payments that would be made based on the add-on amounts specified above and the expected utilization for each service. If the estimated total amount exceeds the percentage limitation, the Secretary will apply a pro rata reduction to the add-on payment amounts so that projected total payments are within the limitation.

The Committee wishes to make it clear that these changes are budget neutral, and do not alter the rules for determining the beneficiary coinsurance. As specified in the BBA, beneficiary coinsurance for each service or group of services is frozen at 20 percent of the median charge for the service (or group of services) in 1996 (adjusted to 1999 to account for inflation). The coinsurance amount remains frozen at that level until it equals 20 percent of the outpatient fee schedule.

On a related policy, the Committee notes that, while Medicare covers drugs and biologicals that are administered in a hospital or physician office, the program does not cover these therapies if they are self-administered by the patient at home for the treatment of the same disease or condition, even though this may in some cases be more cost-effective. With this in mind, the Committee asks the Secretary to review current coverage policy with respect to self injectable biologicals that may provide alternative therapies (than those currently covered by Medicare) for use in the treatment of chronic diseases, including rheumatoid arthritis. The Secretary should consider the costs and methods of administration when assessing the efficacy, safety, and costs of currently covered therapies as compared to self-administrable therapeutic alternatives.

SECTION 212. ESTABLISHING A TRANSITIONAL CORRIDOR FOR APPLICATION OF OPD PPS

Current law

The BBA required the Secretary to implement a prospective payment system for hospital outpatient departments (OPD) in 1999. One of the objectives of the PPS was to contain future rates of cost growth.

Explanation of provision

The provision would establish a three-year corridor system whereby a hospital would receive additional payments if their payments under the new system were less than their payments under the pre-BBA 1997 payment method. During years before January 1, 2002, hospitals would receive 80% of their first 10% of losses, 70% of the next 10% of losses, and 60% of the next 10% of losses. During the second year, the adjustments would change to 70% of the first 10% of losses, and 60% of the next 10% of losses. In the third year, hospitals would receive 60% of their first 10% of losses.

The Secretary is required to submit a report and recommendations to Congress by July 1, 2002 on whether a hospital outpatient prospective payment system (PPS) should continue to apply to Medicare Dependent Hospitals, Sole Community Hospitals, rural health clinics, rural referral centers, and other rural hospitals.

Effective date

Upon implementation of the hospital outpatient prospective payment system.

Reason for change

This provision provides a temporary transition for hospitals to adjust to the new prospective payment system. The approach is intended to offer incentives for improving efficiency while protecting hospitals from large financial losses. The study to be conducted by the Secretary is necessary to assess the impact of the PPS on rural health care providers and to determine whether these rural providers should remain subject to the outpatient PPS after the transitional corridor has ended.

SECTION 213. DELAY IN APPLICATION OF PROSPECTIVE PAYMENT SYSTEM TO CANCER CENTER HOSPITALS

Current law

The BBA permitted the Secretary to delay by one year the application of the outpatient prospective payment system to cancer center hospitals.

Explanation of provision

This provision would direct the Secretary to delay the application of the outpatient prospective payment system to services furnished by cancer center hospitals until the first day of the first year that begins two years after the outpatient PPS is implemented.

Effective date

Upon enactment.

Reason for change

The Committee is concerned about the impact of the new outpatient PPS on caner center hospitals and directs the Secretary to exempt these centers from the outpatient PPS for two years so that the potential impact of the new payment method on these centers can be assessed.

SECTION 214. LIMITATION ON OUTPATIENT HOSPITAL COPAYMENT FOR A PROCEDURE TO THE HOSPITAL DEDUCTIBLE AMOUNT

Current law

Currently, beneficiaries pay 20 percent of charges for outpatient services.

Explanation of provision

This provision would limit the beneficiary copayment amount on outpatient services to the inpatient hospital Part A deductible amount.

Effective date

Upon implementation of the hospital outpatient prospective payment system.

Reason for change

As services and procedures are moved from the inpatient to the outpatient setting, the Committee believes that beneficiary obligations should be held to the amount of the inpatient hospital Part A deductible. The Committee believes that the limitation of beneficiary copayments to no more than the cost of the hospital deductible ($776 in 2000) is an appropriate modification. There are some medical procedures where the beneficiary copay exceeds the hospital deductible. In several cases, the beneficiary faces a $2000 or $3000 bill. This provision is an important protection for beneficiaries and ensures that the hospital outpatient department reforms of the BBA provide some immediate help in high-cost cases.

Subtitle C—Other

SECTION 221. APPLICATION OF SEPARATE CAPS TO PHYSICAL AND SPEECH THERAPY SERVICES

Current law

The BBA established annual payment limits for all outpatient therapy services provided by non-hospital providers. The limits apply to services provided by independent therapists as well as to those provided by comprehensive outpatient rehabilitation facilities (CORFs), skilled nursing facilities (under Part B), and other rehabilitation agencies. The limits do not apply to outpatient services provided by hospitals.

There are two per beneficiary limits. The first is a $1,500 per beneficiary annual cap for all outpatient physical therapy services and speech language pathology services. The second is a $1,500 per beneficiary annual cap for all outpatient occupational therapy services. Beginning in 2002, the amount will increase by the Medicare Economic Index (MEI), rounded to the nearest multiple of $10.

Explanation of provision

The provision would create separate $1,500 caps for physical therapy and speech-language pathology services which would be applied to services furnished on a per beneficiary, per facility (or provider) basis. The cap on occupational therapy services would also be applied on a per beneficiary, per facility (or provider) basis.

Effective date

This provision would become effective for services furnished on or after January 1, 2000.

Reason for change

The Committee believes that this provision would provide additional flexibility under the caps while maintaining the need to control the growth of therapy services.

SECTION 222. TRANSITIONAL OUTLIER PAYMENTS FOR THERAPY SERVICES FOR CERTAIN HIGH ACUITY PATIENTS

Current law

The therapy caps established by the BBA apply to all outpatient therapy services provided by non-hospital providers. The caps apply equally to all beneficiaries regardless of the amount of services needed or their acuity level.

The BBA requires the Secretary to report to Congress, no later than January 1, 2001, recommendations for a revised coverage policy of outpatient physical therapy services and outpatient occupational therapy services. This revised policy would be based on a classification of individuals by diagnostic category and prior use of services, in both inpatient and outpatient settings. This would be in place of uniform dollar limitations. The recommendations are required to include how a system of durational limits by diagnostic category might be implemented in a budget neutral manner.

Explanation of provision

This provision directs the Secretary to establish a process so that a facility could apply to the Secretary for an increase in the limit for services furnished in CY 2000 and CY 2001. The process would take into account clinical diagnosis and would not exceed $40 million in FY 2000, $60 million in FY 2001 and $20 million in FY 2002.

Effective date

This provision is in effect for CY 2000 and CY 2001.

Reason for change

This provision recognizes that some individuals who require intensive and frequent therapy services are unable to receive these services in a hospital outpatient department, and therefore, may exceed the caps that are applied in other settings. By providing for outlier payments for certain high acuity patients, these high cost individuals would have greater access to these services. The Committee is concerned that HCFA has taken no significant action yet to develop the report called for in the BBA which would enable payment for outpatient rehabilitation services on the basis of a classification of individuals by diagnostic category and prior use of services. The development of such a system is essential to replacing the system of rehabilitation caps.

SECTION 223. UPDATE IN RENAL DIALYSIS COMPOSITE RATE

Current law

Dialysis facilities providing care to beneficiaries with end-stage renal disease (ESRD) receive a fixed prospective payment amount for each dialysis treatment. This composite rate also includes payment for tests, services, drugs and supplies routinely required for dialysis treatment. The base composite rate is $126 for hospital-based providers and $122 for free-standing facilities. P.L. 101–508 required that the composite payment rate to dialysis facilities be

increased by $1 above the rate that was in effect as of September 30, 1990. The composite rate has not been changed since then.

Explanation of provision

This provision would provide an update of 1.2% to the composite rate payment for dialysis services furnished during CY 2000 and an update of 1.2% in CY 2001. The provision also calls for MedPAC to conduct a study on the use of home dialysis services by Medicare beneficiaries. MedPAC should make further recommendations to Congress within one year of enactment.

Effective date

January 1, 2000.

Reason for change

This provision would provide an update to the composite rate for dialysis services, which, according to MedPAC, "has remained essentially unchanged since 1983." The Committee asks that MedPAC and HCFA report on whether quality of care could be improved and payments be made more appropriately if billings outside the composite rate were reviewed to include an appropriate mix of additional laboratory tests, pharmaceuticals (other than erythropoietin) and nutritional services.

In the end stage renal disease area, Medicare covers the first 36 months of immuno-suppressive drugs after a transplant. As directed in the BBA, the Committee eagerly awaits the final report of the Institute of Medicine on this issue, and expects to examine the issue in the near future. The Committee is interested in examining this issue to ensure that costly transplants are not rejected due to the lack of coverage of immuno-suppressive drugs, and so that these beneficiaries are able to improve their quality of life by no longer needing dialysis services.

SECTION 224. TEMPORARY UPDATE IN DURABLE MEDICAL EQUIPMENT AND OXYGEN RATES

Current law

Medicare pays for durable medical equipment, oxygen and oxygen equipment on the basis of fee schedules. Prior to the BBA, the fee schedule amounts were updated annually by the consumer price index for all urban consumers (CPI–U). In general, the fee schedules established national payment limits that are subject to floors and ceilings. The BBA eliminated the 1998 through 2002 updates for durable medical equipment. The BBA reduced the national payment limit for oxygen and oxygen equipment by 25% in fiscal year 1998 and by an additional 5% in FY 1999. These reductions were to continue to be reflected in payments for oxygen in subsequent years.

Explanation of provision

This provision would provide an update for the years 2001 and 2002 of CPI minus 2 percentage points.

Effective date

Upon enactment.

Reason for change

These provisions are intended to help reduce the impact of BBA payment adjustments on durable medical equipment suppliers.

SECTION 225. REQUIREMENT FOR NEW PROPOSED RULEMAKING FOR IMPLEMENTATION OF INHERENT REASONABLENESS POLICY

Current law

Section 1842(b) of the Social Security Act permits the Secretary to increase or decrease certain payments under Part B where the payment amount is "grossly excessive or grossly deficient and not inherently reasonable." Section 4316 of the Balanced Budget Act of 1997 modified this authority requiring, among other things, that the Secretary consider certain factors, consult with industry and implement payment changes by formal rulemaking procedures. The Secretary could not apply factors that would increase or decrease the payment for an item or service by more than 15% in any given year.

Explanation of provision

The provision requires the Secretary to publish new proposed and final regulations establishing the procedures by which the Secretary shall exercise inherent reasonableness authority. The provision requires a minimum of sixty days for the public to comment on the new proposed rule, and directs the Secretary to take into account such comments before promulgating a new final rule. The Secretary's authority under section 1842(b) is suspended until the new regulations are in place.

Effective date

Upon enactment.

Reason for change

In January 1998 the Secretary elected to implement the changes made to section 1842(b) buy the Balanced Budget Act by promulgating "interim final regulations" in 63 Fed. Reg. 687. While public comment was solicited as part of this rule, the Secretary chose not to respond publicly to these comments before exercising modified inherent reasonableness authority provided by section 1842(b) should be administered judiciously and applied only after public concerns and suggestions about proposed administrative criteria have been openly addressed. Also, the rules should include an explanation of the Secretary's costing methodology which should be based on statistically valid and relevant data.

SECTION 226. INCREASE IN REIMBURSEMENT FOR PAP SMEARS

Current law

Medicare pays for diagnostic and screening pap smears under regional clinical laboratory test fee schedules. Current laboratory fees are based on 60% of prevailing charge data from 1984 and 1985.

In addition, national payment caps limit the amount that any carrier can pay for a given test to 74% of the national median of the carriers fee schedule amounts for that test. These fees are to be adjusted annually for inflation but, due to provisions included in the BBA, are currently frozen through 2002. The national payment cap for a pap smear under current law is approximately $7.15. The particular technologies providers may use in performing a reimbursable pap smear test vary and the corresponding payment amounts are currently determined on a carrier by carrier basis.

Explanation of provision

The provision would establish a national minimum payment for a pap smear test of $14.60. It would also clarify that this minimum payment rate would apply to pap smear tests conducted using any FDA-approved cervical cancer screening technology. In addition, a Sense of the Congress provision is included which encourages the Secretary to closely monitor the appropriateness of reimbursement rates for tests using new cervical cancer screening technologies in the future.

Effective date

For services provided on or after January 1, 2000.

Reason for change

The Committee is concerned about evidence that suggests that the prevailing reimbursement rates for pap smears are largely inadequate to cover the cost of performing these tests, particularly those utilizing newer and more sophisticated screening technologies. The Committee is concerned that the disparity between estimated costs and actual payments for pap smears may undermine beneficiary future access to these important preventive health tools, and in particular, diminish beneficiary ability to benefit from new and improved diagnostic technologies in this area.

SECTION 227. REFINEMENT OF AMBULANCE SERVICES DEMONSTRATION PROJECT

Current law

The BBA directed the Secretary to establish a demonstration project in which a local government could enter into a contract with the Secretary to furnish ambulance services under Part B for individuals who live in the local government unit. The contract must provide for at least 80% of the individuals who are enrolled under Medicare Part B but who are not enrolled in Medicare+Choice. Capitated payments are made to a local government for those individuals. Currently, payments should be 95% of the first year of what otherwise would have been payable, after which they should be adjusted for inflation.

Explanation of provision

This provision specifies that the Secretary publish a request for proposals for the ambulance services demonstration project by July 1, 2000. The provision also asks that the rate for project be estab-

lished with the most current data available and so aggregate payments do not exceed what they otherwise would have been.

Effective date

As if included in the BBA.

Reason for change

This provision ensures timely implementation of the demonstration project.

SECTION 228. ADDITIONAL PROVISIONS

Current law

Medicare does not currently cover services furnished in post-surgical recovery care centers.

Explanation of provision

This provision would direct MedPAC to conduct a study on the cost effectiveness of Medicare coverage of post-surgical recovery care centers. Within one year of enactment, MedPAC should make recommendations on the feasibility, costs and savings of covering such services in its report to the Congress.

Effective date

Upon enactment.

Reason for change

The Committee is interested in determining the cost effectiveness of these post-surgical recovery care centers.

TITLE III. PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

SECTION 301. ADJUSTMENT TO REFLECT ADMINISTRATIVE COSTS NOT INCLUDED IN THE INTERIM PAYMENT SYSTEM

Current law

The BBA required the Secretary to expand research on a prospective payment system for home health agencies under the Medicare program that ties prospective payments to a unit of service, and it instructed the Secretary to undertake an intensive effort to develop a reliable case-mix adjuster that explains a significant amount of the variances in costs among beneficiaries. It authorized the Secretary, beginning with cost reporting periods beginning on or after October 1, 1997, to require all home health agencies to submit additional information that the Secretary considered necessary for the development of a reliable case-mix system.

HCFA used this authority in the BBA to require home health agencies to administer and report information from a data collection instrument known as the Outcome and Assessment Information Set (OASIS), which had been under design and pilot testing for several years. OASIS will permit HCFA to obtain information for refining the design and case mix adjustment of the home health care prospective payment system. It is a questionnaire required to

be administered by a home health worker to home health beneficiaries at the start of a spell of care and occasionally thereafter. Data are to be encoded and transmitted to state survey agencies.

Explanation of provision

This provision would provide a $10 payment to a home health agency for each beneficiary to whom it furnishes services during the agency's cost reporting period beginning in FY 2000. Payment would be made in April 2000 and upon cost report settlement.

Effective date

Upon enactment.

Reason for change

This provision is intended to assist home health agencies with the administrative costs that are not included in the interim payment system. The Committee also encourages the Secretary to provide home health agencies with the opportunity to repay overpayments (due to incorrect interim payment system estimates) over a three-year period without interest costs.

SECTION 302. DELAY IN APPLICATION OF 15 PERCENT REDUCTION IN PAYMENT RATES FOR HOME HEALTH SERVICES UNTIL ONE YEAR AFTER IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM

Current law

The BBA required the Secretary to implement a prospective payment system for Medicare home health care cost reporting periods beginning on or after October 1, 1999, and required that the new system be designed to reduce the initial aggregate cost of Medicare home health care by 15%. The BBA allows a transition period for implementation of the new system of no longer than 4 years. The BBA also specified that if the new prospective payment system were not ready for implementation on October 1, 1999, the interim payment system then in effect would be changed to reduce cost limits and per beneficiary limits by 15%.

The Omnibus Consolidated and Emergency Supplemental Appropriations Act for Fiscal Year 1999 (P.L. 105–277) moved implementation of the home health care prospective payment system to portions of cost reporting periods beginning on or after October 1, 2000, and moved the 15% reduction in cost limits and per beneficiary limits to coincide with implementation of the prospective payment system.

Explanation of provision

This provision would delay the 15% reduction in payment rates for home health services until one year after the implementation of the prospective payment system.

The Secretary is required to report to Congress on the need for a 15% reduction, or for any reduction, in the base payment amounts no later than 6 months after the Secretary implements the home health prospective payment system.

Effective date

Upon enactment

Reason for change

This provision would delay the scheduled payment reduction to allow home health agencies some time to transition to the new prospective payment system. To ensure that further reductions in home health payments are warranted, the Committee directs the Secretary to analyze the need for further reductions in home health payments. In addition, the Committee encourages the Secretary to consider what changes would be necessary to provide home health care agencies with the flexibility to adopt new market innovations and new technologies that can improve health outcomes while maintaining the goals of quality of care and cost containment.

SECTION 303. CLARIFICATION OF SURETY BOND REQUIREMENTS

Current law

Home health agencies must provide the Secretary on a continuing basis with a surety bond that is not less than $50,000. HCFA regulations require the bond to be not less than 15% for the agency's Medicare payments in the previous year.

Explanation of provision

This provision clarifies that the surety bond requirement for home health agencies should be effective for a period of 4 years and in an amount equal to the lesser of $50,000 or 10% of the aggregate annual amount of payments to the agency.

Effective date

Upon enactment.

Reason for change

This provision would help to stabilize the financial security of home health agencies, while still protecting against fraud and abuse.

SECTION 304. TECHNICAL AMENDMENT CLARIFYING APPLICABLE MARKET BASKET INCREASE FOR PPS

Current law

With respect to FY 2002 and FY 2003, the home health market basket percentage increase is market basket minus 1.1 percentage points.

Explanation of provision

This provision clarifies that the reduction of 1.1 percentage points applies to both FY 2002 and FY 2003.

Effective date

Upon enactment.

Reason for change

This provision is a technical amendment that clarifies the applicable market basket update for FY 2002 and FY 2003.

Subtitle B—Direct Graduate Medical Education

SECTION 311. USE OF NATIONAL AVERAGE PAYMENT METHODOLOGY IN COMPUTING DIRECT GRADUATE MEDICAL EDUCATION (DGME) PAYMENTS

Current law

Under section 1886(h) of the Social Security Act, Medicare pays hospitals for its share of direct graduate medical education (DGME) costs in approved programs using a count of the hospital's number of full-time equivalent residents and a hospital-specific historic cost per resident, updated for inflation. In general, the BBA limited the number of residents that hospitals may count for direct GME to the total recognized by the hospital on or before December 31, 1996.

Explanation of provision

This provision would establish a national average per resident payment amount, adjusted for differences in area wages, for all hospitals with residency training programs starting with cost report periods beginning on or after October 1, 2000. Hospitals would receive the greater of the national average per resident amount or the sum of a percentage of the hospital-specific per resident amount and a percentage of the national average per resident amount. A transition period of five years is provided for hospitals that have current per resident amounts above the national average per resident amount. A budget neutrality adjustment is made to ensure that aggregate payments are not reduced as a result of the transition.

Effective date

This provision would become effective with cost reporting periods beginning on or after October 1, 2000.

Reason for change

This provision would establish a more rational and equitable payment system for direct graduate medical education costs similar to other prospective payment systems in the Medicare program. The transition to the national average per resident amount over a period of five years provides a gradual glide path for those hospitals that have per resident amounts above the national average, while the budget neutrality adjustment ensures that aggregate payments have not been reduced at the end of the transition.

Subtitle C—Other

SECTION 321. GAO STUDY ON GEOGRAPHIC RECLASSIFICATION

Current law

The Omnibus Budget Reconciliation Act of 1990 (OBRA) 1990) established the Medicare Geographic Classification Review Board

to evaluate hospitals' applications for reclassification to a different geographic area. The Board may reclassify a hospital for the purposes of determining its standardized amount, its wage index, or both. Urban and rural hospitals can apply if the hospital can prove, using established guidelines, that its geographic assignment is inappropriate, because it competes for patients and employees with hospitals located in other areas. For FY 2000, there were 416 rural reclassified hospitals and 83 urban reclassified hospitals.

Explanation of provision

This provision requires the GAO to conduct a study of the current laws and regulations for geographic reclassification under the Medicare program and the special designations for determining Medicare payments. The GAO would submit the study to Congress within 18 months of enactment.

Effective date

Upon enactment.

Reason for change

The Committee notes that in recent years the geographic reclassification process and the increasing number of special designations for groups of hospitals have resulted in a system that is administratively cumbersome. In addition, the system, which relies on exceptions and waivers, lacks consistency and undermines the ability of hospitals to implement long-term planning. Most hospitals are required to reapply annually for geographic reclassification with no certainty that they will receive the desired wage index or standardized amount.

The Committee expects the GAO study to provide background, rationale, and analytic justification for the current rural definitions and exceptions process. The Committee hopes that this report will be an important tool in helping the Congress craft a more objective and equitable approach to Medicare payment for rural hospitals. This will only become more critical as the Congress considers extending geographic reclassification to other types of prospective payment systems. The Committee specifically asks the GAO to consider in its analysis whether the geographic reclassification process should be extended to other types of providers, particularly to skilled nursing facilities.

SECTION 322. MEDPAC STUDY ON MEDICARE PAYMENT FOR NON-PHYSICIAN HEALTH PROFESSIONAL CLINICAL TRAINING IN HOSPITALS

Current law

The BBA required the MedPac, within two years of enactment of the BBA, to make recommendations regarding whether and to what extent payments are being made, or should be made, for training in the nursing and allied health professions.

Explanation of provision

This provision would require MedPAC to conduct a study on Medicare payment policy with respect to professional clinical training of different classes of non-physician health professionals. The

Committee expects MedPAC to consider those types of health professionals that Medicare currently supports, such as nurses and allied health professionals, and those categories that are not supported, such as psychologists and physician assistants.

The Committee recognizes that MedPAC has considered this issue in its BBA-mandated report on long-term policies for graduate medical education. However, the Committee requires additional explicit information on Medicare's role in financing clinical training for non-physician health professionals. A continuation of the existing effort, combined with quantitative analysis, will provide the Committee with a sound foundation as it grapples with all aspects of Medicare's support for health professions training, including possible methodologies for making payments and the entities that should receive them.

TITLE IV. RURAL PROVIDER PROVISIONS

SECTION 401. PERMITTING RECLASSIFICATION OF CERTAIN URBAN HOSPITALS AS RURAL HOSPITALS

Current law

Medicare's payments to an acute hospital will vary depending upon the geographic location of the hospital. The Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) established the Medicare Geographic Classification Review Board to evaluate hospital applications for reclassification to a different geographic area. The Board may reclassify a hospital for the purposes of determining its standardized amount, its wage index, or both. Urban and rural hospitals can apply if the hospital can prove, using established guidelines, that its geographic assignment is inappropriate, because it competes for patients and employees with hospitals located in other areas.

Explanation of provision

This provision would require the Secretary to establish a process for hospitals located in urban Metropolitan Statistical Areas (MSAs) to apply to be treated as rural hospitals, supplement the federal criteria used to designate rural providers, allow for state designation as a rural provider, and permit urban hospitals to be designated as sole community hospitals.

Effective date

This provision would become effective on January 1, 2000.

Reason for change

This provision would permit additional flexibility for hospitals to reclassify for purposes of becoming rural hospitals so that they may participate in Medicare as critical access or sole community hospitals.

SECTION 402. UPDATE OF STANDARDS APPLIED FOR GEOGRAPHIC RECLASSIFICATION FOR CERTAIN HOSPITALS

Current law

Section 1886(d)(8)(B) of the Social Security Act requires the Secretary to treat a hospital located in a rural county adjacent to one or more urban areas as being located in the urban Metropolitan Statistical Area (MSA) to which the greatest number of rural workers commute if the rural county's aggregate commuting rate (to all the contiguous MSAs) meets the standards for designating outlier counties to MSAs (and New England County Metropolitan Statistical Areas) that were published in the Federal Register on January 3, 1980.

Explanation of provision

This provision would update the reclassification criteria for hospitals located between two MSAs. For FY 2000, the 1980 census data would be used. A transition is provided for discharges occurring during cost report periods during FY 2001 and 2002 for hospitals to choose between the standards published in 1980 and 1990. Beginning with cost reporting periods during FY 2003, standards would be based on the most recent decennial population data published by the Bureau of the Census as revised by the Office of Management and Budget.

Effective date

This provision is effective with discharges occurring during cost reporting periods beginning on or after October 1, 1999.

Reason for change

This provision would update the standards which are used to classify hospitals located between two MSAs from 1980 to 1990 census data and then to the most recently available decennial population data for FY 2003 and subsequent years. The Committee believes that a transition period for hospitals that might be negatively affected by the change in the standard is appropriate.

SECTION 403. IMPROVEMENTS IN THE CRITICAL ACCESS HOSPITAL (CAH) PROGRAM

Current law

The BBA established the criteria for a small, rural, limited service hospital to be designated as a critical access hospital (CAH). These hospitals are required to be rural nonprofit or public hospitals either located more than 35 miles away (or given geographic constraints, 15 miles away) from another hospital and certified by the State as a necessary provider. The CAHs provide 24-hour emergency services, have up to 15 acute care inpatient beds (or up to 25 beds if the CAH is also a swing bed provider) and have hospital stays of no more than 96 hours except under certain circumstances. For instance, a longer inpatient stay is permitted if inclement weather or other emergency circumstances prevent the transfer of a patient to another hospital; alternatively, a peer review organization or comparable entity may waive the 96-hour restriction on a

case-by-case basis. CAHs are exempt from the hospital outpatient prospective payment system.

Explanation of provision

This provision would apply the 96-hour length of stay limitation on an average annual basis. Not-for-profit hospitals would be permitted to qualify for designation as critical access hospitals. Hospitals that have closed within the past 10 years or facilities that have downsized may convert to critical access hospitals. For outpatient services for cost reporting periods beginning on or after October 1, 1999, hospitals may choose between a cost-based hospital outpatient service payment plus a fee schedule payment for professional services or an all-inclusive rate. Upon enactment, coinsurance for clinical diagnostic laboratory tests furnished by a CAH on an outpatient basis would be eliminated. Statutory language would be clarified to reflect that CAHs may participate in the swing bed program.

Effective date

Upon enactment unless otherwise specified above.

Reason for change

This provision would strengthen and provide increased flexibility for the critical access hospital program.

SECTION 404. FIVE-YEAR EXTENSION OF MEDICARE DEPENDENT HOSPITAL (MDH) PROGRAM

Current law

Medicare Dependent Hospitals (MDH) are small rural hospitals that are not classified as sole community hospitals and that treat relatively high proportions of Medicare patients. From April 1, 1990 to April 1, 1993, MDHs has been reimbursed as sole community hospitals. This special payment status was phased out as of September 30, 1994. The BBA reinstated and extended the MDH classification, starting on October 1, 1997 through September 30, 2001. During that time period, MDH hospitals will be paid at a national standardized rate or, if higher, 50% of their adjusted FY 1982 or FY 1987 hospital-specific costs. These hospitals continue to be protected from volume declines that are beyond their control.

Explanation of provision

This provision would extend the Medicare Dependent Hospital program through FY 2005.

Effective Date

Upon enactment.

Reason for change

This provision would ensure the continuation of the Medicare Dependent Hospital program beyond September 30, 2001 until September 30, 2005.

SECTION 405. REBASING FOR CERTAIN SOLE COMMUNITY HOSPITALS

Current law

Sole community hospitals are paid based on whichever of the following amounts yields the greatest Medicare reimbursement for the cost reporting period: (1) a hospital-specific target amount based on its updated FY 1982 costs; (2) a hospital-specific target amount based on its updated FY 1987 costs; or (3) the federal national standardized amount.

Explanation of provision

This provision would allow those sole community hospitals that now paid the Federal rate to rebase over time to their 1996 costs. Starting in FY 2001, these hospitals would receive payments based on 25% of their 1996 costs and 75% of their 1982 or 1987 costs. In FY 2002, they would receive a 50/50 blend, and in FY 2003, they would receive 25% of their 1982 or 1987 costs and 75% of their 1996 costs. In FY 2004, their rate would be 100% of their 1996 costs.

Effective date

This provision becomes effective for discharges occurring in FY 2001.

Reason for change

This provision would allow those hospitals that had low costs in 1982 or 1987 to rebase gradually to their 1996 costs.

SECTION 406. INCREASED FLEXIBILITY IN PROVIDING GRADUATE PHYSICIAN TRAINING IN RURAL AREAS

Current law

In general, the BBA limited the number of residents that hospitals may count for direct GME to the total recognized by the hospital on or before December 31, 1996.

Explanation of provision

This provision would allow hospitals located in rural areas to increase their per resident limits by 30% for both direct medical education and indirect medical education payments. It also would permit non-rural facilities that operate separately accredited rural training programs, or rural tracks, to increase their resident limits.

Effective date

This provision would become effective with respect to payments on or after October 1, 1999.

Reason for change

Individuals in rural areas often encounter difficulty in receiving medical services near their home. This provision provides increased flexibility to hospitals that train residents in rural areas to provide greater access to these needed services.

SECTION 407. ELIMINATION OF CERTAIN RESTRICTIONS WITH RESPECT TO HOSPITAL SWING BED PROGRAM

Current law

The Omnibus Budget Reconciliation Act of 1980 (OBRA 1980) permitted certain rural hospitals with fewer than 50 beds to use their inpatient facilities, as necessary, to furnish long-term care services. The Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) extended the Medicare swing-bed program to rural hospitals with less than 100 beds with certain payment limitations. These rural swing bed providers will be included in the new SNF prospective per diem system no earlier than July 1, 1999.

Explanation of provision

This provision would eliminate the mandate that states review the need for swing beds through the Certificate of Need (CON) process. The provision also removes constraints on length of stay while maintaining requirements for quality.

Effective date

The provision takes effect on the first day after the expiration of the transition period to the SNF prospective payment system.

Reason for change

This provision would provide flexibility for hospitals between 50 and 100 beds that wish to participate more extensively in the Medicare swing bed program.

SECTION 408. GRANT PROGRAM FOR RURAL HOSPITAL TRANSITION TO PROSPECTIVE PAYMENT

Current law

The BBA replaced and modified the existing Essential Access Community Hospital (EACH) program with the Medicare Rural Flexibility Program. As part of this program, the Secretary was authorized to award grants to States that submitted applications in accordance with development or approval of a rural health plan for the purposes of engaging in activities related to planning and implementing a rural health care plan or rural health network, as well as activities related to designating facilities as critical access hospitals.

Explanation of provision

This provision would modify the grant program to allow rural hospitals with fewer than 50 beds to apply for grants not to exceed $50,000 for meeting the costs associated with implementing new prospective payment systems, such as the purchase of computer software and hardware and the education and training of staff.

Effective date

Upon enactment.

Reason for change

This provision would permit small rural hospitals to apply for grants to help them adjust to the new prospective payment systems required by the BBA.

SECTION 409. MEDPAC STUDY OF RURAL PROVIDERS

Current law

There is no explicit provision in current law.

Explanation of provision

This provision would require MedPAC to conduct a study of rural providers for Congress within 18 months of enactment. The study would examine and evaluate the appropriateness of the categories of special payments, and payment methodologies established for rural hospitals and their impact on beneficiary access and quality of services.

Effective date

The report is due within 18 months of enactment.

Reason for change

This provision would help Congress improve the understanding of the needs of health care providers in rural areas and make informed policy decisions.

SECTION 410. EXPANSION OF ACCESS TO PARAMEDIC INTERCEPT SERVICES IN RURAL AREAS

Current law

The BBA authorized coverage of advanced life support (ALS) services provided by a paramedic intercept service provider in a rural area when medically necessary to the individual being transported and provided under contract with one or more qualified volunteer ambulance services. The volunteer ambulance service is certified, provides only basic life support services, and is prohibited by State law from billing for any services. The entity supplying the advanced life support services is Medicare-certified and bills all recipients who receive ALS services, regardless of whether the recipients are Medicare eligible.

Explanation of provision

For purposes of paramedic intercept services, this provision would allow States to designate an area as rural or would allow an area located in a rural census tract of a metropolitan statistical area (as determined by the Goldsmith modification as published in the February 27, 1992 Federal Register) to be treated as a rural area.

Effective date

Applies to paramedic intercept furnished on or after January 1, 2000.

Reason for change

Many areas depend on paramedic intercept services for survival of those who live in rural areas. A too-narrow definition of a "rural" area may jeopardize the availability of emergency services. The Committee believes that a State-determined designation of a rural area or an area located in a rural census tract of a Metropolitan Statistical Area should be acceptable for purposes of expanding access to paramedic intercept services.

TITLE V. PROVISIONS RELATING TO PART C

Subtitle A—Medicare+Choice

SECTION 501. PHASE-IN OF NEW RISK ADJUSTMENT METHODOLOGY

Current law

The BBA required the Secretary to develop and submit to Congress by March 1, 1999 a report on the method of risk adjustment that would be used to account for variations in per capita costs based on health status. Medicare+Choice organizations and risk contract plans would have to submit data for inpatient hospital services that began on or after July 1, 1997, and data for other services that began on or after July 1, 1998. The Secretary could not require an organization to submit data before January 1, 1998. Finally, the Secretary would have to provide for implementation of a risk adjustment payment methodology that accounts for variation in per capita costs based on health status by no later than January 1, 2000. The payment methodology would be applied uniformly without regard to the type of plan.

Medicare+Choice payments to plans are currently adjusted using demographic factors, including age, gender, coverage by Medicaid, institutionalized status, and working status. The Secretary has proposed use of the principal inpatient diagnostic cost groups (PIP–DCG) method, which would supplement demographic factors with health status factors. This prospective model uses diagnoses in a base year to adjust payment for a future payment year. Payment is determined by each Medicare+Choice enrollee's risk factor, which will initially be based on inpatient data using the PIP–DCG adjusters. These adjusters predict incremental costs, above the average for the demographic group, which are expected to be incurred in the year after hospitalization. the Secretary has proposed moving to comprehensive risk adjustments by 2004, which would take into account a wider range of measures for health status, not just hospitalization.

The Secretary has proposed a phase-in of the new risk adjustment methodology such that Medicare+Choice payments would reflect a blend of payments under the current demographic adjustment procedure and the new PIP–DCG procedure. The proposed phase-in schedule would be: 90% demographic/10% PIP–DCG in 2000; 70% demographic/30% PIP–DCG in 2001; 45% demographic/55% PIP–DCG in 2002; 20% demographic/80% PIP–DCG in 2003; and 10% risk adjustment in 2004.

Explanation of provision

The provision would hold the risk adjuster at the 90% demographic/10% PIP–DCG blend for 2000 and 2001. In 2002, the risk adjuster would be 80% demographic/20% PIP–DCG. In 2003, the risk adjuster would be 70% demographic/30% PIP–DCG. In 2004, Medicare+Choice rates would be risk-adjusted based 100% on data from multiple settings.

Effective date

These provisions would apply for 2001–2004.

Reason for change

This provision would provide Medicare+Choice and HCFA additional time to transition to the new risk adjustment methodology, so as to avoid dramatic changes in Medicare+Choice payments which could destabilize the program and limit choices for seniors.

The Committee notes that in 1997, when Congress required the Secretary to develop a risk adjuster for Medicare+Choice plans, it was concerned that those plans that treated the most severely ill enrollees were not adequately paid. The Congress envisioned a risk adjuster that would be more clinically-based than the old method of adjusting payments. The Congress did not instruct HCFA to implement the provision in a manner that would reduce aggregate Medicare+Choice payments. In addition, the Congressional Budget Office did not estimate that the provision would reduce aggregate Medicare+Choice payments. Consequently, the Committee urges the Secretary to revise the regulations implementing the risk adjuster so as to provide for more accurate payments, without reducing overall Medicare+Choice payments.

The Committee also notes that as currently designed, the proposed Medicare+Choice risk adjuster fails to account for several unique aspects of Medicare's frail elderly population. The Committee notes that the Secretary recently acknowledged her authority to address this problem by waiving application of the risk adjuster within the frail elderly demonstration project commonly known as EverCare. The Committee notes that the Secretary will begin implementation of a multi-setting risk adjuster for all enrollees in 2004, and that such a risk adjuster should be designed to better predict the unique costs associated with caring for frail elderly beneficiaries. Consequently, the Committee encourages the Secretary to consider her ability to waive the application of the new risk adjuster to such beneficiaries until that time.

The Committee also believes that Medicare enrollees with end-stage renal disease (ESRD) could benefit by being offered the opportunity to enroll in Medicare+Choice plans. However, the Committee understands that the current risk adjuster may not adequately reflect the varying costs of these patients and requests further information from the Secretary so that it might address this issue in the future. The Committee also encourages the Secretary to develop proposed quality of care requirements for Medicare beneficiaries with ESRD in this report.

SECTION 502. ENCOURAGING OFFERING OF MEDICARE+CHOICE PLANS IN AREAS WITHOUT PLANS

Current law

For each beneficiary enrolled, the Medicare+Choice plan receives the Medicare+Choice payment rate applicable to the payment area (typically a county) in which the enrollee resides, adjusted for risk. This rate is based on a formula which gives the county the highest of three different rates: a floor, or minimum payment rate, a minimum update rate, and a blended rate.

The floor payment rate was set at $367 per month for aged beneficiaries in 1998. Each year the floor is increased by an annual update factor, equal to adjusted growth in Medicare expenditures per capita, minus 0.8 percentage points in 1998, and minus 0.5 percentage points annually from 1999 through 2002.

The minimum update rate was set at the county rate in 1997 increased by 2%. This rate increases 2% each year.

The blended rate represents an average of local and national rates. The local rate is an area-specific capitation rate, which is adjusted to remove the share of payments that represent payments for graduate medical education (GME), with a phase-out over 5 years. Beginning in 1998, local rates for blending purposes had 20% of GME spending removed. The reduction in GME payments is increased by 20% annually, until all GME funds are removed from 2002 forward. The national rate is the average of local area-specific payment rates, weighted by the number of Medicare beneficiaries in each county. For blending purposes, the national rate is input price-adjusted to reflect differences in the costs of providing medical care across counties. The blended rate is computed as follows: 90% local/10% national in 1998; 82% local/18% national in 1999; 74% local/26% national in 2000; 66% local/34% national in 2001; 58% local/42% national in 2002; 50% local/50% national from 2003 onward.

Explanation of provision

The provision would encourage new Medicare+Choice plans to enter counties that would otherwise not have a private plan participating. The first plan to enter a previously unserved county would receive a 5 percent added payment during their first year and a 3 percent added payment during their second year.

Effective date

This provision would apply during the 2-year period beginning January 1, 2000.

Reason for change

In some counties, beneficiaries have access to only one Medicare option: the fee-for-service Medicare program. This temporary enhancement of payments will encourage new plans to enter areas without Medicare+Choice options.

SECTION 503. MODIFICATION OF FIVE-YEAR RE-ENTRY RULE FOR CONTRACT TERMINATIONS

Current law

The law specifies that the Secretary cannot enter into a Medicare+Choice contract with a Medicare+Choice organization, if within the preceding five years, that organization had a Medicare+Choice contract which it did not renew. An exception may be made for special circumstances that warrant special consideration, as determined by the Secretary.

HCFA has indicated that it will apply the prohibition only in cases where the entire contract is nonrenewed. Thus, the ban would not apply if an organization dropped a single county from a service area while retaining the rest of the service area. It would also not apply if a managed care organization nonrenewed one plan under a contract but retained other plans in that contract.

Explanation of provision

The provision would allow, under certain circumstances, a plan to reenter a county if a legislative or regulatory change that would increase Medicare+Choice payments in the area occurred within 6 months of the plan's decision to terminate its Medicare+Choice contract. A plan would be permitted reentry only if, at the time it notified the Secretary of its intent, there is no more than one Medicare+Choice plan offered in the area.

Effective date

This provision applies to contracts occurring before, on, or after the date of enactment.

Reason for change

Some plans left the Medicare+Choice program because of increased administrative requirements and payment rate growth that was lower than expected. Since this bill would make payment changes affecting Medicare+Choice plans, this provision would provide an opportunity for the plans to return to a county, and therefore, increase options for beneficiaries.

SECTION 504. CONTINUED COMPUTATION AND PUBLICATION OF AAPCC DATA

Current law

The Secretary is required to announce Medicare+Choice payment rates for each payment area, and risk and other factors to be used in adjusting payments, not later than March 1 before the calendar year concerned. At least 45 days before making the announcement for a year, the Secretary must provide notice to Medicare+Choice organizations of proposed changes to be made in the methodology and assumptions used in the previous announcement. The Secretary must also provide sufficient detail so that Medicare+Choice organizations can compute monthly adjusted Medicare+Choice capitation rates for individuals in each Medicare+Choice payment area. The Secretary is not required to publish adjusted annual per capita cost (AAPCC) data. AAPCCs formed the basis of payments to man-

aged care plans prior to enactment of the BBA, and represented the costs of providing Medicare benefits to beneficiaries under fee-for-service care in each county nationwide. Because Medicare+Choice payments are no longer directly tied to a payment area's fee-for-service costs, AAPCCs have not been published.

Explanation of provision

This provision would require the Secretary to continue to publish estimates of AAPCC data.

Effective date

Upon enactment.

Reason for change

This change will ensure that Congress can readily compare the average per capita payments made under the Medicare+Choice program to Medicare's average expenditures for a beneficiary in the traditional fee-for-service program, on a county-by-county basis.

SECTION 505. CHANGES IN MEDICARE+CHOICE ENROLLMENT RULES

Current law

Some HMOs have announced their intention not to renew their Medicare+Choice contracts or to reduce the service area covered by the contracts. These decisions become effective for the next contract period which begins on January 1, 2000. Most beneficiaries enrolled in these Medicare+Choice plans will be able to enroll in another Medicare+Choice plan in their area. Generally this would occur during the November 1999 open enrollment period; coverage under the new plan would begin January 1, 2000. These beneficiaries could also return to fee-for-service Medicare. Beneficiaries in counties with no available managed care plans will be automatically moved to fee-for-service Medicare.

Currently, Medicare+Choice plan enrollees may enroll or disenroll in a plan available to them at any point in the year. Starting in 2002, in conjunction with the introduction of an annual, coordinated election period for all beneficiaries, a beneficiary's ability to change plans in the middle of the year will be more limited. In 2002, beneficiaries may change their plan election at any time during the first six months of the year. In subsequent years, changes in plan election will only be allowed in the first three months of the calendar year.

Beneficiaries returning to original Medicare have certain rights with regard to the purchase of Medigap plans. Medigap refers to individually purchased insurance policies which supplement Medicare's benefits. Beneficiaries select a policy from one of 10 standardized plans; these are known as Plan A through Plan J.

Individuals who are enrolled with an HMO at the time its contract terminates are guaranteed issue of any Medigap A, B, C, or F that is sold to new enrollees by Medigap issuers in the state. This choice must be exercised within 63 days of termination of prior HMO coverage. Since prior coverage is terminated at the end of the calendar year, the 63-day period begins January 1, 2000.

Finally, if a Medicare+Choice plan reduces the size of its service area such that certain enrollees would lose eligibility for the plan, the plan may, if it meets specified requirements established by the Secretary, offer such enrollees the option of continuing enrollment in the plan if the plan can still provide reasonable access within the geographic are to the full range of basic benefits covered by Medicare.

Explanation of provision

Subsection (a) would modify the conditions under which an individual would be entitled to a special election period to include situations where the individual is notified of an impending termination of certification of a plan or an impending termination or discontinuation of the plan.

This provision would allow Medicare+Choice enrollees who are in a plan that will no longer participate in the Medicare+Choice program to choose a Medigap plan within 63 days of receiving notice from their plan, rather than waiting for the contract to end.

Subsection (b) would amend the Medicare+Choice enrollment and disenrollment provisions so that institutionalized beneficiaries could continue to enroll in Medicare+Choice plans at any time during the year.

Subsection (c) provides for a new provision allowing plans who reduce their service area to offer continuing enrollment to prior enrollees who would otherwise lose coverage, if the beneficiary agrees to travel to receive the full range of basic elements (except emergency care and urgent care services) from certain providers designated by the plan, and the beneficiary has no other Medicare+Choice plan available to them in their area of residence.

Effective date

Subsection (a) applies to notices of impending terminations or discontinuations made before, on or after enactment. However, notices made before the date of enactment will be treated as having occurred on the date of enactment. Subsections (b) and (c) are effective as if included in the BBA.

Reason for change

Subsection (a) would enable beneficiaries in a Medicare+Choice plan that is terminating its contract greater latitude in arranging for subsequent coverage arrangements under the Medigap program.

Subsection (b) is included to ensure that the general enrollment restrictions that will accompany the annual, coordinated election period beginning in 2002 will not preclude beneficiaries who become institutionalized in the middle of the year from enrolling in special coordinated care programs provided by some Medicare+Choice plans at the time of the institutionalization.

Subsection (c) is included to help minimize the effects of recent plan withdrawals for certain enrollees. Where a plan agrees, it will enable certain beneficiaries who would otherwise lose access to Medicare+Choice the ability to retain their health plan if they agree to travel to neighboring communities to receive their services.

SECTION 506. ALLOWING VARIATION IN PREMIUM WAIVERS WITHIN A SERVICE AREA IF MEDICARE+CHOICE PAYMENT RATES VARY WITHIN THE AREA

Current law

In general, Medicare+Choice managed care plans offer benefits in addition to those provided under Medicare's benefit package. In certain cases, the beneficiary has the option of selecting the additional benefits, while in other cases some or all of the supplementary benefits are mandatory.

Some plans may require members to accept additional benefits and pay extra for them in some cases. The amount a plan may charge for additional benefits is based on a comparison between the plan's adjusted community rate (essentially the estimated market price) for the Medicare package and the average of the Medicare+Choice payment rate. A plan must offer "additional benefits" at no additional charge is the plan achieves a savings from Medicare.

If the difference between the average Medicare+Choice payment rate and the adjusted community rate (ACR) is insufficient to cover the cost of additional benefits, the plan may charge a supplemental premium for the benefits. Under current law, the monthly basic and supplemental premiums cannot vary among individuals enrolled in the plan.

Explanation of provision

This provision would allow Medicare+Choice plans to waive part or all of the premiums if Medicare+Choice rates vary within the service area.

Effective date

The provision would be effective for contract years beginning on or after January 1, 2001.

Reason for change

This provision recognizes that payment rates to plans vary by county, and would allow greater flexibility to better reflect the actual costs of providing supplemental benefits in each county.

SECTION 507. DELAY IN DEADLINE FOR SUBMISSION OF ADJUSTED COMMUNITY RATES AND RELATED INFORMATION

Current law

The BBA required Medicare+Choice plans to submit adjusted community rate (ACR) proposals by May 1 of the previous calendar year. Medicare+Choice organizations are required to submit ACR proposals to show that the benefit packages they plan to market neither exceed cost sharing for traditional Medicare plans nor unfairly charge enrollees for additional benefits.

Under the law in effect prior to the BBA, risk plans had a November 15 deadline for submission of their ACRs. The earlier deadline means that Medicare+Choice organizations must now project future payments and costs six months further into the future. The earlier deadline was selected, in part, to ensure HCFA had the

time both to review and approve submissions and to include information on all plan choices in the information sent to beneficiaries before the annual open enrollment season.

Explanation of provision

The provision would change the date for ACR submission from May 1 to July 1. Also, the provision would modify the requirement that the Secretary make available to beneficiaries during the annual open enrollment period comparative information on all plan choices. This requirement would apply to the extent that such information was available at the time of preparation of the material for mailing.

Effective date

Upon enactment.

Reason for change

This change will shorten the time between a plan's ACR submission and the start of an associated contract year, and thereby, enable plans to predict more accurately the probable costs of benefits included in their proposed ACR submissions. Despite this change, the Committee notes that HCFA will know by mid-August of each year what the final plan premiums and benefits will be for each Medicare+Choice plan for the following calendar year. To help employees who sponsor retiree health benefits coordinate their own annual enrollment procedures, the Committee urges the Secretary to make this information available to such employers as soon as possible.

SECTION 508. 2 YEAR EXTENSION OF MEDICARE COST CONTRACTS

Current law

Prior to enactment of the BBA, beneficiaries were able to enroll in risk-based HMOs and they could also enroll organizations with cost contracts. These entities were required to meet essentially the same conditions of participation as risk contractors. Under a cost contract, Medicare pays the entity the patient cost incurred in furnishing covered services.

The BBA replaced the risk program with Medicare+Choice. It also specifies cost-based contracts could not be renewed after December 31, 2002.

Explanation of provision

The provision would extend the cost contract program through 2004.

Reason for change

This provision ensures that beneficiaries currently receiving benefits through the cost contract program can continue to receive such benefits through 2004. By this time, better payment methodologies for Medicare+Choice plans, including the use of a multiple setting risk adjuster, should be in place.

SECTION 509. MEDICARE+CHOICE NURSING AND ALLIED HEALTH PROFESSIONAL EDUCATION AND EARMARK

Current law

The calculation of the Medicare+Choice payment rates includes payments for teaching hospitals operating residency training programs. The BBA carved-out the costs attributable to graduate medical education (GME) payments for physicians over a 5-year period and required additional payments to teaching hospitals when they treat Medicare+Choice enrollees. Medicare also recognizes the costs of training nurses and allied health professionals, but the BBA did not remove these payments from the Medicare+Choice payment rates.

Explanation of provision

The provision would set aside a fixed amount of dollars from the GME funds already carved-out of the Medicare+Choice rates under the BBA, and pay them to hospitals that train nurses and allied health professionals that care for Medicare+Choice enrollees.

Effective date

January 1, 2000.

Reason for change

This provision ensures that hospitals with nursing and allied health training programs that serve Medicare+Choice enrollees receive funding for the portion of these costs that are attributable to Medicare.

SECTION 510. MISCELLANEOUS CHANGES AND STUDIES

Current law

Current law permits religious fraternal benefit societies that offer Medicare+Choice plans to restrict enrollment in such plans to their members. Currently this allowable restriction applies only to coordinated care plans.

Under current law, the county-level per capita payment rates for Medicare+Choice plans are based on average spending per beneficiary in the traditional fee-for-service program. There are no considerations given to the amount of health services which beneficiaries in a given community may obtain from Department of Defense or Department of Veterans Affairs health facilities in this calculation.

Section 4207 of the BBA established an Informatics, Telemedicine and Education demonstration project to evaluate the potential for using telemedicine networks to improve the primary care of beneficiaries with diabetes mellitus. The project is aimed at beneficiaries residing in medically underserved rural or inner-city areas. The project was initially scheduled to begin on May 1998. To date, the Secretary has made no grants under the program.

Explanation of provision

Subsection (a) would allow religious benefit societies to offer any type of plan that would qualify under the Medicare+Choice program.

Subsection (b) would require the Secretary, jointly with the Secretary of Defense and the Secretary of Veterans Affairs, to submit to Congress within one year a report estimating the use of health care services furnished by the Departments of Defense and the Department of Veterans Affairs by Medicare beneficiaries.

Subsection (c) would make technical refinements to the Information, Telemedicine and Education demonstration project and require the Secretary to make an award initiating the project within three months of the date of enactment.

Effective date

Upon enactment.

Reason for change

Subsection (a) would increase the range of health plan choices available to Medicare beneficiaries. Subsection (b) is intended to provide the Committee with the means to evaluate the extent to which Medicare+Choice payment rates are understated in areas with large veteran or military retiree populations, and to help the Committee develop potential legislative changes addressing this issue in the future. Subsection (c) is included to prompt the Secretary to take the steps necessary to begin implementing the telemedicine demonstration project required by Congress in the BBA. Technical corrections to this project are included to simplify and clarify various copay, cost-sharing, and geographical definitions so as to ensure that the demonstration is of help to the low-income residents it was initially designed to serve. The changes are also intended to ensure that an agreement on cost sharing can be reached expeditiously.

SECTION 511. MEDPAC ON MEDICARE MSA (MEDICAL SAVINGS ACCOUNT) PLANS

Current law

Medicare allows Medicare+Choice plans to offer Medical Savings Accounts (MSAs) to beneficiaries. To date, no plans have participated in the program.

Explanation of provision

The provision would require MedPAC to submit to Congress a report on specific legislative changes that would make Medical Savings Account (MSA) plans a viable option under the Medicare+Choice program.

Effective date

The report is due 12 months after enactment.

Reason for change

The provision is included to identify possible changes in policy that would make Medicare MSA plans a more viable option for beneficiaries in the future.

SECTION 512. CLARIFICATION OF NONAPPLICABILITY OF CERTAIN PROVISIONS OF DISCHARGE PLANNING PROCESS TO MEDICARE+CHOICE PLANS

Current law

The BBA amended Medicare's discharge planning requirements to ensure that patients were not directed to a single post-acute care facility (such as a home health agency, nursing home, rehabilitation hospital, or other entity). This provision ensures that patients in Medicare fee-for-service are given an opportunity to choose their post-discharge care from those providers available in their area.

Explanation of provision

The section provides an exception from the discharge notification requirement for enrollees in Medicare+Choice plans.

Effective date

Upon enactment.

Reason for change

The BBA did not recognize that Medicare+Choice plans maintain contractual relationships with a selected number of post-acute providers and, as part of their efforts to coordinate care and manage treatment costs, and need to direct patients to those providers with which it has contracts. A Medicare+Choice plan, and the hospitals it contracts with, cannot efficiently administer discharge planning activities without the ability to direct enrollees to specific quality and cost conscious providers.

Subtitle B—Managed Care Demonstration Projects

SECTON 521. EXTENSION AND EXPANSION OF SOCIAL HEALTH MAINTENANCE ORGANIZATION DEMONSTRATION PROJECT AUTHORITY

Current law

The Deficit Reduction Act of 1984 required the Secretary to grant 3-year waivers for demonstrations of social health maintenance organizations (SHMOs) which provide integrated health and long-term care services on a prepaid capitation basis. The waivers have been extended on several occasions since then, and a second generation of projects was authorized by the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990).

The BBA extended waivers for social health maintenance organizations through December 31, 2000, and expanded the number of persons who can be served per site from 12,000 to 36,000.

Explanation of provision

The provision would extend the SHMO demonstration until 18 months after the date that the Secretary reports to Congress on her findings. In addition, the caps on individual sites would be

eliminated, while maintaining the aggregate cap of 324,000 participants.

Effective date

Upon enactment.

Reason for change

The provision ensures that beneficiaries currently receiving benefits through the SHMO demonstration project can continue to receive such benefits until 18 months after the date that the Secretary reports back to Congress on the effectiveness of this program. At this time, Congress will be better able to consider the merits of the program and possible improvements in payment methodologies for all Medicare+Choice plans, such that the objectives of the SHMO program can continue to be served.

SECTION 522. EXTENSION OF CERTAIN MEDICARE COMMUNITY NURSING ORGANIZATION DEMONSTRATION PROJECTS

Current law

The Community Nursing Organization (CNO) demonstration project was established to evaluate the ability of community nursing organizations to deliver coordinated community nursing and ambulatory care services to Medicare Part B beneficiaries. Currently, the project is being conducted at four sites (Tucson, AZ; Urbana, IL; Minneapolis, MN; New York, NY). Although Congress first authorized these projects as part of the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987), they did not begin until January 1994. The BBA subsequently extended the project for two years, through 1999.

Explanation of provision

This provision extends the CNO demonstration project for two years, through 2001. It also requires the Secretary to submit, not later than July 1, 2001, a report, based on data collected from the project through 2000, analyzing the effectiveness of the CNO delivery model.

Effective date

Upon enactment.

Reason for change

The provision is included to give the Secretary additional time to study the long-term effectiveness of the community nursing organization delivery model. The Committee notes that HCFA was initially slow to begin this project, and that a report on the project, which was due on July 1, 1999, has not yet been submitted to Congress for its review. The Committee believes that by extending the project for an additional two years the Secretary will be better able to evaluate the potential of the CNO model in caring for beneficiaries over extended periods of time. Similarly, the extension will allow for a complete report, which takes into account data collected over a longer period of time, to be submitted to Congress by July 1, 2001.

SECITON 523. MEDICARE+CHOICE COMPETITIVE BIDDING DEMONSTRATION PROJECT

Current law

Section 4011 of the BBA established a demonstration project to evaluate the potential for using competitive pricing practices to establish payment rates for Medicare+Choice plans. The law requires the Secretary to designate seven Medicare payment areas to be included in the demonstration project. Section 4012 of the BBA required the Secretary to establish the Competitive Pricing Advisory Committee (CPAC), as well as advisory committees in each of the designated areas, to help implement the project. To date the Secretary has designated two areas in which to begin the project: Kansas City, MO and Phoenix, AZ. However, concerns over the design of the demonstration project have prompted the CPAC to announce that the project would not get underway in either locality until January 1, 2001, at the earliest.

Explanation of provision

This provision would delay implementation of the competitive pricing demonstration project until January 1, 2002 or six months after the date at which the CPAC report to Congress on several specified issues related to the project's preliminary design, whichever is later. In particular, CPAC would be required to report on the feasibility of expanding the demonstration to include the traditional fee-for-service Medicare program, the proposed quality monitoring and improvement requirements for the project, the current viability of extending the project to a rural site, and several plan benefit structure issues related to the project. In addition, the language establishing the demonstration project is modified to allow plans who submit competitive prices to offer prospective enrollees rebates on all or part of their Part B premiums.

Effective date

Upon enactment.

Reason for change

This provision is designed to give both CPAC and Congress more time to resolve some of the initial concerns that have been raised about the demonstration project, as it is currently designed. By delaying the start date an additional year, and by tasking CPAC to report back on the identified areas of concern, the Committee believes appropriate modifications to the project can be implemented before its inauguration so as to improve its chances of success. Similarly, the additional time provided by the delay will afford the Secretary, CPAC and the area advisory committees additional time to work with the communities designated under the project to resolve outstanding issues of concern.

III. VOTES OF THE COMMITTEE

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, the following statements are made concerning the votes of the Committee on Ways and Means in its consideration of the bill, H.R. 3075.

MOTION TO REPORT THE BILL

The bill, H.R. 3075, as amended, was ordered favorably reported by a roll call vote of 26 yeas and 11 nays (with a quorum being present). The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer	X			Mr. Rangel		X	
Mr. Crane	X			Mr. Stark		X	
Mr. Thomas	X			Mr. Matsui		X	
Mr. Shaw	X			Mr. Coyne		X	
Mrs. Johnson	X			Mr. Levin		X	
Mr. Houghton	X			Mr. Cardin	X		
Mr. Herger	X			Mr. McDermott		X	
Mr. McCrery	X			Mr. Kleczka	X		
Mr. Camp				Mr. Lewis (GA)		X	
Mr. Ramstad	X			Mr. Neal	X		
Mr. Nussle	X			Mr. McNulty		X	
Mr. Johnson	X			Mr. Jefferson			
Ms. Dunn	X			Mr. Tanner	X		
Mr. Collins	X			Mr. Becerra		X	
Mr. Portman	X			Mrs. Thurman		X	
Mr. English	X			Mr. Doggett		X	
Mr. Watkins	X						
Mr. Hayworth	X						
Mr. Weller	X						
Mr. Hulshof	X						
Mr. McInnis	X						
Mr. Lewis (KY)	X						
Mr. Foley	X						

VOTES ON AMENDMENTS

Roll call votes were conducted on the following amendment to Mr. Thomas' amendment in the nature of a substitute.

An amendment by Mrs. Thurman and Mr. Doggett to Title I, relating to hospital purchases of outpatient prescription drugs, was defeated by a roll call vote of 15 yeas to 22 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer		X		Mr. Rangel	X		
Mr. Crane		X		Mr. Stark	X		
Mr. Thomas		X		Mr. Matsui	X		
Mr. Shaw		X		Mr. Coyne	X		
Mrs. Johnson		X		Mr. Levin	X		
Mr. Houghton		X		Mr. Cardin	X		
Mr. Herger		X		Mr. McDermott	X		
Mr. McCrery		X		Mr. Kleczka	X		
Mr. Camp				Mr. Lewis (GA)	X		
Mr. Ramstad		X		Mr. Neal	X		
Mr. Nussle		X		Mr. McNulty	X		
Mr. Johnson		X		Mr. Jefferson			
Ms. Dunn		X		Mr. Tanner	X		
Mr. Collins		X		Mr. Becerra	X		
Mr. Portman		X		Mrs. Thurman	X		
Mr. English		X		Mr. Doggett	X		
Mr. Watkins		X					
Mr. Hayworth		X					
Mr. Weller		X					
Mr. Hulshof		X					
Mr. McInnis		X					
Mr. Lewis (KY)		X					
Mr. Foley		X					

An amendment by Mr. Stark, to add a new Title VI, relating to Medicare offsets, was defeated by a roll call vote of 15 yeas to 22 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer		X		Mr. Rangel	X		
Mr. Crane		X		Mr. Stark	X		
Mr. Thomas		X		Mr. Matsui	X		
Mr. Shaw		X		Mr. Coyne	X		
Mrs. Johnson		X		Mr. Levin	X		
Mr. Houghton		X		Mr. Cardin	X		
Mr. Herger		X		Mr. McDermott	X		
Mr. McCrery		X		Mr. Kleczka	X		
Mr. Camp				Mr. Lewis (GA)	X		
Mr. Ramstad		X		Mr. Neal	X		
Mr. Nussle		X		Mr. McNulty	X		
Mr. Johnson		X		Mr. Jefferson			
Ms. Dunn		X		Mr. Tanner	X		
Mr. Collins		X		Mr. Becerra	X		
Mr. Portman		X		Mrs. Thurman	X		
Mr. English		X		Mr. Doggett	X		
Mr. Watkins		X					
Mr. Hayworth		X					
Mr. Weller		X					
Mr. Hulshof		X					
Mr. McInnis		X					
Mr. Lewis (Ky)		X					
Mr. Foley		X					

IV. BUDGET EFFECTS OF THE BILL

A. Committee Estimate of Budgetary Effects

In compliance with clause 3(d)(2) of rule XIII of the Rules of the House of Representatives, the following statement is made:

The Committee agrees with the estimate prepared by the Congressional Budget Office (CBO) which is included below.

B. Statement Regarding New Budget Authority and Tax Expenditures

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee states that the Committee bill results in increased federal direct spending of $10.5 billion over 5 years.

C. Cost Estimate Prepared by the Congressional Budget Office

In compliance with clause 3(c)(3) of rule XIII of the Rules of the House of Representatives requiring a cost estimate prepared by the Congressional Budget Office (CBO), the following report prepared by CBO is provided.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, October 29, 1999.

Hon. BILL ARCHER,
Chairman, Committee on Ways and Means,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed revised cost estimate for H.R. 3075, the Medicare Balanced Budget Refinement Act of 1999. This estimate supercedes the estimate provided earlier today by correcting an error with regard to certain payments to hospitals for patients enrolled in a Medicare+Choice plan. As a result, our estimate of the 5-year costs of H.R. 3075 has declined from $10.7 billion to $10.5 billion.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Tom Bradley.

Sincerely,

DAN L. CRIPPEN, *Director.*

Enclosure.

H.R. 3075—Medicare Balanced Budget Refinement Act of 1999

Summary: The Medicare Balanced Budget Refinement Act would modify Medicare's payment rates for many services, including those furnished by hospitals, skilled nursing facilities, home health agencies, physicians, physical and speech therapists, occupational therapists, and managed care plans. In addition, the bill includes technical provisions that would have no effect on federal spending.

CBO estimates that the bill would increase federal direct spending by $0.5 billion in fiscal year 2000, by $10.5 billion over the 2000–2004 period, and by a total of $17.2 billion over the 2000–2009 period. Because the bill would increase direct spending, pay-as-you-go procedures would apply.

H.R. 3075 contains no intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). However, the increases to the Medicare Part B premiums would result in additional state expenditures for Medicaid totaling about $70 million over the 2000–2004 period. The bill contains one private-sector mandate as defined in UMRA. CBO estimates that its cost would be well below the threshold specified in UMRA ($100 million in 1996, adjusted annually for inflation).

Estimated cost to the Federal Government: The estimated budgetary impact of H.R. 3075 is shown in the following table. The costs of this legislation fall within budget functions 550 (health) and 570 (Medicare).

	Outlays, by fiscal years, in billions of dollars—				
	2000	2001	2002	2003	2004
CHANGES IN DIRECT SPENDING					
Medicare:					
Hospital Inpatient Provisions	0	0.5	0.3	0.1	0.1
Hospital Outpatient Department Provisions	0.1	0.4	0.7	0.6	0.2
Skilled Nursing Facility Provisions	0.2	0.5	0.5	0.4	0.4
Physician Update	0	0.3	0.1	−0.1	−0.3
Home Health Provisions	(2)	1.0	0.3	(2)	(2)
Rural Provisions	(2)	0.1	0.2	0.2	0.1

	Outlays, by fiscal years, in billions of dollars—				
	2000	2001	2002	2003	2004
Managed Care Provisions	(2)	0.4	0.4	0.6	0.1
Other Provisions	0.2	0.3	0.3	0.3	0.3
Interaction of Fee-for-Service Provisions and Medicare+Choice Payment Rates [1]	0	0.8	0.5	0.4	0.2
Subtotal, Gross Medicare Outlays	0.5	4.3	3.3	2.4	1.1
Part B Premium Receipts	0	−0.4	−0.4	−0.3	−0.1
Subtotal, Net Medicare Outlays	0.5	3.9	2.9	2.1	1.1
Medicaid Interaction with Part B Premium [3]	(2)	(2)	(2)	(2)	(2)
Total Changes	0.5	4.0	2.9	2.1	1.1

[1] The effect of changes in per-enrollee spending in the fee-for-service sector on payment rates for enrollees in Medicare+Choice plans.
[2] The federal share of Medicaid payments for Part B premiums on behalf of certain low-income Medicare enrollees.
[3] Costs or savings of less than $50 million.

Note.—Components may not sum to totals because of rounding.

Basis of estimate

Medicare

Compared with spending projected under current law, the bill would increase Medicare outlays by $0.5 billion in fiscal year 2000 and by $10.4 billion over the 2000–2004 period. The following sections discuss changes in gross outlays directly attributable to provisions of the bill. In addition, the estimate includes three interactions: the effect of changes in per-enrollee spending in the fee-for-service sector on payment rates for enrollees in Medicare+Choice plans, the effect of changes in Medicare Part B outlays on receipts from Part B premiums, and the effect of changes in Part B premiums on federal spending for Medicaid.

Payment rates for Medicare+Choice plans are based on spending in the fee-for-service sector, so provisions of the bill that increase fee-for-service spending would lead to higher payments to Medicare+Choice plans, beginning in 2001. No interaction with Medicare+Choice payments would occur in 2000 because the rates for 2000 have already been published and will not be adjusted unless services covered by the Medicare program change; the bill would not change covered services. CBO estimates the increase in spending attributable to the interaction between fee-for-service spending and Medicare+Choice payment rates would total $1.9 billion during the 2000–2004 period.

Part B premiums for 2000 have already been announced and would not be changed by this bill. In subsequent years, however, about 25 percent of new Part B outlays would be covered by premium payments by beneficiaries. CBO estimates that those premium payments would total $1.1 billion from 2000 through 2004.

A change in the Medicare Part B premium affects federal Medicaid spending because Medicaid covers the cost of the Medicare Part B premium for individuals dually eligible for Medicaid and Medicare and for other low-income Medicare beneficiaries not poor enough to qualify for full Medicaid benefits. CBO estimates that by increasing the amount of the Part B premium, the bill would increase federal Medicaid costs by about $0.1 billion over the 2000–2004 period.

Hospital Inpatient Services. H.R. 3075 contains numerous provisions that would affect Medicare payments to hospitals for inpatient care. CBO estimates these provisions would increase Medicare payments by about $1 billion during the 2000–2004 period.

Prospective Payment Hospitals. Medicare's prospective payment system (PPS) for hospital inpatient services adjusts payments to reflect higher patient care costs associated with medical education. The bill would set the adjustment at 6.0 percent for every 0.1 change in the ratio of residents to beds in 2001. In 2002, the adjustment would revert to the 5.5 percent specified in current law. CBO estimates that provision would increase outlays by $0.3 billion over the 2000–2004 period.

The bill also requires that Medicare's payment formula for its share of the direct costs of medical education be revised in a budget-neutral manner to be based on a national-average rate, adjusted for differences in local wage rates, rather than the current system in which payments are based on hospital-specific historical costs. Hospitals that would receive higher payments under the national-average rate would receive that rate immediately. However, the national-average rate would be phased in over a five-year period for hospitals that would receive payments. This provision would increase spending by $0.3 billion during 2000 through 2004.

Hospitals that serve a large number of low-income patients receive a "disproportionate share" adjustment to their prospective payment rates. Balanced Budget Act of 1997 (BBA) reduced those adjustments by 4 percent in 2001 and by 5 percent in 2002. The bill would limit those reductions to 3 percent in 2001 and 4 percent in 2002, which would increase spending by less than $0.1 billion during the 2000–2004 period.

PPS-exempt Hospitals. Hospitals that generally do not provide acute care services are exempted from the PPS and are paid on the basis of target amounts, (that is, hospital-specific historical costs, adjusted for inflation). The BBA capped the target amounts at the 75th percentile. The bill would adjust the 75th-percentile cap for differences in local wages rates. CBO estimates that those adjustments would increase outlays by $0.3 billion over the 2000–2004 period. The bill would also increase the bonuses paid to psychiatric and long-term care hospitals with costs during cost-reporting periods beginning in 2001 and 2002 that are below their target amounts. We estimate that provision would increase outlays by less than $50 million over five years.

The BBA required the Secretary of Health and Human Services (HHS) to develop a new PPS for inpatient services furnished by rehabilitation hospitals, and to phase-in that PPS over three years, beginning in 2001. During the transition, the bill would permit hospitals to choose the higher of the PPS payment rate or the transitional blend of PPS and hospital-specific rates. To offset the cost of that choice, the bill would reduce the PPS payment rate by 10 percent. Following analysis of claims and payment date, the Secretary would subsequently adjust payment rates to compensate hospitals or the Medicare program for the amount by which that 10-percent reduction was an over-adjustment or under-adjustment for the cost of permitting hospitals to choose the higher of PPS rates or transi-

tional rates. CBO estimates this provision would have no effect on federal spending.

The bill also mandates that new prospective payment systems be developed for long-term and psychiatric hospitals by the Secretary of HHS by October 1, 2001, so that they may be implemented beginning in 2003. The bill would direct the Secretary to devise payment systems which are budget neutral. CBO estimates that implementing those prospective payment systems would not have a significant effect on Medicare spending.

Hospital Outpatient Department Services. The BBA required the Secretary of HHS to implement a PPS to replace cost-based reimbursement for most outpatient hospital services. The Secretary plans to implement that PPS in July 2000. Some hospitals will experience gains under the PPS—Medicare payments will exceed the cost of providing outpatient services—while other hospitals will experience losses. The bill would reduce each hospital's loss during the first three years of the PPS, temporarily exempt cancer hospitals from the PPS, establish outlier adjustment payments for high-cost cases and transitional payments for certain drugs, biologicals, and medical devices under the PPS, and limit the beneficiary copayment for an outpatient hospital procedure to the Medicare Part A deductible. CBO estimates that those provisions would increase Medicare expenditures by $0.1 billion in 2000 and by $2.0 billion over the 2000–2004 period.

Skilled Nursing Facilities. The bill would amend several policies enacted in the BBA regarding payment to skilled nursing facilities (SNFs). During the transition to a fully prospective payment system, H.R. 3075 would allow SNFs to elect to be paid exclusively under the federal rate, rather than a blend of federal and facility-specific rates. The bill would increase the federal rates paid for cases assigned to the extensive services, special care, or clinically complex categories by 10 percent for services provided from April 1, 2000, through September 30, 2000. The bill would increase the update to federal payment rates for 2001 by 1.8 percentage points. It would exclude specified services—ambulance services, certain prosthetic devices, chemotherapy, and procedures using radiopharmaceuticals—from the SNF PPS and permit separate billing for those services. The bill also would enable SNFs that participated in the Nursing Home Case Mix and Quality Demonstration to receive an additional payment for Part B services in the facility-specific component of their payment rates. The final provision would require Medicare to pay SNFs that treat a large share of immuno-compromised patients a 50:50 blend of the federal and facility-specific rates for service furnished through 2001. CBO estimates that those provisions would increase Medicare expenditures by $0.2 billion in 2000 and by $1.9 billion over the 2000–2004 period.

Physician Update. The BBA established payment formulas that tie the growth of per-enrollee expenditures for physician services to the growth of gross domestic product. Those formulas generate annual rate changes that oscillate widely around a smooth trend. CBO projects stable growth rates, however, because the timing of those oscillations is impossible to predict.

The bill would modify the payment formulas to reduce the oscillations around the smooth trend. CBO estimates this provision would not change spending in 2000 and would not change cumulative spending during the 2000–2004 period. Compared to current law, however, payments to physicians would be higher in 2001 and 2002 and lower in 2003 and 2004.

Home Health. The bill would amend three policies enacted in the BBA regarding payment to home health agencies. First, it would lower the surety bond requirement for some agencies, eliminate the requirement that agencies have separate bonds for Medicare and Medicaid, and no longer require agencies to hold bonds after 4 years. Second, it would eliminate the contingency reduction and delay the 15-percent cut mandated in BBA until one year after the PPS for home health services is implemented. Third, it would pay home health agencies $10 per beneficiary served during their cost reporting period beginning in 2000. Those policies would increase Medicare expenditures by less than $50 million in 2000 and by $1.4 billion over the 2000–2004 period.

Rural Provisions. Sole community hospitals are paid the highest of PPS payment rates or their average cost per patient in 1982 or 1987, adjusted for inflation. The bill would allow sole community hospitals that currently receive PPS payment rates to choose between PPS rates and a blend of those rates and their inflation-adjusted costs in 1996. CBO estimates that provision would increase Medicare spending by $0.1 billion during 2000 through 2004.

The BBA created a new classification of limited-service hospitals, called Critical Access Hospitals (CAHs), which are exempted from the PPS. Those hospitals are limited to providing inpatient hospital stays no longer than 96 hours (with case-by-case exceptions). The bill would allow longer inpatient stays in CAHs, provided that stays average 96 hours; and it would permit investor-owned and closed or converted facilities to qualify as CAHs. CBO assumes those provisions would make it more attractive for facilities that meet the size and geographic eligibility requirements to obtain certification as a CAH, and would increase Medicare outlays by exempting more inpatient stays from the PPS. CBO estimates that those provisions would increase Medicare outlays by less than $50 million in 2000 and by $0.3 billion over the 2000–2004 period.

The bill would extend for five years the Medicare-dependent small rural hospital program (which will expire at the end of 2000), require the Secretary to permit certain hospitals located in urban areas to be reclassified as rural, and make other changes to the geographic classification system, which would allow these hospitals to obtain higher payment rates. The bill would enable all hospitals in rural areas with up to 100 beds to have swing beds, and also would expand access to paramedic services in rural areas. Those provisions would not affect spending in 2000, but would increase spending by $0.2 billion during 2001 through 2004.

Finally, the bill would allow rural teaching hospitals and hospitals with accredited rural graduate medical education programs to increase the number of residency positions above the limits established by the BBA. Those provisions would increase spending by less than $50 million a year, with a cumulative increase in spending of $0.1 billion during the 2000–2004 period.

Managed Care. The bill would slow the implementation of adjustment of Medicare+Choice payment rates to more accurately reflect differences in cost per enrollee that are associated with health status. CBO estimates that this provision would not change spending in 2000, but would increase Medicare spending by $1.1 billion over the 2001–2004 period.

H.R. 3075 would authorize $60 million a year for payments to hospitals with nursing and allied health education programs when they provide inpatient care to patients enrolled in a Medicare+Choice plan, but would offset that spending with reductions in payments to hospitals with graduate medical education programs. Thus, CBO estimates that provision would have no effect on Medicare spending.

Other provisions would make the administration of the Medicare+Choice program more flexible by allowing beneficiaries more time to enroll in Medicare+Choice or medigap plans when plans withdraw from markets, increasing Medicare+Choice payments for plans entering counties that had been without Medicare+Choice plans since 1997, allowing cost contracts with health maintenance organizations to be renewed until December 31, 2004, expanding the types of Medicare+Choice plans that may be offered by religious fraternal benefit societies, and easing certain requirements that limit how potential providers design and market managed care products to offer to Medicare beneficiaries. In addition, the bill would modify and extend a number of demonstration projects. Those provisions would increase federal spending by $0.6 billion during 2000 through 2004.

Other Medicare Provisions. The bill includes numerous other modifications of Medicare law that are either technical in nature—that is, they have no effect on federal spending—or would result in relatively small changes in Medicare spending. The additional provisions that would affect Medicare spending are discussed below. In total, CBO estimates that these other provisions would increase Medicare outlays by $1.2 billion over the 2000–2004 period.

Outpatient Therapy Services. The BBA established annual limits on per-beneficiary payments for outpatient therapy services provided by independent therapists, comprehensive outpatient rehabilitation facilities (CORFs), SNFs, and other nonhospital providers. The limits are a $1,500 combined annual cap on physical therapy and speech language pathology services, and a $1,500 annual cap on occupational therapy services. The bill would create separate $1,500 caps for physical therapy and for speech language pathology, implement the caps on a per-facility rather than a per-beneficiary basis, and authorize transitional outlier payments for high-cost beneficiaries. We estimate that this provision would increase Medicare expenditures by $0.1 billion in 2000 and by $0.6 billion over the 2000–2004 period.

Renal Dialysis. The bill would increase Medicare's composite rate for renal dialysis by 1.2 percent beginning in January 2000 and an additional 1.2 percent beginning in January 2001. That provision would increase Medicare expenditures by less than $50 million in 2000 and by $0.3 billion over the 2000–2004 period.

Durable Medical Equipment and Oxygen. The bill would update Medicare's payment rate for durable medical equipment and oxy-

gen by the consumer price index for all urban consumers less 2 percentage points in 2001 and 2002. That provision would have no budgetary effect in 2000, but would increase Medicare expenditures by $0.1 billion over the 2001–2004 period.

Pap Smears. The bill would increase Medicare's payment rate for the clinical laboratory component of pap smear tests. That provision would increase Medicare expenditures by less than $50 million in 2000 and $0.1 billion over the 2000–2004 period.

Inherent Reasonableness Authority. The BBA granted the Secretary of HHS the authority to adjust Medicare Part B payment rates when they are not "inherently reasonable." The bill would suspend the Secretary's authority to use the inherent reasonableness provision until publication of a new proposed rule and a final rule. That provision would increase Medicare expenditures by less than $50 million over the 2000–2004 period.

Ambulance Demonstration Project. The BBA authorized demonstration projects under which units of local government can contract directly with HHS to provide ambulance services under Medicare at a capitated rate. The bill would modify the capitated rate. That provision would increase Medicare expenditures by less than $50 million over the 2000–2004 period.

Telemedicine Demonstration Project. The BBA established a telemedicine demonstration project to improve primary care for diabetics living in medically underserved areas. The bill would direct the Secretary to make the award within three months of enactment and would change certain specifications of the project design. Modifications, such as altering the reimbursement rates, would affect the pattern of federal spending on the project over the 2000–2004 period. CBO estimates that this provision would increase spending by less than $5 million a year in 2000 and 2001, with offsetting reductions in 2002 and 2003. Thus, the provision would not change cumulative spending over the 2000–2004 period.

Pay-as-you-go considerations: The Balanced Budget and Emergency Deficit Control Act sets up-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays that would be subject to pay-as-you-go procedures are shown in the following table. For the purposes of enforcing pay-as-you-go procedures, only the effects in the budget year and the succeeding four years are counted.

	By fiscal years, in millions of dollars—									
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Changes in outlays	500	4,000	2,900	2,100	1,050	1,150	1,200	1,300	1,450	1,550
Change in receipts	Not applicable									

Estimated impact of state, local, and tribal governments: H.R. 3075 contains no intergovernmental mandates as defined in UMRA. However, the increases to the Medicare Part B premiums would result in additional state expenditures for Medicaid totaling about $70 million over the 2000–2004 period.

Estimated impact on the private Sector: The bill contains a mandate on private-sector insurers who provide medigap coverage to Medicare beneficiaries. Under current law, Medicare beneficiaries who lose supplemental coverage because of the termination or dis-

continuation of the employer-sponsored supplemental plan or the HMO in which they are enrolled are entitled to purchase medigap coverage on favorable terms if they apply within 63 days of the termination of enrollment.

The bill would allow Medicare beneficiaries to obtain medigap coverage under those same favorable terms if they applied within 63 days of being notified of the pending termination or discontinuation of their plan, effectively giving them two windows of opportunity to apply. Because of restrictions on the premiums that medigap insurers may charge in these circumstances, this provision could impose costs that insurers might not immediately recover from premiums. However, because of the small additional number of beneficiaries that the provision would affect, the costs that would be imposed on medigap insurers would be well below the threshold specified in UMRA ($100 million in 1996, adjusted annually for inflation).

Previous CBO Estimate: This estimate supersedes a previous estimate that was transmitted earlier today (October 29). The previous estimate included a cost of $0.2 billion over the 2000–2004 period for payments to hospitals with nursing and allied health programs when they provide inpatient care to patients enrolled in a Medicare+Choice plan. However, that provision would have no cost. This revised estimate corrects the error in the previous estimate.

Estimate prepared by: Federal Costs: Charles Betley, Michael Brinbaum, Julia Christensen, Jeanne De Sa, Cyndi Dudzinski, and Dorothy Rosenbaum. Impact on State, Local, and Tribal Governments: Leo Lex. Impact on the Private Sector: Bruce Vavrichek.

Estimate approved by: Peter H. Fontaine, Deputy Assistant Director for Budget Analysis.

V. OTHER MATTERS REQUIRED TO BE DISCUSSED UNDER THE RULES OF THE HOUSE

A. Committee Oversight Finding and Recommendations

In compliance with clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee reports that the need for this legislation was confirmed by the oversight hearings of the Subcommittee on Health. The hearings were as follows:

The Subcommittee on Health held a hearing on February 11, 1999, to examine the Health Care Financing Administration's (HCFA) ability to administer the current Medicare program and to manage the future needs of the program's growing number of beneficiaries. Testimony at the hearing was presented by HCFA, the General Accounting Office, and contractors who process and audit claims for the Medicare program.

On March 2, 1999, the Subcommittee held a hearing on the annual Medicare Payment Advisory Commission (MedPAC) Report to the Congress on Medicare Payment Policy, with testimony from the MedPAC Chair. In addition, on March 18, 1999, the Subcommittee held a hearing on the Medicare+Choice program to examine the Administration's proposed new risk adjustment method, dissemination of health plan information to seniors, and new plan requirements for quality measurement.

Finally, on October 1, 1999, the Subcommittee held a hearing on Medicare Balanced Budget Act refinements. The hearing included testimony from the Administration, Congressional advisory bodies, and providers about the implementation and impact of policy changes included in the Balanced Budget Act of 1997, including changes in various payment methodologies.

B. Summary of Findings and Recommendations of the Government Reform and Oversight Committee

In compliance with clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the Committee states that no oversight findings or recommendations have been submitted to the Committee on Governmental Reform regarding the subject of the bill.

C. Constitutional Authority Statement

In compliance with clause 3(d)(1) of rule XIII of the Rules of the House of Representatives, relating to Constitutional Authority, the Committee states that the Committee's action in reporting the bill is derived from Article I of the Constitution, Section 8 ("The Congress shall have power to lay and collect taxes, duties, imposts and excises, to pay the debts and to provide for * * * the general Welfare of the United States * * *").

VI. CHANGES IN EXISTING LAWS MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * * * *

TITLE XI—GENERAL PROVISIONS, PEER REVIEW, AND ADMINISTRATIVE SIMPLIFICATION

* * * * * * *

Part A—General Provisions

* * * * * * *

COORDINATION OF MEDICARE AND MEDICAID SURETY BOND PROVISIONS

Sec. 1148. In the case of a home health agency that is subject to a surety bond under title XVIII and title XIX, the surety bond provided to satisfy the requirement under one such title shall satisfy the requirement under the other such title so long as the bond applies to guarantee return of overpayments under both such titles.

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TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

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PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

MEDICARE PAYMENT ADVISORY COMMISSION

SEC. 1805. (a) * * *

* * * * * * *

(b) DUTIES.—

(1) REVIEW OF PAYMENT POLICIES AND ANNUAL REPORTS.—The Commission shall—

(A) * * *

* * * * * * *

(D) by not later than June 1 of each year (beginning with 1998), submit a report to Congress containing an examination of issues affecting the medicare program, including the implications of changes in health care delivery in the United States and in the market for health care services on the medicare program *and including a review of the estimate of the conversion factor submitted under section 1848(d)(1)(E)(ii)*.

* * * * * * *

MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM

SEC. 1820. (a) * * *

* * * * * * *

(c) MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM DESCRIBED.—

(1) * * *

* * * * * * *

(2) STATE DESIGNATION OF FACILITIES.—

(A) IN GENERAL.—A State may designate 1 or more facilities as a critical access hospital in accordance with [subparagraph (B)] *subparagraphs (B), (C), and (D)*.

(B) CRITERIA FOR DESIGNATION AS CRITICAL ACCESS HOSPITAL.—A State may designate a facility as a critical access hospital if the facility—

(i) is a [nonprofit or public] hospital and is located in a county (or equivalent unit of local government) in a rural area (as defined in section 1886(d)(2)(D)) *or is treated as being located in a rural area pursuant to section 1886(d)(8)(E)* that—

(I) * * *

* * * * * * *

(iii) provides not more than 15 (or, in the case of a facility under an agreement described in subsection (f), 25) acute care inpatient beds (meeting such standards as the Secretary may establish) for providing inpatient

care [for a period not to exceed 96 hours (unless a longer period is required because transfer to a hospital is precluded because of inclement weather or other emergency conditions), except that a peer review organization or equivalent entity may, on request, waive the 96-hour restriction on a case-by-case basis;] *for a period that does not exceed, as determined on an annual, average basis, 96 hours per patient;*

(C) RECENTLY CLOSED FACILITIES.—A State may designate a facility as a critical access hospital if the facility—

(i) was a hospital that ceased operations on or after the date that is 10 years before the date of enactment of this subparagraph; and

(ii) as of the effective date of such designation, meets the criteria for designation under subparagraph (B).

(D) DOWNSIZED FACILITIES.—A State may designate a health clinic or a health center (as defined by the State) as a critical access hospital if such clinic or center—

(i) is licensed by the State as a health clinic or a health center;

(ii) was a hospital that was downsized to a health clinic or health center; and

(iii) as of the effective date of such designation, meets the criteria for designation under subparagraph (B).

* * * * * * *

(g) GRANTS.—

(1) * * *

* * * * * * *

(3) UPGRADING DATA SYSTEMS.—

(A) GRANTS TO HOSPITALS.—The Secretary may award grants to hospitals that have submitted applications in accordance with subparagraph (C) to assist eligible small rural hospitals in meeting the costs of implementing data systems required to meet requirements established under the medicare program pursuant to amendments made by the Balanced Budget Act of 1997.

(B) ELIGIBLE SMALL RURAL HOSPITAL DEFINED.—For purposes of this paragraph, the term "eligible small rural hospital" means a non-Federal, short-term general acute care hospital that—

(i) is located in a rural area (as defined for purposes of section 1886(d)); and

(ii) has less than 50 beds.

(C) APPLICATION.—A hospital seeking a grant under this paragraph shall submit an application to the Secretary on or before such date and in such form and manner as the Secretary specifies.

(D) AMOUNT OF GRANT.—A grant to a hospital under this paragraph may not exceed $50,000.

(E) USE OF FUNDS.—A hospital receiving a grant under this paragraph may use the funds for the purchase of computer software and hardware and for the education and training of hospital staff on computer information systems

and costs related to the implementation of prospective payment systems.

(F) REPORT.—

(i) INFORMATION.—A hospital receiving a grant under this section shall furnish the Secretary with such information as the Secretary may require to evaluate the project for which the grant is made and to ensure that the grant is expended for the purposes for which it is made.

(ii) REPORTING.—

(I) INTERIM REPORTS.—The Secretary shall report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate at least annually on the grant program established under this section, including in such report information on the number of grants made, the nature of the projects involved, the geographic distribution of grant recipients, and such other matters as the Secretary deems appropriate.

(II) FINAL REPORT.—The Secretary shall submit a final report to such committees not later than 180 days after the completion of all of the projects for which a grant is made under this section.

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PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

* * * * * * *

PAYMENT OF BENEFITS

SEC. 1833. (a) Except as provided in section 1876, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

(1) in the case of services described in section 1832(a)(1)—80 percent of the reasonable charges for the services; except that (A) an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis (and either is sponsored by a union or employer, or does not provide, or arrange for the provision of, any inpatient hospital services) may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b), (B) with respect to items and services described in section 1861(s)(10)(A), the amounts paid shall be 100 percent of the reasonable charges for such items and services, (C) with re-

spect to expenses incurred for those physicians' services for which payment may be made under this part that are described in section 1862(a)(4), the amounts paid shall be subject to such limitations as may be prescribed by regulations, (D) with respect to clinical diagnostic laboratory tests for which payment is made under this part (i) on the basis of a fee schedule under subsection (h)(1) or section 1834(d)(1), the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on an assignment-related basis *or which are furnished on an outpatient basis by a critical access hospital*) of the lesser of the amount determined under such fee schedule, the limitation amount for that test determined under subsection (h)(4)(B), or the amount of the charges billed for the tests, or (ii) on the basis of a negotiated rate established under subsection (h)(6), the amount paid shall be equal to 100 percent of such negotiated rate, (E) with respect to services furnished to individuals who have been determined to have end stage renal disease, the amounts paid shall be determined subject to the provisions of section 1881, (F) with respect to clinical social worker services under section 1861(s)(2)(N), the amounts paid shall be 80 percent of the lesser of (i) the actual charge for the services or (ii) 75 percent of the amount determined for payment of a psychologist under clause (L), (H) with respect to services of a certified registered nurse anesthetist under section 1861(s)(11), the amounts paid shall be 80 percent of the least of the actual charge, the prevailing charge that would be recognized (or, for services furnished on or after January 1, 1992, the fee schedule amount provided under section 1848) if the services had been performed by an anesthesiologist, or the fee schedule for such services established by the Secretary in accordance with subsection (l), (I) with respect to covered items (described in section 1834(a)(13)), the amounts paid shall be the amounts described in section 1834(a)(1), and (J) with respect to expenses incurred for radiologist services (as defined in section 1834(b)(6)), subject to section 1848, the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount provided under the fee schedule established under section 1834(b), (K) with respect to certified nurse-midwife services under section 1861(s)(2)(L), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph (but in no event shall such fee schedule exceed 65 percent of the prevailing charge that would be allowed for the same service performed by a physician, or, for services furnished on or after January 1, 1992, 65 percent of the fee schedule amount provided under section 1848 for the same service performed by a physician), (L) with respect to qualified psychologist services under section 1861(s)(2)(M), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph, (M) with respect to prosthetic devices and orthotics and prosthetics (as defined

in section 1834(h)(4)), the amounts paid shall be the amounts described in section 1834(h)(1), (N) with respect to expenses incurred for physicians' services (as defined in section 1848(j)(3)), the amounts paid shall be 80 percent of the payment basis determined under section 1848(a)(1), (O) with respect to services described in section 1861(s)(2)(K) (relating to services furnished by physician assistants, nurse practitioners, or clinic nurse specialists), the amounts paid shall be equal to 80 percent of (i) the lesser of the actual charge or 85 percent of the fee schedule amount provided under section 1848, or (ii) in the case of services as an assistant at surgery, the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery; (P) with respect to surgical dressings, the amounts paid shall be the amounts determined under section 1834(i), (Q) with respect to items or services for which fee schedules are established pursuant to section 1842(s), the amounts paid shall be 80 percent of the lesser of the actual charge or the fee schedule established in such section, (R) with respect to ambulance service, the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary under section 1834(l), and (S) with respect to drugs and biologicals not paid on a cost or prospective payment basis as otherwise provided in this part (other than items and services described in subparagraph (B)), the amounts paid shall be 80 percent of the lesser of the actual charge or the payment amount established in section 1842(o);

* * * * * * *

(g)(1)*(A)* In the case of physical therapy services of the type described in section 1861(p), but not described in section 1833(a)(8)(B), and physical therapy services of such type which are furnished by a physician or as incident to physicians' services, with respect to expenses incurred in any calendar year, no more than the amount specified in paragraph (2) for the year shall be considered as incurred expenses for purposes of subsections (a) and (b).

(B) Subparagraph (A) shall be applied separately for speech-language pathology services described in the fourth sentence of section 1861(p) and for other outpatient physical therapy services.

* * * * * * *

(4) The limitations of this subsection apply to the services involved on a per beneficiary, per facility (or provider) basis.

(5)(A) The Secretary shall establish a process under which a facility or provider that is providing therapy services to which the limitation of this subsection applies to a beneficiary may apply to the Secretary for an increase in such limitation under this paragraph for services furnished in 2000 or in 2001.

(B) Such process shall take into account the clinical diagnosis and shall provide that the aggregate amount of additional payments resulting from the application of this paragraph—

(i) during fiscal year 2000 may not exceed $40,000,000;

(ii) during fiscal year 2001 may not exceed $60,000,000; and

(iii) during fiscal year 2002 may not exceed $20,000,000.

* * * * * * *

(h)(1) * * *

* * * * * * *

(7) Notwithstanding paragraphs (1) and (4), the Secretary shall establish a minimum payment amount under this subsection for all areas for a diagnostic or screening pap smear laboratory test (including all cervical cancer screening technologies that have been approved by the Food and Drug Administration) of not less than $14.60.

(l)(1) * * *

* * * * * * *

(4)(A) Except as provided in subparagraphs (C) and (D), in determining the amount paid under the fee schedule under this subsection for services furnished on or after January 1, 1991, by a certified registered nurse anesthetist who is not medically directed—

(i) the conversion factor shall be—

(I) * * *

* * * * * * *

(VII) for services furnished in calendar years after 1996, the previous year's conversion factor increased by the update determined under section [1848(d)(3)] *1848(d)* for physician anesthesia services for that year;

* * * * * * *

(t) PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.—

(1) AMOUNT OF PAYMENT.—

(A) * * *

(B) DEFINITION OF COVERED OPD SERVICES.—For purposes of this subsection, the term "covered OPD services"—

(i) * * *

(ii) subject to [clause (iii)] *clause (iv)*, includes inpatient hospital services designated by the Secretary that are covered under this part and furnished to a hospital inpatient who (I) is entitled to benefits under part A but has exhausted benefits for inpatient hospital services during a spell of illness, or (II) is not so entitled; [but]

(iii) includes medical devices (such as implantable medical devices); but

[(iii)] *(iv)* does not include any therapy services described in subsection (a)(8) or ambulance services, for which payment is made under a fee schedule described in section 1834(k) or section 1834(l).

(2) SYSTEM REQUIREMENTS.—Under the payment system—

(A) * * *

(B) the Secretary may establish groups of covered OPD services, within the classification system described in subparagraph (A), so that services classified within each group are comparable clinically and with respect to the use

of resources *and so that a device is classified to the group that includes the service to which the device relates*;

(C) the Secretary shall, using data on claims from 1996 and using data from the most recent available cost reports, establish relative payment weights for covered OPD services (and any groups of such services described in subparagraph (B)) based on median *(or, at the election of the Secretary, mean)* hospital costs and shall determine projections of the frequency of utilization of each such service (or group of services) in 1999;

* * * * * * *

(E) the Secretary shall establish **[**other adjustments, in a budget neutral manner, as determined to be necessary to ensure equitable payments, such as outlier adjustments or**]***, in a budget neutral manner, outlier adjustments under paragraph (5) and transitional pass-through payments under paragraph (6) and other adjustments as determined to be necessary to ensure equitable payments, such as* adjustments for certain classes of hospitals; and

(F) the Secretary shall develop a method for controlling unnecessary increases in the volume of covered OPD services.

For purposes of subparagraph (B), items and services within a group shall not be treated as 'comparable with respect to the use of resources' if the highest median cost (or mean cost, if elected by the Secretary under subparagraph (C)) for an item or service within the group is more than 2 times greater than the lowest median cost (or mean cost, if so elected) for an item or service within the group; except that the Secretary may make exceptions in unusual cases, such as low volume items and services.

* * * * * * *

(4) MEDICARE PAYMENT AMOUNT.—The amount of payment made from the Trust Fund under this part for a covered OPD service (and such services classified within a group) furnished in a year is determined*, subject to paragraph (7),* as follows:

(A) * * *

* * * * * * *

(C) APPLY PAYMENT PROPORTION TO REMAINDER.—The amount of payment is the amount so determined under subparagraph (B) multiplied by the pre-deductible payment percentage (as determined under paragraph (3)(E)) for the service or group and year involved*, plus the amount of any reduction in the copayment amount attributable to paragraph (5)(C)*.

(5) OUTLIER ADJUSTMENT.—

(A) IN GENERAL.—The Secretary shall provide for an additional payment for each covered OPD service (or group of services) for which a hospital's charges, adjusted to cost, exceed—

(i) a fixed multiple of the sum of—

(I) the applicable Medicare OPD fee schedule amount determined under paragraph (3)(D), as adjusted under paragraph (4)(A) (other than for adjustments under this paragraph or paragraph (6)); and

(II) any transitional pass-through payment under paragraph (6); and

(ii) at the option of the Secretary, such fixed dollar amount as the Secretary may establish.

(B) AMOUNT OF ADJUSTMENT.—The amount of the additional payment under subparagraph (A) shall be determined by the Secretary and shall approximate the marginal cost of care beyond the applicable cutoff point under such subparagraph.

(C) LIMIT ON AGGREGATE OUTLIER ADJUSTMENTS.—

(i) IN GENERAL.—The total of the additional payments made under this paragraph for covered OPD services furnished in a year (as projected or estimated by the Secretary before the beginning of the year) may not exceed the applicable percentage (specified in clause (ii)) of the total program payments projected or estimated to be made under this subsection for all covered OPD services furnished in that year. If this paragraph is first applied to less than a full year, the previous sentence shall apply only to the portion of such year.

(ii) APPLICABLE PERCENTAGE.—For purposes of clause (i), the term "applicable percentage" means a percentage specified by the Secretary up to (but not to exceed)—

(I) for a year (or portion of a year) before 2004, 2.5 percent; and

(II) for 2004 and thereafter, 3.0 percent.

(6) TRANSITIONAL PASS-THROUGH FOR ADDITIONAL COSTS OF INNOVATIVE MEDICAL DEVICES, DRUGS, AND BIOLOGICALS.—

(A) IN GENERAL.—The Secretary shall provide for an additional payment under this paragraph for any of the following that are provided as part of a covered OPD service (or group of services):

(i) CURRENT ORPHAN DRUGS.—A drug or biological that is used for a rare disease or condition with respect to which the drug or biological has been designated as an orphan drug under section 526 of the Federal Food, Drug and Cosmetic Act if payment for the drug or biological as an outpatient hospital service under this part was being made on the first date that the system under this subsection is implemented.

(ii) CURRENT CANCER THERAPY DRUGS AND BIOLOGICALS.—A drug or biological that is used in cancer therapy if payment for the drug or biological as an outpatient hospital service under this part was being made on such first date.

(iii) NEW MEDICAL DEVICES, DRUGS, AND BIOLOGICALS.—A medical device, drug, or biological not described in clause (i) or (ii) if—

(I) payment for the device, drug, or biological as an outpatient hospital services under this part was not being made as of December 31, 1996; and

(II) the cost of the device, drug, or biological is not insignificant in relation to the OPD fee schedule amount (as calculated under paragraph (3)(D)) payable for the service (or group of services) involved.

(B) LIMITED PERIOD OF PAYMENT.—The payment under this paragraph with respect to a medical device, drug, or biological shall only apply during a period of at least 2 years, but not more than 3 years, that begins—

(i) on the first date this subsection is implemented in the case of a drug or biological described in clause (i) or (ii) of subparagraph (A) and in the case of a device, drug, or biological described in subparagraph (A)(iii) for which payment under this part is made as an outpatient hospital service before such first date; or

(ii) in the case of a device, drug, or biological described in subparagraph (A)(iii) not described in clause (i), on the first date on which payment is made under this part for the device, drug, or biological as an outpatient hospital service.

(C) AMOUNT OF ADDITIONAL PAYMENT.—Subject to subparagraph (D)(iii), the amount of the payment under this paragraph with respect to a device, drug, or biological provided as part of a covered OPD service is—

(i) in the case of a drug or biological, the amount by which the amount determined under section 1842(o) for the drug or biological exceeds the portion of the otherwise applicable medicare OPD fee schedule that the Secretary determines is associated with the drug or biological; or

(ii) in the case of a medical device, the amount by which the hospital's charges for the device, adjusted to cost, exceeds the portion of the otherwise applicable medicare OPD fee schedule that the Secretary determines is associated with the device.

(D) LIMIT ON AGGREGATE ANNUAL ADJUSTMENT.—

(i) IN GENERAL.—The total of the additional payments made under this paragraph for covered OPD services furnished in a year (as projected or estimated by the Secretary before the beginning of the year) may not exceed the applicable percentage (specified in clause (ii)) of the total program payments projected or estimated to be made under this subsection for all covered OPD services furnished in that year. If this paragraph is first applied to less than a full year, the previous sentence shall apply only to the portion of such year.

(ii) APPLICABLE PERCENTAGE.—For purposes of clause (i), the term "applicable percentage" means—

(I) for a year (or portion of a year) before 2004, 2.5 percent; and

(II) for 2004 and thereafter, a percentage specified by the Secretary up to (but not to exceed) 2.0 percent.

(iii) UNIFORM PROSPECTIVE REDUCTION IF AGGREGATE LIMIT PROJECTED TO BE EXCEEDED.—If the Secretary projects or estimates before the beginning of a year that the amount of the additional payments under this paragraph for the year (or portion thereof) as determined under clause (i) without regard to this clause) will exceed the limit established under such clause, the Secretary shall reduce pro rata the amount of each of the additional payments under this paragraph for that year (or portion thereof) in order to ensure that the aggregate additional payments under this paragraph (as so projected or estimated) do not exceed such limit.

(7) TRANSITIONAL ADJUSTMENT TO LIMIT DECLINE IN PAYMENT.—

(A) BEFORE 2002.—For covered OPD services furnished before January 1, 2002, for which the PPS amount (as defined in subparagraph (D)(i)) is—

(i) at least 90 percent, but less than 100 percent, of the pre-BBA amount (as defined in subparagraph (D)(ii)), the amount of payment under this subsection shall be increased by 80 percent of the amount of such difference;

(ii) at least 80 percent, but less than 90 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount by which (I) the product of 0.71 and the pre-BBA amount, exceeds (II) the product of 0.70 and the PPS amount;

(iii) at least 70 percent, but less than 80 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount by which (I) the product of 0.63 and the pre-BBA amount, exceeds (II) the product of 0.60 and the PPS amount;

(iv) less than 70 percent of the pre-BBA amount, the amount of payment under this subsection shall be increased by 21 percent of the pre-BBA amount.

(B) 2002.—For covered OPD services furnished during 2002, for which the PPS amount is—

(i) at least 90 percent, but less than 100 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by 70 percent of the amount of such difference;

(ii) at least 80 percent, but less than 90 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount by which (I) the product of 0.61 and the pre-BBA amount, exceeds (II) the product of 0.60 and the PPS amount;

(iii) less than 80 percent of the pre-BBA amount, the amount of payment under this subsection shall be increased by 13 percent of the pre-BBA amount.

(C) 2003.—For covered OPD services furnished during 2003, for which the PPS amount is—

(i) at least 90 percent, but less than 100 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by 60 percent of the amount of such difference; or

(ii) less than 90 percent of the pre-BBA amount, the amount of payment under this subsection shall be increased by 6 percent of the pre-BBA amount.

(D) DEFINITIONS.—For purposes of this subparagraph:

(i) PPS AMOUNT.—The term "PPS amount" means, with respect to a covered OPD service, the amount of payment under this title for such service (determined without regard to this paragraph).

(ii) PRE-BBA AMOUNT.—The term "pre-BBA amount" means, with respect to a covered OPD service, the amount that would have been paid under this title for such service if this subsection did not apply.

(E) CONSTRUCTION.—Nothing in this paragraph shall be construed to affect the copayment amount under paragraph (8).

[(5)**]** *(8)* COPAYMENT AMOUNT.—

(A) IN GENERAL.—Except as provided in **[**subparagraph (B)**]** *subparagraphs (B) and (C)*, the copayment amount under this subsection is the amount by which the amount described in paragraph (4)(B) exceeds the amount of payment determined under paragraph (4)(C).

(B) ELECTION TO OFFER REDUCED COPAYMENT AMOUNT.—The Secretary shall establish a procedure under which a hospital, before the beginning of a year (beginning with 1999), may elect to reduce the copayment amount otherwise established under subparagraph (A) for some or all covered OPD services to an amount that is not less than 20 percent of the medicare OPD fee schedule amount (computed under paragraph (3)(D)) for the service involved. Under such procedures, such reduced copayment amount may not be further reduced or increased during the year involved and the hospital may disseminate information on the reduction of copayment amount effected under this subparagraph.

(C) LIMITING COPAYMENT AMOUNT TO INPATIENT HOSPITAL DEDUCTIBLE AMOUNT.—In no case shall the copayment amount for a procedure performed in a year exceed the amount of the inpatient hospital deductible established under section 1813(b) for that year.

[(C)**]** *(D)* NO IMPACT ON DEDUCTIBLES.—Nothing in this paragraph shall be construed as affecting a hospital's authority to waive the charging of a deductible under section 1833(b).

(E) COMPUTATION IGNORING OUTLIER AND PASS-THROUGH ADJUSTMENTS.—The copayment amount shall be computed under subparagraph (A) as if the adjustments under paragraphs (5) and (6) (and any adjustment made under paragraph (2)(E) in relation to such adjustments) had not occurred.

[(6)] *(9)* PERIODIC REVIEW AND ADJUSTMENTS COMPONENTS OF PROSPECTIVE PAYMENT SYSTEM.—

(A) PERIODIC REVIEW.—The Secretary [may periodically review] *shall review not less often than annually* and revise the groups, the relative payment weights, and the wage and other adjustments described in paragraph (2) to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors.

* * * * * * *

[(7)] *(10)* SPECIAL RULE FOR AMBULANCE SERVICES.—The Secretary shall pay for hospital outpatient services that are ambulance services on the basis described in [the matter in subsection (a)(1) preceding subparagraph (A)] *section 1961(v)(1)(U)*, or, if applicable, the fee schedule established under section 1834(l).

[(8)] *(11)* SPECIAL RULES FOR CERTAIN HOSPITALS.—In the case of hospitals described in section 1886(d)(1)(B)(v)—

(A) the system under this subsection shall not apply to covered OPD services furnished before [January 1, 2000] *the first day of the first year that begins 2 years after the date the prospective payment system under this section is first implemented*; and

* * * * * * *

[(9)] *(12)* LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of—

(A) the development of the classification system under paragraph (2), including the establishment of groups and relative payment weights for covered OPD services, of wage adjustment factors, other adjustments, and methods described in paragraph (2)(F);

(B) the calculation of base amounts under paragraph (3);

(C) periodic adjustments made under paragraph (6); [and]

(D) the establishment of a separate conversion factor under paragraph (8)(B)[.]*; and*

(E) the determination of the fixed multiple, or a fixed dollar cutoff amount, the marginal cost of care, or applicable percentage under paragraph (5) or the determination of insignificance of cost, the duration of the additional payments (consistent with paragraph (6)(B)), the portion of the Medicare OPD fee schedule amount associated with particular devices, drugs, or biologicals, and the application of any pro rata reduction under paragraph (6).

(13) MISCELLANEOUS PROVISIONS.—

(A) APPLICATION OF RECLASSIFICATION OF CERTAIN HOSPITALS.—If a hospital is being treated as being located a rural area under section 1886(d)(8)(E), that hospital shall be treated under this subsection as being located in that rural area.

* * * * * * *

SPECIAL PAYMENT RULES FOR PARTICULAR ITEMS AND SERVICES

SEC. 1834. (a) PAYMENT FOR DURABLE MEDICAL EQUIPMENT.—

(1) * * *

* * * * * * *

(9) MONTHLY PAYMENT AMOUNT RECOGNIZED WITH RESPECT TO OXYGEN AND OXYGEN EQUIPMENT.—For purposes of paragraph (5), the amount that is recognized under this paragraph for payment for oxygen and oxygen equipment is the monthly payment amount described in subparagraph (C) of this paragraph. Such amount shall be computed separately (i) for all items of oxygen and oxygen equipment (other than portable oxygen equipment) and (ii) for portable oxygen equipment (each such group referred to in this paragraph as an "item").

(A) * * *

* * * * * * *

(B) COMPUTATION OF NATIONAL LIMITED MONTHLY PAYMENT RATE.—With respect to the furnishing of an item in a year, the Secretary shall compute a national limited monthly payment rate equal to—

(i) * * *

* * * * * * *

(v) for 1998, 75 percent of the amount determined under this subparagraph for 1997; [and]

(vi) for 1999 and [each subsequent year] *2000*, 70 percent of the amount determined under this subparagraph for 1997[.]*; and*

(vii) for 2001 and each subsequent year, the amount determined under this subparagraph for the preceding year increased by the covered item update for such subsequent year.

* * * * * * *

(14) COVERED ITEM UPDATE.—In this subsection, the term "covered item update" means, with respect to a year—

(A) * * *

* * * * * * *

[(C) for each of the years 1998 through 2002, 0 percentage points; and]

(C) for each of the years 1998 through 2000, 0 percentage points;

(D) for each of the years 2001 and 2002, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year minus 2 percentage points; and

[(D)] *(E)* for a subsequent year, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year.

* * * * * * *

[(g) PAYMENT FOR OUTPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—The amount of payment under this part for outpatient critical access hospital services is the reasonable costs of the critical access hospital in providing such services.]

(g) PAYMENT FOR OUTPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—

(1) ELECTION OF CAH.—At the election of a critical access hospital, the amount of payment for outpatient critical access hospital services under this part shall be determined under paragraph (2) or (3), such amount determined under either paragraph without regard to the amount of the customary or other charge.

(2) COST-BASED HOSPITAL OUTPATIENT SERVICE PAYMENT PLUS FEE SCHEDULE FOR PROFESSIONAL SERVICES.—If a hospital elects this paragraph to apply, there shall be paid amounts equal to the sum of the following:

(A) FACILITY FEE.—With respect to facility services, not including any services for which payment may be made under subparagraph (B), the reasonable costs of the critical access hospital in providing such services, less the amount that such hospital may charge as described in section 1866(a)(2)(A).

(B) FEE SCHEDULE FOR PROFESSIONAL SERVICES.—With respect to professional services otherwise included within outpatient critical access hospital services, such amounts as would otherwise be paid under this part if such services were not included in outpatient critical access hospital services.

(3) ALL-INCLUSIVE RATE.—If a hospital elects this paragraph to apply, with respect to both facility services and professional services, there shall be paid amounts equal to the reasonable costs of the critical access hospital in providing such services, less the amount that such hospital may charge as described in section 1866(a)(2)(A).

* * * * * * *

SEC. 1847. DEMONSTRATION PROJECTS FOR COMPETITIVE ACQUISITION OF ITEMS AND SERVICES.

(a) * * *

* * * * * * *

(b) AWARDING OF CONTRACTS IN AREAS.—

(1) * * *

(2) CONDITIONS FOR AWARDING CONTRACT.—The Secretary may not award a contract to any entity under the competition conducted pursuant to paragraph (1) to furnish an item or service unless the Secretary finds that the entity meets quality standards specified by the Secretary *and* that the total amounts to be paid under the contract are expected to be less than the total amounts that would otherwise be paid.

* * * * * * *

PAYMENT FOR PHYSICIANS' SERVICES

SEC. 1848. (a) * * *

* * * * * * *

(d) CONVERSION FACTORS.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The conversion factor for each year shall be the conversion factor established under this subsection for the previous year (or, in the case of 1992, specified in subparagraph (B)) adjusted by the update (established under paragraph (3)) for the year involved *(for years before 2001) and, for years beginning with 2001, multiplied by the update (established under paragraph (4)) for the year involved*.

* * * * * * *

[(E) PUBLICATION.—The Secretary shall cause to have published in the Federal Register, during the last 15 days of October of—

[(i) 1991, the conversion factor which will apply to physicians' services for 1992, and the update determined under paragraph (3) for 1992 and

[(ii) each succeeding year, the conversion factor which will apply to physicians' services for the following year and the update determined under paragraph (3) for such year.]

(E) PUBLICATION AND DISSEMINATION OF INFORMATION.—The Secretary shall—

(i) cause to have published in the Federal Register not later than November 1 of each year (beginning with 2000) the conversion factor which will apply to physicians' services for the succeeding year, the update determined under paragraph (4) for such succeeding year, and the allowed expenditures under such paragraph for such succeeding year; and

(ii) make available to the Medicare Payment Advisory Commission and the public by March 1 of each year (beginning with 2000) an estimate of the conversion factor which will apply to physicians' services for the succeeding year and data used in making such estimate.

* * * * * * *

(3) UPDATE *FOR 1999 AND 2000*.—

(A) IN GENERAL.—Unless otherwise provided by law, subject to subparagraph (D) and the budget-neutrality factor determined by the Secretary under subsection (c)(2)(B)(ii), the update to the single conversion factor established in paragraph (1)(C) for [a year beginning with 1999] *1999 and 2000* is equal to the product of—

(i) * * *

* * * * * * *

(C) DETERMINATION OF ALLOWED EXPENDITURES.—For purposes of this paragraph *and paragraph (4)*, the allowed

expenditures for physicians' services for the 12-month period ending with March 31 of—

(i) * * *

* * * * * * *

(4) UPDATE FOR YEARS BEGINNING WITH 2001.—

(A) IN GENERAL.—Unless otherwise provided by law, subject to the budget-neutrality factor determined by the Secretary under subsection (c)(2)(B)(ii) and subject to adjustment under subparagraph (F), the update to the single conversion factor established in paragraph (1)(C) for a year beginning with 2001 is equal to the product of—

(i) 1 plus the Secretary's estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year (divided by 100), and

(ii) 1 plus the Secretary's estimate of the update adjustment factor under subparagraph (B) for the year.

(B) UPDATE ADJUSTMENT FACTOR.—For purposes of subparagraph (A)(ii), subject to subparagraph (D), the "update adjustment factor" for a year is equal (as estimated by the Secretary) to the sum of the following:

(i) PRIOR YEAR ADJUSTMENT COMPONENT.—An amount determined by—

(I) computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services for the prior year (as determined under subparagraph (C)) and the amount of the actual expenditures for such services for that year;

(II) dividing that difference by the amount of the actual expenditures for such services for that year; and

(III) multiplying that quotient by 0.75.

(ii) CUMULATIVE ADJUSTMENT COMPONENT.—An amount determined by—

(I) computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services (as determined under subparagraph (C)) from April 1, 1996, through the end of the prior year and the amount of the actual expenditures for such services during that period;

(II) dividing that difference by actual expenditures for such services for the prior year as increased by the sustainable growth rate under subsection (f) for the year for which the update adjustment factor is to be determined; and

(III) multiplying that quotient by 0.33.

(C) DETERMINATION OF ALLOWED EXPENDITURES.—For purposes of this paragraph:

(i) PERIOD UP TO APRIL 1, 1999.—The allowed expenditures for physicians' services for a period before April 1, 1999, shall be the amount of the allowed expenditures for such period as determined under paragraph (3)(C).

(ii) TRANSITION TO CALENDAR YEAR ALLOWED EXPENDITURES.—Subject to subparagraph (E), the allowed expenditures for—

(I) the 9-month period beginning April 1, 1999, shall be the Secretary's estimate of the amount of the allowed expenditures that would be permitted under paragraph (3)(C) for such period; and

(II) the year of 1999, shall be the Secretary's estimate of the amount of the allowed expenditures that would be permitted under paragraph (3)(C) for such year.

(iii) YEARS BEGINNING WITH 2000.—The allowed expenditures for a year (beginning with 2000) is equal to the allowed expenditures for physicians' services for the previous year, increased by the sustainable growth rate under subsection (f) for the year involved.

(D) RESTRICTION ON UPDATE ADJUSTMENT FACTOR.—The update adjustment factor determined under subparagraph (B) for a year may not be less than −0.07 or greater than 0.03.

(E) RECALCULATION OF ALLOWED EXPENDITURES FOR UPDATES BEGINNING WITH 2001.—For purposes of determining the update adjustment factor for a year beginning with 2001, the Secretary shall recompute the allowed expenditures for previous periods beginning on or after April 1, 1999, consistent with subsection (f)(3).

(F) TRANSITIONAL ADJUSTMENT DESIGNED TO PROVIDE FOR BUDGET NEUTRALITY.—Under this subparagraph the Secretary shall provide for an adjustment to the update under subparagraph (A)—

(i) for each of 2001, 2002, 2003, and 2004, of −0.2 percent; and

(ii) for 2005 of +0.8 percent.

* * * * * * *

(f) SUSTAINABLE GROWTH RATE.—

[(1) PUBLICATION.—The Secretary shall cause to have published in the Federal Register the sustainable growth rate for each fiscal year beginning with fiscal year 1998. Such publication shall occur by not later than August 1 before each fiscal year, except that such rate for fiscal year 1998 shall be published not later than November 1, 1997.**]**

(1) PUBLICATION.—The Secretary shall cause to have published in the Federal Register not later than—

(A) November 1, 2000, the sustainable growth rate for 2000 and 2001; and

(B) November 1 of each succeeding year the sustainable growth rate for such succeeding year and each of the preceding 2 years.

(2) SPECIFICATION OF GROWTH RATE.—The sustainable growth rate for all physicians' services for a fiscal year (beginning with **[**fiscal year 1998**]** *fiscal year 1998 and ending with fiscal year 2000) and a year beginning with 2000* shall be equal to the product of—

(A) 1 plus the Secretary's estimate of the weighted average percentage increase (divided by 100) in the fees for all physicians' services in the [fiscal year] *applicable period* involved,

(B) 1 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than Medicare+Choice plan enrollees) from the previous [fiscal year] *applicable period* to the [fiscal year] *applicable period* involved,

(C) 1 plus the Secretary's estimate of the projected percentage growth in real gross domestic product per capita (divided by 100) from the previous [fiscal year] *applicable period* to the [fiscal year] *applicable period* involved, and

(D) 1 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services in the [fiscal year] *applicable period* (compared with the previous [fiscal year] *applicable period*) which will result from changes in law and regulations, determined without taking into account estimated changes in expenditures resulting from the update adjustment factor determined under subsection (d)(3)(B) *or (d)(4)(B), as the case may be*,

minus 1 and multiplied by 100.

(3) DATA TO BE USED.—For purposes of determining the update adjustment factor under subsection (d)(4)(B) for a year beginning with 2001, the sustainable growth rates taken into consideration in the determination under paragraph (2) shall be determined as follows:

(A) FOR 2001.—For purposes of such calculations for 2001, the sustainable growth rates for fiscal year 2000 and the years 2000 and 2001 shall be determined on the basis of the best data available to the Secretary as of September 1, 2000.

(B) FOR 2002.—For purposes of such calculations for 2002, the sustainable growth rates for fiscal year 2000 and for years 2000, 2001, and 2002 shall be determined on the basis of the best data available to the Secretary as of September 1, 2001.

(C) FOR 2003 AND SUCCEEDING YEARS.—For purposes of such calculations for a year after 2002—

(i) the sustainable growth rates for that year and the preceding 2 years shall be determined on the basis of the best data available to the Secretary as of September 1 of the year preceding the year for which the calculation is made; and

(ii) the sustainable growth rate for any year before a year described in clause (i) shall be the rate as most recently determined for that year under this subsection.

Nothing in this paragraph shall be construed as affecting the sustainable growth rates established for fiscal year 1998 or fiscal year 1999.

[(3)] *(4)* DEFINITIONS.—In this subsection:

(A) SERVICES INCLUDED IN PHYSICIANS' SERVICES.—The term "physicians' services" includes other items and serv-

ices (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office, but does not include services furnished to a Medicare+Choice plan enrollee.

(B) MEDICARE+CHOICE PLAN ENROLLEE.—The term "Medicare+Choice plan enrollee" means, with respect to a fiscal year, an individual enrolled under this part who has elected to receive benefits under this title for the fiscal year through a Medicare+Choice plan offered under part C, and also includes an individual who is receiving benefits under this part through enrollment with an eligible organization with a risk-sharing contract under section 1876.

(C) APPLICABLE PERIOD.—The term "applicable period" means—

(i) a fiscal year, in the case of fiscal year 1998, fiscal year 1999, and fiscal year 2000; or

(ii) a calendar year with respect to a year beginning with 2000;

as the case may be.

PART C—MEDICARE+CHOICE PROGRAM

ELIGIBILITY, ELECTION, AND ENROLLMENT

SEC. 1851. (a) * * *

* * * * * * *

(b) SPECIAL RULES.—

(1) RESIDENCE REQUIREMENT.—

(A) IN GENERAL.—Except as the Secretary may otherwise provide *and except as provided in subparagraph (C)*, an individual is eligible to elect a Medicare+Choice plan offered by a Medicare+Choice organization only if the plan serves the geographic area in which the individual resides.

* * * * * * *

(C) CONTINUATION OF ENROLLMENT PERMITTED WHERE SERVICE CHANGED.—Notwithstanding subparagraph (B), if a Medicare+Choice organization eliminates from its service area a geographic area that was previously within its service area, the organization may elect to offer individuals residing in the affected geographic area who would otherwise be ineligible to continue enrollment the option to continue enrollment in a Medicare+Choice plan it offers so long as—

(i) the enrollee agrees to receive the full range of basic benefits (excluding emergency and urgently needed care) exclusively at facilities designated by the organization within the plan service area; and

(ii) there is no other Medicare+Choice plan offered in the area in which the enrollee resides at the time of the organization's election.

* * * * * * *

(d) PROVIDING INFORMATION TO PROMOTE INFORMED CHOICE.—

(1) * * *

(2) PROVISION OF NOTICE.—

(A) OPEN SEASON NOTIFICATION.—At least 15 days before the beginning of each annual, coordinated election period (as defined in subsection (e)(3)(B)), the Secretary shall mail to each Medicare+Choice eligible individual residing in an area the following:

(i) * * *

(ii) LIST OF PLANS AND COMPARISON OF PLAN OPTIONS.—A list identifying the Medicare+Choice plans that are (or will be) available to residents of the area and information described in paragraph (4) concerning such plans*, to the extent such information is available at the time of preparation of the material for mailing*. Such information shall be presented in a comparative form.

* * * * * * *

(e) COVERAGE ELECTION PERIODS.—

(1) * * *

(2) OPEN ENROLLMENT AND DISENROLLMENT OPPORTUNITIES.—Subject to paragraph (5)—

(A) * * *

(B) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT FOR FIRST 6 MONTHS DURING 2002.—

(i) IN GENERAL.—Subject to clause (ii) *and subparagraph (D)*, at any time during the first 6 months of 2002, or, if the individual first becomes a Medicare+Choice eligible individual during 2002, during the first 6 months during 2002 in which the individual is a Medicare+Choice eligible individual, a Medicare+Choice eligible individual may change the election under subsection (a)(1).

* * * * * * *

(C) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT FOR FIRST 3 MONTHS IN SUBSEQUENT YEARS.—

(i) IN GENERAL.—Subject to clause (ii) *and subparagraph (D)*, at any time during the first 3 months of a year after 2002, or, if the individual first becomes a Medicare+Choice eligible individual during a year after 2002, during the first 3 months of such year in which the individual is a Medicare+Choice eligible individual, a Medicare+Choice eligible individual may change the election under subsection (a)(1).

* * * * * * *

(D) CONTINUOUS OPEN ENROLLMENT FOR INSTITUTIONALIZED INDIVIDUALS.—At any time after 2001 in the case of a Medicare+Choice eligible individual who is institutionalized, the individual may change the election under subsection (a)(1).

* * * * * * *

(4) SPECIAL ELECTION PERIODS.—Effective as of January 1, 2002, an individual may discontinue an election of a Medicare+Choice plan offered by a Medicare+Choice organiza-

tion other than during an annual, coordinated election period and make a new election under this section if—

[(A) the organization's or plan's certification under this part has been terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;]

(A)(i) the certification of the organization or plan under this part has been terminated, or the organization or plan has notified the individual or the Secretary of an impending termination of such certification; or

(ii) the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides, or has notified the individual or Secretary of an impending termination or discontinuation of such plan;

* * * * * * *

PAYMENTS TO MEDICARE+CHOICE ORGANIZATIONS

SEC. 1853. (a) PAYMENTS TO ORGANIZATIONS.—

(1) MONTHLY PAYMENTS.—

(A) IN GENERAL.—Under a contract under section 1857 and subject to [subsections (e) and (f)] *subsections (e), (g), and (i)* and section 1859(e)(4), the Secretary shall make monthly payments under this section in advance to each Medicare+Choice organization, with respect to coverage of an individual under this part in a Medicare+Choice payment area for a month, in an amount equal to 1/12 of the annual Medicare+Choice capitation rate (as calculated under subsection (c)) with respect to that individual for that area, adjusted for such risk factors as age, disability status, gender, institutional status, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such factors, if such changes will improve the determination of actuarial equivalence.

* * * * * * *

(3) ESTABLISHMENT OF RISK ADJUSTMENT FACTORS.—

(A) * * *

* * * * * * *

(C) INITIAL IMPLEMENTATION.—

(i) IN GENERAL.—The Secretary shall first provide for implementation of a risk adjustment methodology that accounts for variations in per capita costs based on health status and other demographic factors for payments by no later than January 1, 2000.

(ii) PHASE-IN.—Such risk adjustment methodology shall be implemented in a phased-in manner so that the new methodology applies only to—

(I) 10 percent of the payment amount in 2000 and 2001;

(II) 20 percent of such amount in 2002;

(III) 30 percent of such amount in 2003; and

(IV) 100 percent of such amount in any subsequent year (at which time the risk adjustment methodology should reflect data from multiple settings).

* * * * * * *

(b) ANNUAL ANNOUNCEMENT OF PAYMENT RATES.—

(1) * * *

* * * * * * *

(4) CONTINUED COMPUTATION AND PUBLICATION OF COUNTY-SPECIFIC PER CAPITA FEE-FOR-SERVICE EXPENDITURE INFORMATION.—The Secretary, through the Chief Actuary of the Health Care Financing Administration, shall provide for the computation and publication, on an annual basis at the time of publication of the annual Medicare+Choice capitation rates, of information on the level of the average annual per capita costs (described in section 1876(a)(4)) for each Medicare+Choice payment area.

* * * * * * *

(c) CALCULATION OF ANNUAL MEDICARE+CHOICE CAPITATION RATES.—

(1) * * *

* * * * * * *

(5) PAYMENT ADJUSTMENT BUDGET NEUTRALITY FACTOR.—For purposes of paragraph (1)(A), for each year, the Secretary shall determine a budget neutrality adjustment factor so that the aggregate of the payments under this part *(other than those attributable to subsection (i))* shall equal the aggregate payments that would have been made under this part if payment were based entirely on area-specific capitation rates.

* * * * * * *

(d) PROVIDING INFORMATION TO PROMOTE INFORMED CHOICE.—

(1) * * *

(2) PROVISION OF NOTICE.—

(A) OPEN SEASON NOTIFICATION.—At least 15 days before the beginning of each annual, coordinated election period (as defined in subsection (e)(3)(B)), the Secretary shall mail to each Medicare+Choice eligible individual residing in an area the following:

(i) * * *

(ii) LIST OF PLANS AND COMPARISON OF PLAN OPTIONS.—A list identifying the Medicare+Choice plans that are (or will be) available to residents of the area and information described in paragraph (4) concerning such plans*, to the extent such information is available at the time of preparation of the material for mailing*. Such information shall be presented in a comparative form.

* * * * * * *

(i) NEW ENTRY BONUS.—

(1) IN GENERAL.—Subject to paragraphs (2) and (3), in the case of Medicare+Choice payment area in which a

Medicare+Choice plan has not been offered since 1997 (or in which any organization that offered a plan since such date has announced, as of October 13, 1999, that it will not be offering such plan as of January 1, 2000), the amount of the monthly payment otherwise made under this subsection shall be increased—

(A) only for the first 12 months in which any Medicare+Choice plan is offered in the area, by 5 percent of the payment rate otherwise computed; and

(B) only for the subsequent 12 months, by 3 percent of the payment rate otherwise computed.

If such 12 months are not a calendar year, the Secretary shall provide for an appropriate blend of such percentage increases for the second and third calendar years in which months described in subparagraph (B) occur to reflect the proportion of such months in each such year.

(2) PERIOD OF APPLICATION.—Paragraph (1) shall only apply to payment for Medicare+Choice plans which are first offered in a Medicare+Choice payment area during the 2-year period beginning with January 1, 2000.

(3) LIMITATION TO ORGANIZATION OFFERING FIRST PLAN IN AN AREA.—Paragraph (1) shall only apply to payment to the first Medicare+Choice organization that offers a Medicare+Choice plan in each Medicare+Choice payment area, except that if more than one such organization first offers such a plan in an area on the same date, paragraph (1) shall apply to payment for such organizations.

(4) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as affecting the Medicare+Choice capitation rate for any area or as applying to payment for any period not described in such paragraph.

(5) OFFERED DEFINED.—In this subsection, the term 'offered' means, with respect to a Medicare+Choice plan as of a date, that a Medicare+Choice eligible individual may enroll with the plan on that date, regardless of when the enrollment takes effect or the individual obtain benefits under the plan.

PREMIUMS

SEC. 1854. (a) SUBMISSION OF PROPOSED PREMIUMS AND RELATED INFORMATION.—

(1) IN GENERAL.—Not later than **[**May 1**]** *July 1* of each year, each Medicare+Choice organization shall submit to the Secretary, in a form and manner specified by the Secretary and for each Medicare+Choice plan for the service area in which it intends to be offered in the following year—

* * * * * * *

(c) UNIFORM PREMIUM.—**[**The**]**

(1) IN GENERAL.—Subject to paragraph (2), the Medicare+Choice monthly basic and supplemental beneficiary premium, the Medicare+Choice monthly MSA premium charged under subsection (b) of a Medicare+Choice organization under this part may not vary among individuals enrolled in the plan.

(2) VARIATION IN PREMIUM WAIVER PERMITTED.—A Medicare+Choice organization may waive part or all of a premium described in paragraph (1) for one or more Medicare+Choice payment areas within its service area if the annual Medicare+Choice capitation rates under section 1853(c) vary between such payment area and other payment areas within such service area.

* * * * * * *

CONTRACTS WITH MEDICARE+CHOICE ORGANIZATIONS

SEC. 1857. (a) * * *

* * * * * * *

(c) CONTRACT PERIOD AND EFFECTIVENESS.—

(1) * * *

* * * * * * *

(4) PREVIOUS TERMINATIONS.—

(A) IN GENERAL.—The Secretary may not enter into a contract with a Medicare+Choice organization if a previous contract with that organization under this section was terminated at the request of the organization within the preceding 5-year period, except *as provided in paragraph (2) and except* in circumstances which warrant special consideration, as determined by the Secretary.

(B) EARLIER RE-ENTRY PERMITTED WHERE CHANGE IN PAYMENT POLICY AND NO MORE THAN ONE OTHER PLAN AVAILABLE.—Subparagraph (A) shall not apply with respect to the offering by a Medicare+Choice organization of a Medicare+Choice plan in a Medicare+Choice payment area if—

(i) during the 6-month period beginning on the date the organization notified the Secretary of the intention to terminate the most recent previous contract, there was a legislative change enacted (or a regulatory change adopted) that has the effect of increasing payment rates under section 1853 for that Medicare+Choice payment area; and

(ii) at the time the organization notifies the Secretary of its intent to enter into a contract to offer such a plan in the area, there is no more than one Medicare+Choice plan offered in the area.

* * * * * * *

DEFINITIONS; MISCELLANEOUS PROVISIONS

SEC. 1859. (a) * * *

* * * * * * *

(e) RESTRICTION ON ENROLLMENT FOR CERTAIN MEDICARE+CHOICE PLANS.—

(1) * * *

(2) MEDICARE+CHOICE RELIGIOUS FRATERNAL BENEFIT SOCIETY PLAN DESCRIBED.—For purposes of this subsection, a Medicare+Choice religious fraternal benefit society plan de-

scribed in this paragraph is a Medicare+Choice plan described in section [1851(a)(2)(A)] *1851(a)(2)* that—

(A) * * *

* * * * * * *

PART D—MISCELLANEOUS PROVISIONS

DEFINITIONS OF SERVICES, INSTITUTIONS, ETC.

SEC. 1861. For purposes of this title—

Spell of Illness

(a) * * *

* * * * * * *

Home Health Agency

(o) The term "home health agency" means a public agency or private organization, or a subdivision of such an agency or organization, which—

(1) * * *

* * * * * * *

(7) provides the Secretary with a surety bond—

(A) effective for a period of 4 years (as specified by the Secretary) or in the case of a change in the ownership or control of the agency (as determined by the Secretary) during or after such 4-year period, an additional period of time that the Secretary determines appropriate, such additional period not to exceed 4 years from the date of such change in ownership or control;

(B) in a form specified by the Secretary; and

(C) for a year in the period described in subparagraph (A) in an amount that is equal to the lesser of $50,000 or 10 percent of the aggregate amount of payments to the agency under this title and title XIX for that year, as estimated by the Secretary; and

* * * * * * *

Discharge Planning Process

(ee)(1) * * *

(2) The Secretary shall develop guidelines and standards for the discharge planning process in order to ensure a timely and smooth transition to the most appropriate type of and setting for post-hospital or rehabilitative care. The guidelines and standards shall include the following:

(A) * * *

* * * * * * *

(H) Consistent with section 1802, the discharge plan shall—

(i) *subject to clause (iii),* not specify or otherwise limit the qualified provider which may provide post-hospital home health services, [and]

(ii) identify (in a form and manner specified by the Secretary) any entity to whom the individual is referred in which the hospital has a disclosable financial interest (as specified by the Secretary consistent with section 1866(a)(1)(S)) or which has such an interest in the hospital[.], *and*

(iii) for individuals enrolled under a Medicare+Choice plan, under a contract with the Secretary under section 1857, for whom a hospital furnishes inpatient hospital services, the hospital may specify with respect to such individual the provider of post-hospital home health services or other post-hospital services under the plan.

* * * * * * *

PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS

SEC. 1876. (a) * * *

* * * * * * *

(h)(1) * * *

* * * * * * *

(5)(A) * * *

(B) The Secretary may not extend or renew a reasonable cost reimbursement contract under this subsection for any period beyond December 31, [2002] *2004*.

* * * * * * *

MEDICARE COVERAGE FOR END STAGE RENAL DISEASE PATIENTS

SEC. 1881. (a) * * *

(b)(1) * * *

* * * * * * *

(7) The Secretary shall provide by regulation for a method (or methods) for determining prospectively the amounts of payments to be made for dialysis services furnished by providers of services and renal dialysis facilities to individuals in a facility and to such individuals at home. Such method (or methods) shall provide for the prospective determination of a rate (or rates) for each mode of care based on a single composite weighted formula (which takes into account the mix of patients who receive dialysis services at a facility or at home and the relative costs of providing such services in such settings) for hospital-based facilities and such a single composite weighted formula for other renal dialysis facilities, or based on such other method or combination of methods which differentiate between hospital-based facilities and other renal dialysis facilities and which the Secretary determines, after detailed analysis, will more effectively encourage the more efficient delivery of dialysis services and will provide greater incentives for increased use of home dialysis than through the single composite weighted formulas. The amount of a payment made under any method other than a method based on a single composite weighted formula may not exceed the amount (or, in the case of continuous cycling peritoneal dialysis, 130 percent of the amount) of the median payment

that would have been made under the formula for hospital-based facilities. The Secretary shall provide for such exceptions to such methods as may be warranted by unusual circumstances (including the special circumstances of sole facilities located in isolated, rural areas and of pediatric facilities). Each application for such an exception shall be deemed to be approved unless the Secretary disapproves it by not later than 60 working days after the date the application is filed. The Secretary may provide that such method will serve in lieu of any target reimbursement rate that would otherwise be established under paragraph (6). The Secretary shall reduce the amount of each composite rate payment under this paragraph for each treatment by 50 cents (subject to such adjustments as may be required to reflect modes of dialysis other than hemodialysis) and provide for payment of such amount to the organizations (designated under subsection (c)(1)(A)) for such organizations' necessary and proper administrative costs incurred in carrying out the responsibilities described in subsection (c)(2). The Secretary shall provide that amounts paid under the previous sentence shall be distributed to the organizations described in subsection (c)(1)(A) to ensure equitable treatment of all such network organizations. The Secretary in distributing any such payments to network organizations shall take into account—

(A) * * *

* * * * * * *

(D) the proportion of the aggregate administrative funds collected in the network area.

The Secretary shall increase the amount of each composite rate payment for dialysis services furnished on or after January 1, 2000, and on or before December 31, 2000, by 1.2 percent above such composite rate payment amounts for such services furnished on December 31, 1999, and for such services furnished on or after January 1, 2001, by 1.2 percent above such composite rate payment amounts for such services furnished on December 31, 2000.

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CERTIFICATION OF MEDICARE SUPPLEMENTAL HEALTH INSURANCE POLICIES

SEC. 1882. (a) * * *

* * * * * * *

(s)(1) * * *

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(3)(A) The issuer of a medicare supplemental policy—

(i) * * *

* * * * * * *

(iii) may not impose an exclusion of benefits based on a preexisting condition under such policy,

in the case of an individual described in subparagraph (B) who seeks to enroll under the policy not later than 63 days after the date of the termination of enrollment described in such subparagraph *(or, if elected by the individual, the date of notification of the individual or the Secretary by the plan or organization of the im-*

pending termination or discontinuance of the plan in the area in which the individual resides) and who submits evidence of the date of termination or disenrollment *(or the date of such notification)* along with the application for such medicare supplemental policy.

* * * * * * *

HOSPITAL PROVIDERS OF EXTENDED CARE SERVICES

SEC. 1883. (a)(1) Any hospital [(other than a hospital which has in effect a waiver under subparagraph (A) of the last sentence of section 1861(e))] which has an agreement under section 1866 may (subject to subsection (b)) enter into an agreement with the Secretary under which its inpatient hospital facilities may be used for the furnishing of services of the type which, if furnished by a skilled nursing facility, would constitute extended care services.

* * * * * * *

[(b) The Secretary may not enter into an agreement under this section with any hospital unless—

[(1) except as provided under subsection (g), the hospital is located in a rural area and has less than 100 beds, and

[(2) the hospital has been granted a certificate of need for the provision of long-term care services from the State health planning and development agency (designated under section 1521 of the Public Health Service Act) for the State in which the hospital is located.]

(b) The Secretary may not enter into an agreement under this section with any hospital unless, except as provided under subsection (g), the hospital is located in a rural area and has less than 100 beds.

(c) An agreement with a hospital under this section shall, except as otherwise provided under regulations of the Secretary, be of the same duration and subject to termination on the same conditions as are agreements with skilled nursing facilities under section 1866 and shall, where not inconsistent with any provision of this section, impose the same duties, responsibilities, conditions, and limitations, as those imposed under such agreements entered into under section 1866; except that no such agreement with any hospital shall be in effect for any period during which the hospital does not have in effect an agreement under section 1866[, or during which there is in effect for the hospital a waiver under subparagraph (A) of the last sentence of section 1861(e)]. A hospital with respect to which an agreement under this section has been terminated shall not be eligible to enter into a new agreement until a two-year period has elapsed from the termination date.

(d)[(1)] Any agreement with a hospital under this section shall provide that payment for services will be made only for services for which payment would be made as post-hospital extended care services if those services had been furnished by a skilled nursing facility under an agreement entered into under section 1866; and any individual who is furnished services, for which payment may be made under an agreement under this section, shall, for purposes of this title (other than this section), be deemed to have received post-hospital extended care services in like manner and to the same extent as if the services furnished to him had been post-hospital ex-

tended care services furnished by a skilled nursing facility under an agreement under section 1866.

[(2)(A) Any agreement under this section with a hospital with more than 49 beds shall provide that no payment may be made for extended care services which are furnished to an extended care patient after the end of the 5-day period (excluding weekends and holidays) beginning on an availability date for a skilled nursing facility, unless the patient's physician certifies, within such 5-day period, that the transfer of that patient to that facility is not medically appropriate on the availability date. The Secretary shall prescribe regulations to provide for notice by skilled nursing facilities of availability dates to hospitals which have agreements under this section and which are located within the same geographic region (as defined by the Secretary).

[(B) In this paragraph:

[(i) The term "availability date" means, with respect to an extended care patient at a hospital, any date on which a bed is available for the patient in a skilled nursing facility located within the geographic region in which the hospital is located.

[(ii) The term "extended care patient" means an individual being furnished extended care services at a hospital pursuant to an agreement with the Secretary under this section.

[(3) In the case of an agreement for a cost reporting period under this section with a hospital that has more than 49 beds, payment may not be made in the period for patient-days of extended care services that exceed 15 percent of the product of the number of days in the period and the average number of licensed beds in the hospital in the period, except that such payment shall continue to be made in the period for those patients who are receiving extended care services at the time the hospital reaches the limit specified in this paragraph.]

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PAYMENT TO HOSPITALS FOR INPATIENT HOSPITAL SERVICES

SEC. 1886. (a) * * *

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(b)(1) * * *

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(2)(A) [In addition to] *Except as provided in subparagraph (E), in addition to* the payment computed under paragraph (1), in the case of an eligible hospital (described in subparagraph (B)) for a cost reporting period beginning on or after October 1, 1997, the amount of payment on a per discharge basis under paragraph (1) shall be increased by the lesser of—

* * * * * * *

(E)(i) In the case of an eligible hospital that is a hospital or unit that is within a class of hospital described in clause (ii) with a 12-month cost reporting period beginning before the enactment of this subparagraph, in determining the amount of the increase under subparagraph (A), the Secretary shall substitute for the percentage of the target amount applicable under subparagraph (A)(ii)—

(I) for a cost reporting period beginning on or after October 1, 2000, and before September 30, 2001, 1.5 percent; and

(II) for a cost reporting period beginning on or after October 1, 2001, and before September 30, 2002, 2 percent.

(ii) For purposes of clause (i), each of the following shall be treated as a separate class of hospital:

(I) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

(II) Hospitals described in clause (iv) of such subsection.

* * * * * * *

(3)(A) * * *

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(C) In the case of a hospital that is a sole community hospital (as defined in subsection (d)(5)(D)(iii)), *subject to subparagraph (I)* the term "target amount" means—

(i) * * *

* * * * * * *

(D) For cost reporting periods ending on or before September 30, 1994, [and for cost reporting periods beginning on or after October 1, 1997, and before October 1, 2001,] *and for discharges beginning on or after October 1, 1997, and before October 1, 2006,* in the case of a hospital that is a medicare-dependent, small rural hospital (as defined in subsection (d)(5)(G)), the term "target amount" means—

(i) * * *

* * * * * * *

(iv) with respect to discharges occurring during fiscal year 1998 through fiscal year [2000] *2005*, the target amount for the preceding year increased by the applicable percentage increase under subparagraph (B)(iv).

There shall be substituted for the base cost reporting period described in clause (i) a hospital's cost reporting period (if any) beginning during fiscal year 1987 if such substitution results in an increase in the target amount for the hospital.

* * * * * * *

(H)(i) In the case of a hospital or unit that is within a class of hospital described in clause (iv), for a cost reporting period beginning during fiscal years 1998 through 2002, the target amount for such a hospital or unit may not exceed the amount as updated up to or for such cost reporting period under clause (ii).

[(H)(i)] *(ii)(I)* In the case of a hospital or unit that is within a class of hospital described in clause (iv), the Secretary shall estimate the 75th percentile of the target amounts for such hospitals within such class for cost reporting periods ending during fiscal year 1996*, as adjusted under clause (iii)*.

[(ii)] *(II)* The Secretary shall update the amount determined under [clause (i)] *subclause (I)*, for each cost reporting period after the cost reporting period described in [such clause] *such subclause* and up to the first cost reporting period beginning on or after October 1, 1997, by a factor equal to the market basket percentage increase.

[(iii)] *(III)* For cost reporting periods beginning during each of fiscal years 1999 through 2002, the Secretary shall update such amount by a factor equal to the market basket percentage increase.

(iii) In applying clause (ii)(I) in the case of a hospital or unit, the Secretary shall provide for an appropriate adjustment to the labor-related portion of the amount determined under such subparagraph to take into account differences between average wage-related costs in the area of the hospital and the national average of such costs within the same class of hospital.

* * * * * * *

(I)(i) For cost reporting periods beginning on or after October 1, 2000, in the case of a sole community hospital that for its cost reporting period beginning during 1999 is paid on the basis of the target amount applicable to the hospital under subparagraph (C) and that elects (in a form and manner determined by the Secretary) this subparagraph to apply to the hospital, there shall be substituted for the base cost reporting period described subparagraph (C) the rebased target amount determined under this subparagraph.

(ii) For purposes of clause (i), the rebased target amount applicable to a hospital making an election under this subparagraph is equal to the sum of the following:

(I) With respect to discharges occurring in fiscal year 2001, 75 percent of the target amount applicable to the hospital under subparagraph (C) (hereinafter in this subparagraph referred to as the "subparagraph (C) target amount") and 25 percent of the amount of the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital for the 12-month cost reporting period beginning during fiscal year 1996 (hereinafter in this subparagraph referred to as the "rebase target amount"), increased by the applicable percentage increase under subparagraph (B)(iv).

(II) With respect to discharges occurring in fiscal year 2002, 50 percent of the subparagraph (C) target amount and 50 percent of the rebase target amount, increased by the applicable percentage increase under subparagraph (B)(iv).

(III) With respect to discharges occurring in fiscal year 2003, 25 percent of the subparagraph (C) target amount and 75 percent of the rebase target amount, increased by the applicable percentage increase under subparagraph (B)(iv).

(IV) With respect to discharges occurring in fiscal year 2003 or any subsequent fiscal year, 100 percent of the rebase target amount, increased by the applicable percentage increase under subparagraph (B)(iv).

(4)(A)(i) The Secretary shall provide for an exception and adjustment to (and in the case of a hospital [or unit] described in subsection (d)(1)(B)(iii), may provide an exemption from) the method under this subsection for determining the amount of payment to a hospital where events beyond the hospital's control or extraordinary circumstances, including changes in the case mix of such hospital, create a distortion in the increase in costs for a cost reporting period (including any distortion in the costs for the base period against which such increase is measured). The Secretary may provide for such other exemptions from, and exceptions and adjustments to, such method as the Secretary deems appropriate, includ-

ing the assignment of a new base period which is more representative, as determined by the Secretary, of the reasonable and necessary cost of inpatient services and including those which he deems necessary to take into account a decrease in the inpatient hospital services that a hospital provides and that are customarily provided directly by similar hospitals which results in a significant distortion in the operating costs of inpatient hospital services. The Secretary shall announce a decision on any request for an exemption, exception, or adjustment under this paragraph not later than 180 days after receiving a completed application from the intermediary for such exemption, exception, or adjustment, and shall include in such decision a detailed explanation of the grounds on which such request was approved or denied.

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(d)(1) * * *

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(2) The Secretary shall determine a national adjusted DRG prospective payment rate, for each inpatient hospital discharge in fiscal year 1984 involving inpatient hospital services of a subsection (d) hospital in the United States, and shall determine a regional adjusted DRG prospective payment rate for such discharges in each region, for which payment may be made under part A of this title. Each such rate shall be determined for hospitals located in urban or rural areas within the United States or within each such region, respectively, as follows:

(A) * * *

* * * * * * *

(C) STANDARDIZING AMOUNTS.—The Secretary shall standardize the amount updated under subparagraph (B) for each hospital by—

(i) excluding an estimate of indirect medical education costs (taking into account, for discharges occurring after September 30, 1986, the amendments made by section 9104(a) of the Medicare and Medicaid Budget Reconciliation Amendments of 1985), except that the Secretary shall not take into account any reduction in the amount of additional payments under paragraph (5)(B)(ii) resulting from the amendment made by section 4621(a)(1) of the Balanced Budget Act of 1997 *or any additional payments under such paragraph resulting from the amendment made by section 101(a) of Medicare Balanced Budget Refinement Act of 1999*,

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(5)(A) * * *

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(B) The Secretary shall provide for an additional payment amount for subsection (d) hospitals with indirect costs of medical education, in an amount computed in the same manner as the adjustment for such costs under regulations (in effect as of January 1, 1983) under subsection (a)(2), except as follows:

(i) * * *

(ii) For purposes of clause (i)(II), the indirect teaching adjustment factor is equal to c × (((1+r) to the nth power) − 1), where "r" is the ratio of the hospital's full-time equivalent interns and residents to beds and "n" equals .405. For discharges occurring—

(I) * * *

* * * * * * *

(IV) during fiscal year 2000 *and 2001*, "c" is equal to 1.47; and

(V) on or after October 1, [2000] *2001*, "c" is equal to 1.35.

* * * * * * *

(v) In determining the adjustment with respect to a hospital for discharges occurring on or after October 1, 1997, the total number of full-time equivalent interns and residents in the fields of allopathic and osteopathic medicine in either a hospital or nonhospital setting may not exceed the number *(or, 130 percent of such number in the case of a hospital located in a rural area)* of such full-time equivalent interns and residents in the hospital with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996.

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(F)(i) * * *

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(ix) In the case of discharges occurring—

(I) * * *

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(III) [during fiscal year 2000] *during each of fiscal years 2000 and 2001*, such additional payment amount shall be reduced by 3 percent;

[(IV) during fiscal year 2001, such additional payment amount shall be reduced by 4 percent;]

[(V)] *(IV)* during fiscal year 2002, such additional payment amount shall be reduced by [5] *4* percent; and

[(VI)] *(V)* during fiscal year 2003 and each subsequent fiscal year, such additional payment amount shall be reduced by 0 percent.

* * * * * * *

(G)(i) For any cost reporting period beginning on or after April 1, 1990, and before October 1, 1994, [or beginning on or after October 1, 1997, and before October 1, 2001,] *or discharges on or after October 1, 1997, and before October 1, 2006,* in the case of a subsection (d) hospital which is a medicare-dependent, small rural hospital, payment under paragraph (1)(A) shall be equal to the sum of the amount determined under clause (ii) and the amount determined under paragraph (1)(A)(iii).

(ii) The amount determined under this clause is—

(I) * * *

(II) for discharges occurring during any subsequent cost reporting period (or portion thereof) and before October 1, 1994, [or beginning on or after October 1, 1997, and before October

1, 2001,] *or discharges on or after October 1, 1997, and before October 1, 2006,* 50 percent of the amount by which the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(D)) exceeds the amount determined under paragraph (1)(A)(iii).

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(8)(A) * * *

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(B)*(i)* For purposes of this subsection, the Secretary shall treat a hospital located in a rural county adjacent to one or more urban areas as being located in the urban metropolitan statistical area to which the greatest number of workers in the county commute, if the rural county would otherwise be considered part of an urban area, under the standards for designating Metropolitan Statistical Areas (and for designating New England County Metropolitan Areas) [published in the Federal Register on January 3, 1980] *described in clause (ii)*, if the commuting rates used in determining outlying counties (or, for New England, similar recognized areas) were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of all contiguous Metropolitan Statistical Areas (or New England County Metropolitan Areas).

(ii) The standards described in this clause for cost reporting periods beginning in a fiscal year—

(I) before fiscal year 2003, are the standards published in the Federal Register on January 3, 1980, or, at the election of the hospital with respect to fiscal years 2001 and 2002, standards so published on March 30, 1990; and

(II) after fiscal year 2002, are the standards published in the Federal Register by the Director of the Office of Management and Budget based on the most recent available decennial population data.

Subparagraphs (C) and (D) shall not apply with respect to the application of subclause (I).

* * * * * * *

(E)(i) For purposes of this subsection and section 1833(t), not later than 60 days after the receipt of an application from a subsection (d) hospital described in clause (ii), the Secretary shall treat the hospital as being located in the rural area (as defined in such paragraph (2)(D)) of the State in which the hospital is located.

(ii) For purposes of clause (i), a subsection (d) hospital described in this clause is a subsection (d) hospital that is located in an urban area (as defined in paragraph (2)(D)) and satisfies any of the following criteria:

(I) The hospital is located in a rural census tract of a metropolitan statistical area (as determined under the Goldsmith Modification, as published in the Federal Register on February 27, 1992 (57 FR 6725)).

(II) The hospital is located in an area designated by any law or regulation of such State as a rural area (or is designated by such State as a rural hospital).

(III) The hospital would qualify as a sole community hospital under paragraph (5)(D) if the hospital were located in a rural area.

(IV) The hospital meets such other criteria as the Secretary may specify.

* * * * * * *

(11) ADDITIONAL PAYMENTS FOR MANAGED CARE ENROLLEES.—

(A) IN GENERAL.—*(i)* For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount for each applicable discharge of any subsection (d) hospital that has an approved medical residency training program.

(ii) For portions of cost reporting periods occurring on or after January 1, 2000, the Secretary shall provide for an additional payment amount for each applicable discharge of any subsection (d) hospital that has direct costs of approved education activities for nurse and allied health professional training.

* * * * * * *

(C) DETERMINATION OF AMOUNT.—*(i)* The amount of the payment [under this paragraph] *under subparagraph (A)(i)* with respect to any applicable discharge shall be equal to *the DGME portion of* the applicable percentage (as defined in subsection (h)(3)(D)(ii)) of the estimated average per discharge amount that would otherwise have been paid under paragraph (5)(B) if the individuals had not been enrolled as described in subparagraph (B).

(ii) The amount of the payment under subparagraph (A)(ii) with respect to any applicable discharge shall be equal to an amount, specified by the Secretary, in a manner consistent with the following:

(I) The total payments under such subparagraph in a year are equal to $60,000,000.

(II) The payments to different hospitals are proportional to the direct costs of each hospital described in such subparagraph.

(iii) For purposes of this subparagraph, the "DGME portion" means, for a year, the ratio of—

(I) the amount by which (aa) the Secretary's estimate of the total additional payments that would be payable under this paragraph for the year if subparagraph (A)(ii) and clause (ii) of this subparagraph did not apply, exceeds (bb) $60,000,000; to

(II) the total additional payments estimated under subclause (I)(aa) for the year.

* * * * * * *

(g)(1)(A) Notwithstanding section 1861(v), instead of any amounts that are otherwise payable under this title with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs of inpatient hospital services, the Secretary shall, for hospital cost reporting peri-

ods beginning on or after October 1, 1991, provide for payments for such costs in accordance with a prospective payment system established by the Secretary. Aggregate payments made under subsection (d) and this subsection during fiscal years 1992 through 1995 shall be reduced in a manner that results in a reduction (as estimated by the Secretary) in the amount of such payments equal to a 10 percent reduction in the amount of payments attributable to capital-related costs that would otherwise have been made during such fiscal year had the amount of such payments been based on reasonable costs (as defined in section 1861(v)). For discharges occurring after September 30, 1993, the Secretary shall reduce by 7.4 percent the unadjusted standard Federal capital payment rate (as described in 42 CFR 412.308(c), as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993) and shall (for hospital cost reporting periods beginning on or after October 1, 1993) redetermine which payment methodology is applied to the hospital under such system to take into account such reduction. In addition to the reduction described in the preceding sentence, for discharges occurring on or after October 1, 1997, the Secretary shall apply the budget neutrality adjustment factor used to determine the Federal capital payment rate in effect on September 30, 1995 (as described in section 412.352 of title 42 of the Code of Federal Regulations), to (i) the unadjusted standard Federal capital payment rate (as described in section 412.308(c) of that title, as in effect on September 30, 1997), and (ii) the unadjusted hospital-specific rate (as described in section 412.328(e)(1) of that title, as in effect on September 30, 1997), and, for discharges occurring on or after October 1, 1997, and before [September 30, 2002,] *October 1, 2002,* reduce the rates described in clauses (i) and (ii) by 2.1 percent.

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(h) PAYMENTS FOR DIRECT GRADUATE MEDICAL EDUCATION COSTS.—

(1) * * *

* * * * * * *

(3) HOSPITAL PAYMENT AMOUNT PER RESIDENT.—

(A) * * *

* * * * * * *

(B) AGGREGATE APPROVED AMOUNT.—As used in subparagraph (A), the term "aggregate approved amount" means, for a hospital cost reporting period, the product of—

[(i) the hospital's approved FTE resident amount (determined under paragraph (2)) for that period, and]

(i)(I) for a cost reporting period beginning before October 1, 2000, the hospital's approved FTE resident amount (determined under paragraph (2)) for that period;

(II) for a cost reporting period beginning on or after October 1, 2000, and before October 1, 2004, the national average per resident amount determined under paragraph (7) or, if greater, the sum of the hospital-

specific percentage (as defined in subparagraph (E)) of the hospital's approved FTE resident amount (determined under paragraph (2)) for the period and the national percentage (as defined in such subparagraph) of the national average per resident amount determined under paragraph (7); and

(III) for a cost reporting period beginning on or after October 1, 2004, the national average per resident amount determined under paragraph (7); and

* * * * * * *

(E) TRANSITION TO NATIONAL AVERAGE PER RESIDENT PAYMENT SYSTEM.—For purposes of subparagraph (B)(i)(II), for the cost reporting period of a hospital beginning—

(i) during fiscal year 2001, the hospital-specific percentage is 80 percent and the national percentage is 20 percent;

(ii) during fiscal year 2002, the hospital-specific percentage is 60 percent and the national percentage is 40 percent;

(iii) during fiscal year 2003, the hospital-specific percentage is 40 percent and the national percentage is 60 percent; and

(iv) during fiscal year 2004, the hospital-specific percentage is 20 percent and the national percentage is 80 percent.

(4) DETERMINATION OF FULL-TIME-EQUIVALENT RESIDENTS.—

(A) * * *

* * * * * * *

(F) LIMITATION ON NUMBER OF RESIDENTS IN ALLOPATHIC AND OSTEOPATHIC MEDICINE.—Such rules shall provide that for purposes of a cost reporting period beginning on or after October 1, 1997, the total number of full-time equivalent residents before application of weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic medicine and osteopathic medicine may not exceed the number *(or, 130 percent of such number in the case of a hospital located in a rural area)* of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.

* * * * * * *

(H) SPECIAL RULES FOR APPLICATION OF SUBPARAGRAPHS (F) AND (G).—

(i) * * *

(iv) NON-RURAL HOSPITALS OPERATING TRAINING PROGRAMS IN UNDERSERVED RURAL AREAS.—In the case of a hospital that is not located in a rural area but establishes separately accredited approved medical residency training programs (or rural tracks) in an underserved rural area or has an accredited training program with an integrated rural track, the Secretary shall adjust

the limitation under subparagraph (F) in an appropriate manner insofar as it applies to such programs in such underserved rural areas in order to encourage the training of physicians in underserved rural areas.

* * * * * * *

(7) NATIONAL AVERAGE PER RESIDENT AMOUNT.—The national average per resident amount for a hospital for a cost reporting period beginning in a fiscal year is an amount determined as follows:

(A) DETERMINATION OF HOSPITAL SINGLE PER RESIDENT AMOUNT.—The Secretary shall compute for each hospital operating an approved graduate medical education program a single per resident amount equal to the average (weighted by number of full-time equivalent residents) of the primary care per resident amount and the non-primary care per resident amount computed under paragraph (2) for cost reporting periods ending during fiscal year 1997.

(B) DETERMINATION OF WAGE AND NON-WAGE-RELATED PROPORTION OF THE SINGLE PER RESIDENT AMOUNT.—The Secretary shall estimate the average proportion of the single per resident amounts computed under subparagraph (A) that is attributable to wages and wage-related costs.

(C) STANDARDIZING PER RESIDENT AMOUNTS.—The Secretary shall establish a standardized per resident amount for each such hospital—

(i) by dividing the single per resident amount computed under subparagraph (A) into a wage-related portion and a non-wage-related portion by applying the proportion determined under subparagraph (B);

(ii) by dividing the wage-related portion by the factor applied under subsection (d)(3)(E) for discharges occurring during fiscal year 1999 for the hospital's area; and

(iii) by adding the non-wage-related portion to the amount computed under clause (ii).

(D) DETERMINATION OF NATIONAL AVERAGE.—The Secretary shall compute a national average per resident amount equal to the average of the standardized per resident amounts computed under subparagraph (C) for such hospitals, with the amount for each hospital weighted by the average number of full-time equivalent residents at such hospital.

(E) APPLICATION TO INDIVIDUAL HOSPITALS.—The Secretary shall compute for each such hospital a per resident amount—

(i) by dividing the national average per resident amount computed under subparagraph (D) into a wage-related portion and a non-wage-related portion by applying the proportion determined under subparagraph (B);

(ii) by multiplying the wage-related portion by the factor described in subparagraph (C)(ii) for the hospital's area; and

(iii) by adding the non-wage-related portion to the amount computed under clause (ii).

(F) INITIAL UPDATING RATE.—The Secretary shall update such per resident amount for the hospital's cost reporting period that begins during fiscal year 2001 for each such hospital by the estimated percentage increase in the consumer price index for all urban consumers during the period beginning October 1997 and ending with the midpoint of the hospital's cost reporting period that begins during fiscal year 2001.

(G) SUBSEQUENT UPDATING.—For each subsequent cost reporting period, subject to subparagraph (H), the national average per resident amount for a hospital is equal to the amount determined under this paragraph for the previous cost reporting period updated, through the midpoint of the period, by projecting the estimated percentage change in the consumer price index during the 12-month period ending at that midpoint, with appropriate adjustments to reflect previous under-or over-estimations under this subparagraph in the projected percentage change in the consumer price index.

(H) TRANSITIONAL BUDGET NEUTRALITY ADJUSTMENT.—

(i) IN GENERAL.—If the Secretary estimates that, as a result of the amendments made by section 311 of the Medicare Balanced Budget Refinement Act of 1999, the post-MBBRA expenditures for fiscal year 2005 will be greater or less than the pre-MBBRA expenditures for that fiscal year—

(I) the Secretary shall adjust the update applied under subparagraph (G) in determining the national average per resident amount for cost reporting periods beginning during fiscal year 2005 so that the amount of the post-MBBRA expenditures for those cost reporting periods is equal to the amount of the pre-MBBRA expenditures for such periods; and

(II) the Secretary shall, taking into account the adjustment made under subclause (I), adjust the national average per resident amount, as applied for the portion of a cost reporting period beginning during fiscal year 2004 that occur in fiscal year 2005, so that the amount of the post-MBBRA expenditures made during fiscal year 2005 is equal to the amount of the pre-MBBRA expenditures during such fiscal year.

(ii) DEFINITIONS.—In this subparagraph:

(I) AGGREGATE SUBSECTION (h)-RELATED EXPENDITURES.—The term "aggregate subsection (h)-related expenditures" means, with respect to cost reporting periods beginning during a fiscal year or with respect to a fiscal year, the aggregate expenditures under this title for such periods or fiscal year, respectively, which are attributable to the operation of this subsection.

(II) PRE-MBBRA EXPENDITURES.—The term "pre-MBBRA expenditures" means aggregate subsection (h)-related expenditures determined as if the amendments made by section 311 of the Medicare Balanced Budget Refinement Act of 1999 had not been enacted.

(III) POST-MBBRA EXPENDITURES.—The term "post-MBBRA expenditures" means aggregate subsection (h)-related expenditures determined taking into account the amendments made by section 311 of the Medicare Balanced Budget Refinement Act of 1999.

* * * * * * *

(j) PROSPECTIVE PAYMENT FOR INPATIENT REHABILITATION SERVICES.—

(1) PAYMENT DURING TRANSITION PERIOD.—

(A) * * *

* * * * * * *

(C) TEFRA AND PROSPECTIVE PAYMENT PERCENTAGES SPECIFIED.—For purposes of subparagraph (A), *subject to subparagraph (E),* for a cost reporting period beginning—

(i) * * *

* * * * * * *

(D) PAYMENT UNIT.—For purposes of this subsection, the term "payment unit" means a discharge**[**, day of inpatient hospital services, or other unit of payment defined by the Secretary**]**.

(E) ELECTION TO APPLY FULL PROSPECTIVE PAYMENT SYSTEM.—A rehabilitation facility may elect for either or both cost reporting periods described in subparagraph (C) to have the TEFRA percentage and prospective payment percentage set at 0 percent and 100 percent, respectively, for the facility.

(F) CONSTRUCTION RELATING TRANSFER AUTHORITY.—Nothing in this subsection shall be construed as preventing the Secretary from providing for an adjustment to payments to take into account the early transfer of a patient from a rehabilitation facility to another site of care.

* * * * * * *

(2) PATIENT CASE MIX GROUPS.—

(A) ESTABLISHMENT.—The Secretary shall establish—

[(i) classes of patients of rehabilitation facilities (each in this subsection referred to as a "case mix group"), based on such factors as the Secretary deems appropriate, which may include impairment, age, related prior hospitalization, comorbidities, and functional capability of the patient; and**]**

(i) classes of patient discharges of rehabilitation facilities (each in this subsection referred to as a 'case mix group'), based on impairment, age, comorbidities, and functional capability of the patient and such other factors as the Secretary deems appropriate to improve

the explanatory power of functional independence measure-function related groups; and

* * * * * * *

(3) PAYMENT RATE.—

(A) * * *

* * * * * * *

(B) BUDGET NEUTRAL RATES.—The Secretary shall establish the prospective payment amounts under this subsection for payment units during fiscal years 2001 and 2002 at levels such that, in the Secretary's estimation *and taking into account the election permitted under paragraph (1)(E)*, the amount of total payments under this subsection for such fiscal years (including any payment adjustments pursuant to paragraphs (4) and (6)) shall be equal to 98 percent of the amount of payments that would have been made under this title during the fiscal years for operating and capital costs of rehabilitation facilities had this subsection not been enacted. In establishing such payment amounts, the Secretary shall consider the effects of the prospective payment system established under this subsection on the total number of payment units from rehabilitation facilities and other factors described in subparagraph (A).

* * * * * * *

PAYMENT TO SKILLED NURSING FACILITIES FOR ROUTINE SERVICE COSTS

SEC. 1888. (a) * * *

* * * * * * *

(e) PROSPECTIVE PAYMENT.—

(1) PAYMENT PROVISION.—Notwithstanding any other provision of this title, subject to **[**paragraph (7)**]** *paragraphs (7), (11), and (12)*, the amount of the payment for all costs (as defined in paragraph (2)(B)) of covered skilled nursing facility services (as defined in paragraph (2)(A)) for each day of such services furnished—

(A) * * *

* * * * * * *

(2) DEFINITIONS.—For purposes of this subsection:

(A) COVERED SKILLED NURSING FACILITY SERVICES.—

(i) IN GENERAL.—The term "covered skilled nursing facility services"—

(I) * * *

(II) includes all items and services (other than **[**services described in clause (ii)**]** *items and services described in clauses (ii) and (iii)*) for which payment may be made under part B and which are furnished to an individual who is a resident of a skilled nursing facility during the period in

which the individual is provided covered post-hospital extended care services.

* * * * * * *

(iii) EXCLUSION OF CERTAIN ADDITIONAL ITEMS.—Items described in this clause are the following:

(I) Ambulance services furnished to an individual in conjunction with renal dialysis services described in section 1861(s)(2)(F).

(II) Chemotherapy items (identified as of July 1, 1999, by HCPCS codes J9000–J9020; J9040–J9151; J9170–J9185; J9200–J9201; J9206–J9208; J9211; J9230–J9245; and J9265–J9600 (and as subsequently modified by the Secretary)).

(III) Chemotherapy administration services (identified as of July 1, 1999, by HCPCS codes 36260–36262; 36489; 36530–36535; 36640; 36823; and 96405–96542 (and as subsequently modified by the Secretary)).

(IV) Radioisotope services (identified as of July 1, 1999, by HCPCS codes 79030–79440 (and as subsequently modified by the Secretary)).

(V) Customized prosthetic devices (commonly known as artificial limbs or components or artifical limbs) under the following HCPCS codes (as of July 1, 1999 (and as subsequently modified by the Secretary)) if delivered to an inpatient for use during the stay in the extended care facility and intended to be used by the patient after discharge from the facility: L5050–L5340; L5500–L5610; L5613–L5986; L5988; L6050–L6370; L6400–L6880; L6920–L7274; and L7362–7366.

* * * * * * *

(3) DETERMINATION OF FACILITY SPECIFIC PER DIEM RATES.—The Secretary shall determine a facility-specific per diem rate for each skilled nursing facility not described in paragraph (2)(E)(ii) for a cost reporting period as follows:

(A) DETERMINING BASE PAYMENTS.—The Secretary shall determine, on a per diem basis, the total of—

(i) the allowable costs of extended care services for the facility for cost reporting periods beginning in fiscal year 1995, including costs associated with facilities described in subsection (d), with appropriate adjustments (as determined by the Secretary) to non-settled cost reports *or, in the case of a facility participating in the Nursing Home Case-Mix and Quality Demonstration (RUGS–III), the RUGS–III rate received by the facility during the cost reporting period beginning in 1997*, and

(ii) an estimate of the amounts that would be payable under part B (disregarding any applicable deductibles, coinsurance, and copayments) for covered skilled nursing facility services described in paragraph (2)(A)(i)(II) ⟦furnished during such period⟧ *furnished*

during the applicable cost reporting period described in clause (i) to an individual who is a resident of the facility, regardless of whether or not the payment was made to the facility or to another entity.

* * * * * * *

[(B) UPDATE TO FIRST COST REPORTING PERIOD.—

[(i) IN GENERAL.—Subject to clause (ii), the Secretary shall update the amount determined under subparagraph (A), for each cost reporting period after the cost reporting period described in subparagraph (A)(i) and up to the first cost reporting period by a factor equal to the skilled nursing facility market basket percentage increase minus 1 percentage point.

[(ii) CERTAIN DEMONSTRATION PROJECTS.—In the case of a facility participating in the Nursing Home Case-Mix and Quality Demonstration (RUGS–III), there shall be substituted for the amount described in clause (i) the RUGS–III rate received by the facility for 1997.]

(B) UPDATE TO FIRST COST REPORTING PERIOD.—The Secretary shall update the amount determined under subparagraph (A), for each cost reporting period after the applicable cost reporting period described in subparagraph (A)(i) and up to the first cost reporting period by a factor equal to the skilled nursing facility market basket percentage increase minus 1 percentage point (except that for the cost reporting period beginning in fiscal year 2001, the factor shall be equal to such market basket percentage plus 0.8 percentage point).

* * * * * * *

(4) FEDERAL PER DIEM RATE.—

(A) * * *

(E) UPDATING.—

(i) * * *

(ii) SUBSEQUENT FISCAL YEARS.—The Secretary shall compute an unadjusted federal per diem rate equal to the federal per diem rate computed under this subparagraph—

(I) for fiscal year 2000, the rate computed for the initial period described in clause (i), increased by the skilled nursing facility market basket percentage change for the initial period minus 1 percentage point;

[(II) for each of fiscal years 2001 and 2002, the rate computed for the previous fiscal year increased by the skilled nursing facility market basket percentage change for the fiscal year involved minus 1 percentage point; and]

(II) for fiscal year 2001, the rate computed for fiscal year 2000 (determined without regard to section 121 of the Medicare Balanced Budget Refinement Act of 1999) increased by the skilled nursing

facility market basket percentage change for the fiscal year involved plus 0.8 percentage point;

(III) for fiscal year 2002, the rate computed for the previous fiscal year increased by the skilled nursing facility market basket percentage change for the fiscal year involved minus 1 percentage point; and

[(III)] *(IV)* for each subsequent fiscal year, the rate computed for the previous fiscal year increased by the skilled nursing facility market basket percentage change for the fiscal year involved.

* * * * * * *

(G) DETERMINATION OF FEDERAL RATE.—The Secretary shall compute for each skilled nursing facility for each fiscal year (beginning with the initial period described in subparagraph (E)(i)) an adjusted Federal per diem rate equal to the unadjusted Federal per diem rate determined under subparagraph (E), as adjusted under subparagraph (F), and as further adjusted as follows:

(i) * * *

* * * * * * *

(iii) ADJUSTMENT FOR EXCLUSION OF CERTAIN ADDITIONAL ITEMS.—The Secretary shall provide for an appropriate proportional reduction in payments so that beginning with fiscal year 2001, the aggregate amount of such reductions is equal to the aggregate increase in payments attributable to the exclusion effected under clause (iii) of paragraph (2)(A).

* * * * * * *

(9) PAYMENT FOR CERTAIN SERVICES.—In the case of an item or service furnished to a resident of a skilled nursing facility or a part of a facility that includes a skilled nursing facility (as determined under regulations) for which payment would (but for this paragraph) be made under part B in an amount determined in accordance with section 1833(a)(2)(B), the amount of the payment under such part shall be the amount provided under the fee schedule for such item or service. *In the case of an item or service described in clause (iii) of paragraph (2)(A) that would be payable under part A but for the exclusion of such item or service under such clause, payment shall be made for the item or service, in an amount otherwise determined under part B of this title for such item or service, from the Federal Hospital Insurance Trust Fund under section 1817 (rather than from the Federal Supplementary Medical Insurance Trust Fund under section 1841).*

* * * * * * *

(11) PERMITTING FACILITIES TO WAIVE 3-YEAR TRANSITION.—Notwithstanding paragraph (1)(A), a facility may elect to have the amount of the payment for all costs of covered skilled nursing facility services for each day of such services furnished in cost reporting periods beginning after the date of such election determined pursuant to subparagraph (B) of paragraph (1).

(12) PAYMENT RULE FOR CERTAIN FACILITIES.—

(A) IN GENERAL.—In the case of a qualified acute skilled nursing facility described in subparagraph (B), the per diem amount of payment shall be determined by applying the non-Federal percentage and Federal percentage specified in paragraph (2)(C)(ii).

(B) FACILITY DESCRIBED.—For purposes of subparagraph (A), a qualified acute skilled nursing facility is a facility that—

(i) was certified by the Secretary as a skilled nursing facility eligible to furnish services under this title before July 1, 1992;

(ii) is a hospital-based facility; and

(iii) for the cost reporting period beginning in fiscal year 1998, the facility had more than 60 percent of total patient days comprised of patients who are described in subparagraph (C).

(C) DESCRIPTION OF PATIENTS.—For purposes of subparagraph (B), a patient described in this subparagraph is an individual who—

(i) is entitled to benefits under part A; and

(ii) is immuno-compromised secondary to an infectious disease, with specific diagnoses as specified by the Secretary.

* * * * * * *

PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES

SEC. 1895. (a) * * *

* * * * * * *

(b) SYSTEM OF PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES.—

(1) * * *

* * * * * * *

(3) PAYMENT BASIS.—

(A) INITIAL BASIS.—

[(i) IN GENERAL.—Under such system the Secretary shall provide for computation of a standard prospective payment amount (or amounts). Such amount (or amounts) shall initially be based on the most current audited cost report data available to the Secretary and shall be computed in a manner so that the total amounts payable under the system for fiscal year 2001 shall be equal to the total amount that would have been made if the system had not been in effect but if the reduction in limits described in clause (ii) had been in effect. Such amount shall be standardized in a manner that eliminates the effect of variations in relative case mix and wage levels among different home health agencies in a budget neutral manner consistent with the case mix and wage level adjustments provided under paragraph (4)(A). Under the system, the Secretary may recognize regional differences or

differences based upon whether or not the services or agency are in an urbanized area.]

(i) IN GENERAL.—Under such system the Secretary shall provide for computation of a standard prospective payment amount (or amounts). Such amount (or amounts) shall initially be based on the most current audited cost report data available to the Secretary and shall be computed in a manner so that the total amounts payable under the system—

(I) for the 12-month period beginning on the date the Secretary implements the system, shall be equal to the total amount that would have been made if the system had not been in effect; and

(II) for periods beginning after the period described in subclause (I), shall be equal to the total amount that would have been made for fiscal year 2001 if the system had not been in effect but if the reduction in limits described in clause (ii) had been in effect, and updated under subparagraph (B).

Each such amount shall be standardized in a manner that eliminates the effect of variations in relative case mix and wage levels among different home health agencies in a budget neutral manner consistent with the case mix and wage level adjustments provided under paragraph (4)(A). Under the system, the Secretary may recognize regional differences or differences based upon whether or not the services or agency are in an urbanized area.

* * * * * * *

(B) ANNUAL UPDATE.—

(i) * * *

(ii) HOME HEALTH APPLICABLE INCREASE PERCENTAGE.—For purposes of this subparagraph, the term "home health applicable increase percentage" means, with respect to—

(I) [fiscal year 2002 or 2003] *each of fiscal years 2002 and 2003*, the home health market basket percentage increase (as defined in clause (iii)) minus 1.1 percentage points; or

* * * * * * *

TITLE IV OF THE BALANCED BUDGET ACT OF 1997

TITLE IV—MEDICARE, MEDICAID, AND CHILDREN'S HEALTH PROVISIONS

* * * * * * *

Subtitle A—Medicare+Choice Program

* * * * * * *

CHAPTER 2—DEMONSTRATIONS

Subchapter A—Medicare+Choice Competitive Pricing Demonstration Project

SEC. 4011. MEDICARE PREPAID COMPETITIVE PRICING DEMONSTRATION PROJECT.

(a) ESTABLISHMENT OF PROJECT.—[The Secretary]

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary of Health and Human Services (in this subchapter referred to as the "Secretary") shall establish a demonstration project (in this subchapter referred to as the "project") under which payments to Medicare+Choice organizations in medicare payment areas in which the project is being conducted are determined in accordance with a competitive pricing methodology established under this subchapter.

(2) DELAY IN IMPLEMENTATION.—The Secretary shall not implement the project until January 1, 2002, or, if later, 6 months after the date the Competitive Pricing Advisory Committee has submitted to Congress a report on each of the following topics:

(A) INCORPORATION OF ORIGINAL FEE-FOR-SERVICE MEDICARE PROGRAM INTO PROJECT.—What changes would be required in the project to feasibly incorporate the original fee-for-service medicare program into the project in the areas in which the project is operational.

(B) QUALITY ACTIVITIES.—The nature and extent of the quality reporting and monitoring activities that should be required of plans participating in the project, the estimated costs that plans will incur as a result of these requirements, and the current ability of the Health Care Financing Administration to collect and report comparable data, sufficient to support comparable quality reporting and monitoring activities with respect to beneficiaries enrolled in the original fee-for-service medicare program generally.

(C) RURAL PROJECT.—The current viability of initiating a project site in a rural area, given the site specific budget neutrality requirements of the project, and insofar as the Committee decides that the addition of such a site is not viable, recommendations on how the project might best be changed so that such a site is viable.

(D) BENEFIT STRUCTURE.—The nature and extent of the benefit structure that should be required of plans participating in the project, the rationale for such benefit structure, the potential implications that any benefit standardization requirement may have on the number of plan choices available to a beneficiary in an area designated under the project, the potential implications of requiring participating plans to offer variations on any standardized benefit package the committee might recommend, such that a beneficiary could elect to pay a higher percentage of out-

of-pocket costs in exchange for a lower premium (or premium rebate as the case may be), and the potential implications of expanding the project (in conjunction with the potential inclusion of the original fee-for-service medicare program) to require medicare supplemental insurance plans operating in an area designated under the project to offer a coordinated and comparable standardized benefit package.

(3) CONFORMING DEADLINES.—Any dates specified in the succeeding provisions of this section shall be delayed (as specified by the Secretary) in a manner consistent with the delay effected under paragraph (2).

* * * * * * *

(c) PROJECT IMPLEMENTATION.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall for each medicare payment area designated under subsection (b)—

(A) in accordance with the recommendations of the Competitive Pricing Advisory Committee—

(i) establish the benefit design among plans offered in such area, [and]

* * * * * * *

(iii) establish beneficiary premiums for plans offered in such area in a manner such that a beneficiary who enrolls in an offered plan with a below average price (as established by the competitive pricing methodology established for such area) may, at the plan's election, be offered a rebate of some or all of the medicare part B premium that such individual must otherwise pay in order to participate in a Medicare+Choice plan under the Medicare+Choice program; and

* * * * * * *

Subtitle B—Prevention Initiatives

* * * * * * *

SEC. 4205. RURAL HEALTH CLINIC SERVICES.

(a) PER-VISIT PAYMENT LIMITS FOR PROVIDER-BASED CLINICS.—

(1) EXTENSION OF LIMIT.—

(A) * * *

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) applies to [services furnished] *cost reporting periods beginning* on or after January 1, 1998.

* * * * * * *

SEC. 4207. INFORMATICS, TELEMEDICINE, AND EDUCATION DEMONSTRATION PROJECT.

(a) PURPOSE AND AUTHORIZATION.—

(1) IN GENERAL.—Not later than 9 months after the date of enactment of this section, the Secretary of Health and Human Services shall provide for a demonstration project described in paragraph (2). *The Secretary shall make an award for such*

project not later than 3 months after the date of the enactment of the Medicare Balanced Budget Refinement Act of 1999. The Secretary shall accept the proposal adjudged to be the best technical proposal as of such date of enactment without the need for additional review or resubmission of proposals.

(2) DESCRIPTION OF PROJECT.—

(A) IN GENERAL.—The demonstration project described in this paragraph is a single demonstration project to use eligible health care provider telemedicine networks to apply high-capacity computing and advanced networks to improve primary care (and prevent health care complications) to medicare beneficiaries with diabetes mellitus who are residents of medically underserved rural areas or residents of medically underserved inner-city areas *that qualify as Federally designated medically underserved areas or health professional shortage areas at the time of enrollment of beneficiaries under the project*.

* * * * * * *

(c) ELIGIBLE HEALTH CARE PROVIDER TELEMEDICINE NETWORK DEFINED.—For purposes of this section, the term "eligible health care provider telemedicine network" means a consortium that includes at least one tertiary care hospital (but no more than 2 such hospitals), at least one medical school, no more than 4 facilities in rural or urban areas, and at least one regional telecommunications provider and that meets the following requirements:

(1) * * *

(2) The consortium submits to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the use to which the consortium would apply any amounts received under the project **[**and the source and amount of non-Federal funds used in the project**]**.

* * * * * * *

(d) COVERAGE AS MEDICARE PART B SERVICES.—

(1) * * *

(2) PAYMENTS.—

(A) IN GENERAL.—Subject to paragraph (3), payment for such services shall be made **[**at a rate of 50 percent of the costs that are reasonable and**]** *for the costs that are related* related to the provision of such services. In computing such costs, the Secretary shall include costs described in subparagraph (B), but may not include costs described in subparagraph (C).

(B) COSTS THAT MAY BE INCLUDED.—The costs described in this subparagraph are the permissible costs (as recognized by the Secretary) for the following:

(i) The acquisition of telemedicine equipment for use in patients' homes **[**(but only in the case of patients located in medically underserved areas)**]** *or at sites providing health care to patients located in medically underserved areas*.

* * * * * * *

(C) COSTS NOT INCLUDED.—The costs described in this subparagraph are costs for any of the following:

(i) The purchase or installation of transmission equipment (other than such equipment used by health professionals [to deliver medical informatics services under] *for activities related to* the project).

(ii) The establishment or operation of a telecommunications common carrier network.

(iii) Construction (except for minor renovations related to the installation of reimbursable equipment) or the acquisition or building of real property.

* * * * * * *

[(4) LIMITATION ON COST-SHARING.—The project may not impose cost sharing on a medicare beneficiary for the receipt of services under the project in excess of 20 percent of the costs that are reasonable and related to the provision of such services.]

(4) COST-SHARING.—The project may not impose cost sharing on a medicare beneficiary for the receipt of services under the project. Project costs will cover all costs to patients and providers related to participation in the project.

* * * * * * *

Subtitle E—Provisions Relating to Part A Only

CHAPTER 1—PAYMENT OF PPS HOSPITALS

SEC. 4401. PPS HOSPITAL PAYMENT UPDATE.

(a) * * *

* * * * * * *

(b) TEMPORARY RELIEF FOR CERTAIN NON-TEACHING, NON-DSH HOSPITALS.—

(1) IN GENERAL.—In the case of a hospital described in paragraph (2) for its cost reporting period—

(A) * * *

(B) beginning in fiscal year 1999 the amount of payment made to the hospital under section 1886(d) of the Social Security Act for discharges occurring during such fiscal year only shall be increased as though the applicable percentage increase (otherwise applicable to discharges occurring during fiscal year 1999 under section [1886(b)(3)(B)(i)(XIII) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)(XIII)))] *section 1886(b)(3)(B)(i)(XIV) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)(XIV)))* had been increased by 0.3 percentage points.

* * * * * * *

CHAPTER 4—PROVISIONS RELATED TO HOSPICE SERVICES

* * * * * * *

SEC. 4442. PAYMENT FOR HOME HOSPICE CARE BASED ON LOCATION WHERE CARE IS FURNISHED.

(a) * * *

(b) EFFECTIVE DATE.—The amendment made by subsection (a) [applies to cost reporting periods beginning] *applies to items and services furnished* on or after October 1, 1997.

Subtitle F—Provisions Relating to Part B Only

* * * * * * *

CHAPTER 3—AMBULANCE SERVICES

SEC. 4531. PAYMENTS FOR AMBULANCE SERVICES.

(a) * * *

* * * * * * *

(c) AUTHORIZING PAYMENT FOR PARAMEDIC INTERCEPT SERVICE PROVIDERS IN RURAL COMMUNITIES.—In promulgating regulations to carry out section 1861(s)(7) of the Social Security Act (42 U.S.C. 1395x(s)(7)) with respect to the coverage of ambulance service, the Secretary of Health and Human Services may include coverage of advanced life support services (in this subsection referred to as "ALS intercept services") provided by a paramedic intercept service provider in a rural area if the following conditions are met:

(1) * * *

* * * * * * *

For purposes of this subsection, an area shall be treated as a rural area if it is designated as a rural area by any law or regulation of the State or if it is located in a rural census tract of a metropolitan statistical area (as determined under the Goldsmith Modification, as published in the Federal Register on February 27, 1992 (57 FR 6725)).

SEC. 4532. DEMONSTRATION OF COVERAGE OF AMBULANCE SERVICES UNDER MEDICARE THROUGH CONTRACTS WITH UNITS OF LOCAL GOVERNMENT.

(a) DEMONSTRATION PROJECT CONTRACTS WITH LOCAL GOVERNMENTS.—The Secretary of Health and Human Services shall establish up to 3 demonstration projects under which, at the request of a unit of local government, the Secretary enters into a contract with the unit of local government under which—

(1) * * *

* * * * * * *

The projects may extend over a period of not to exceed 3 years each. *The Secretary shall publish by not later than July 1, 2000, a request for proposals for such projects.*

(b) AMOUNT OF PAYMENT.—

(1) * * *

[(2) CAPITATED PAYMENT RATE DEFINED.—In this subsection, the "capitated payment rate" applicable to a contract under this subsection for a calendar year is equal to 95 percent of—

[(A) for the first calendar year for which the contract is in effect, the average annual per capita payment made under part B of title XVIII of the Social Security Act with respect to ambulance services furnished to such individuals during the 3 most recent calendar years for which data on the amount of such payment is available; and

[(B) for a subsequent year, the amount provided under this paragraph for the previous year increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year.]

(2) CAPITATED PAYMENT RATE DEFINED.—In this subsection, the "capitated payment rate" means, with respect to a demonstration project—

(A) in its first year, a rate established for the project by the Secretary, using the most current available data, in a manner that ensures that aggregate payments under the project will not exceed the aggregate payment that would have been made for ambulance services under part B of title XVIII of the Social Security Act in the local area of government's jurisdiction; and

(B) in a subsequent year, the capitated payment rate established for the previous year increased by an appropriate inflation adjustment factor.

* * * * * * *

Subtitle G—Provisions Relating to Parts A and B

CHAPTER 1—HOME HEALTH SERVICES AND BENEFITS

Subchapter A—Payments For Home Health Services

* * * * * * *

SEC. 4603. PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES.

(a) * * *

* * * * * * *

(e) CONTINGENCY.—If the Secretary of Health and Human Services for any reason does not establish and implement the prospective payment system for home health services described in section 1895(b) of the Social Security Act (as added by subsection (a)) for portions of cost reporting periods described in subsection (d), for such portions the Secretary shall provide for a reduction by 15 percent in the cost limits and per beneficiary limits described in section 1861(v)(1)(L) of such Act, as those limits would otherwise be in effect on [September 30, 2000] *on the date that is 12 months after the date the Secretary implements such system*.

* * * * * * *

SECTION 9335 OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1986

* * * * * * *

SEC. 9335. PAYMENT RATES FOR RENAL SERVICES AND IMPROVEMENTS IN ADMINISTRATION OF END STAGE RENAL DISEASE NETWORKS AND PROGRAMS.

(a) COMPOSITE RATES FOR DIALYSIS SERVICES.—

[(1) IN GENERAL.—Effective with respect to dialysis services provided on or after December 1, 1990, and before October 1, 1998, the Secretary of Health and Human Services shall establish the base rate for routine dialysis treatment in a freestanding facility and in a hospital-based facility under section 1881(b)(7) of the Social Security Act, at a level equal to the respective rate in effect as of May 13, 1986, reduced by $2.00. With respect to services furnished on or after January 1, 1991, such base rate shall be equal to the respective rate in effect as of September 30, 1990 (determined without regard to any reductions imposed pursuant to section 6201 of the Omnibus Budget Reconciliation Act of 1989), increased by $1.00. No change may be made in the base rate in effect as of September 30, 1990, unless the Secretary makes such change in accordance with notice and comment requirements set forth in section 1871(b)(1) of such Act.]

* * * * * * *

OMNIBUS BUDGET RECONCILIATION ACT OF 1993

CHAPTER 2—HEALTH CARE, HUMAN RESOURCES, INCOME SECURITY, AND CUSTOMS AND TRADE PROVISIONS

Subchapter A—Medicare

* * * * * * *

PART I—PROVISIONS RELATING TO PART A

SEC. 13501. PAYMENTS FOR PPS HOSPITALS.

(a) * * *

* * * * * * *

(e) EXTENSION FOR MEDICARE-DEPENDENT, SMALL RURAL HOSPITALS.—

(1) * * *

(2) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—If any hospital fails to qualify as a medicare-dependent, small rural hospital under section 1886(d)(5)(G)(i) of the Social Security Act as a result of a decision by the Medicare Geographic Classification Review Board under section 1886(d)(10) of such Act to reclassify the hospital as being located in an urban area for fiscal year 1993, fiscal year 1994, fiscal year 1998, fiscal year 1999, [or fiscal year 2000] *or fiscal year 2000 through fis-*

cal year 2005, the Secretary of Health and Human Services shall—

(A) * * *

* * * * * * *

PART III—PROVISIONS RELATING TO PARTS A AND B

SEC. 13567. EXTENSION OF SOCIAL HEALTH MAINTENANCE ORGANIZATION DEMONSTRATIONS.

(a) * * *

[(c) EXPANSION OF NUMBER OF MEMBERS PER SITE.—The Secretary of Health and Human Services may not impose a limit of less than 36,000 on the number of individuals that may participate in a project conducted under section 2355 of the Deficit Reduction Act of 1984.**]**

(c) AGGREGATE LIMIT ON NUMBER OF MEMBERS.—The Secretary of Health and Human Services may not impose a limit on the number of individuals that may participate in a project conducted under section 2355 of the Deficit Reduction Act of 1984 (including under any subsequent expansion under such section), other than an aggregate limit of not less than 324,000 for all sites.

* * * * * * *

SECTION 4018 OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987

SEC. 4018. SPECIAL RULES.

(a) * * *

(b) EXTENSION OF WAIVERS FOR SOCIAL HEALTH MAINTENANCE ORGANIZATIONS.—

(1) The Secretary of Health and Human Services shall extend without interruption, through December 30, **[**2000**]** *the date that is 18 months after the date that the Secretary submits to Congress the report described in section 4014(c) of the Balanced Budget Act of 1997*, the approval of waivers granted under subsection (a) of section 2355 of the Deficit Reduction Act of 1984 for the demonstration project described in subsection (b) of that section, subject to the terms and conditions (other than duration of the project) established under that section (as amended by paragraph (2) of this subsection).

* * * * * * *

(4) The Secretary of Health and Human Services shall submit a final report to the Congress on the project referred to in paragraph (1) not later than March 31, 2001. *Not later than 6 months after the date the Secretary submits such final report, the Medicare Payment Advisory Commission shall submit to Congress a report containing recommendations regarding such project.*

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VII. ADDITIONAL VIEWS

This bill has many needed, good features and long-term reforms (such as psychiatric and long-term care hospital prospective payment systems) that caused a number of us to vote to report it to the House. Except for the fact that the bill is not paid for, most of us would have voted for the package.

We commend Health Subcommittee Chairman Bill Thomas for significant improvements in the bill between the Subcommittee markup and the full Committee's consideration. Extra help was provided for disproportionate share/safety net hospitals, teaching hospitals, and home health agencies. Of particular note is help for beneficiaries under-going expensive, high-tech medical procedures in hospital outpatient departments.[1] The bill limits a beneficiaries' out-of-pocket expense for these procedures to no more than the cost of the hospital deductible ($776 in the year 2000). This provision is estimated to save beneficiaries half a billion dollars over the next 10 years. The provision reaffirms our commitment to provide beneficiary relief in the hospital outpatient sector, where beneficiaries are today paying about 50 percent of the total cost, instead of Medicare's normal 20 percent–80 percent split.

THE NEED TO DO MORE

In other areas, the bill misses an opportunity to do more for Medicare providers in distress—particularly our nation's hospitals serving the poor and uninsured, our academic teaching hospitals, rural hospital outpatient departments, and home health agencies. Democratic amendments to provide more help in these areas were all rejected. The bill also does not do enough to offer relief from the arbitrary $1,500 therapy caps, which is causing some of our sicker seniors (for example, stroke patients) to be denied continuity of treatment.[2] Another area of concern, raised in a colloquy by Representative Cardin and Portman, is hospice care, where soaring pharmaceutical costs coupled with the BBA cuts have created severe pressures on these important end-of-life caregivers. We believe more assistance is needed for these providers.

REPUBLICANS REJECT RX PRICE RELIEF FOR SENIORS

The bill also misses a golden opportunity to provide major help for seniors in meeting the costs of pharmaceuticals. The Republican majority voted unanimously against Representative Karen Thurman's amendment to give seniors prescription drug discounts. Her amendment, a variation of the Allen-Turner-Waxman-Berry bill (H.R. 664), would require that Medicare providers (like hospitals)

[1] For example, the beneficiary payment for the implantation of a hearing device can run over $3,000.

[2] The bill provides an "outlier" pool of about 1 percent for difficult cases, but data indicates that over 10 percent of seniors needing rehab are likely to reach the cap.

must only purchase drugs from manufacturers who also make available to pharmacies (for sale to seniors) drugs at the best available discount price.

Today, seniors who pay out-of-pocket for their medications are frequently charged more than twice as much as favored customers, such as large group health plans. This Medicare legislation is our best hope this year to provide prescription drug price relief to seniors and disabled. We look forward to debating this issue on the floor of the House.

In the area of drugs, the Republicans also opposed an amendment by Representative Neal to allow a State to require HMO's operating in the State to offer a drug benefit (the BBA pre-empted Massachusetts's program ensuring a drug benefit for its managed care enrollees). The Majority also rejected Representative Cardin's proposal that when a Medicare+Choice managed care plan leaves an area, enrollees should have the right of guaranteed issue of medi-gap policies that offer a prescription drug benefit (plans H, I, and J). Beneficiaries abandoned by their managed care plans often lose a valuable drug benefit, and we should ensure that they have the right to convert to a medi-gap plan that also offers prescription drug coverage.

(On the bright side, Chairman Thomas and the Majority responded to a request by Representative Thurman for more Medicare coverage of immuno-suppressive drugs (so that transplant patients don't reject or lose their expensive, transplanted organs) by offering to discuss and work on the issue in the coming days. Medicare drug expansion in this area could save money and improve the quality of life for many very vulnerable citizens. Two hundred and fifty-eight Members of the House are co-sponsoring legislation in this area.)

REPUBLICANS REJECT PAYING FOR RELIEF: SHRINK THE SOLVENCY OF MEDICARE

The bill's major fault is that it is not paid for, and thus chops off a year's solvency from the Medicare Part A Trust Fund and raises beneficiary's Part B premiums.

All of the Committee Democrats voted to pay for the cost of this bill. All of the Republicans voted against our effort to be financially responsible. They voted to spend another $10.6 billion of the surpluses which do not exist, thus making it harder to save Medicare in the long run—and thus further dipping into the Social Security surplus.

In voting for Medicare relief to health care providers without paying for it, we must remember that every dollar we give back in Part A reduces the solvency of the Part A Trust Fund. Every dollar we give back to the providers in Part B results in higher Part B premiums on beneficiaries. Over the next 5 years Medicare will spend about $1.2 trillion dollars. Surely in this 5 year budget window we can find zero point seven percent (0.7 percent) in savings. Surely, working with the Republican Majority, we can find tax loopholes and unjustified tax subsidies to offset the cost of this bill.

If we cannot pay for this bill now, before we face the crisis of the Baby Boomers retiring, it calls into serious question Congress's ability to govern.[3]

Because of the failure to pay for the bill, eleven of us voted against final passage. We will all continue to work to find a way to finance this needed relief from the excessive cuts in the Balanced Budget Act of 1997.

THE NEED TO SUPPORT THE HEALTH CARE FINANCING ADMINISTRATION'S BUDGET

We make one other point: this bill piles major new tasks on the Health Care Financing Administration. Unless all of us in Congress work together to protect HCFA's budget and find new ways to pay for Medicare's administrative costs, the agency will be unable to carry out the tasks we gave it in 1997, let alone these major new assignments.

ROBERT T. MATSUI.
SANDER LEVIN.
PETE STARK.
WILLIAM J. COYNE.
JOHN LEWIS.
LLOYD DOGGETT.
BEN CARDIN.
RICHARD E. NEAL.
CHARLES B. RANGEL.
MICHAEL R. MCNULTY.
KAREN L. THURMAN.
JOHN TANNER.
XAVIER BECERRA.
JIM MCDERMOTT.
WILLIAM J. JEFFERSON.
JERRY KLECZKA.

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[3] Senator Bob Graham, offering a similar pay-for amendment in the Senate Finance Committee last week, noted that it would be "ironic" in a year which started with a Commission on how to extend the life of the Medicare Trust Fund to meet the needs of the Baby Boomers, if we ended up reducing the Fund's solvency. More than ironic, we would say it is tragic.