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Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP): Changes to Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) Provisions

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ABSTRACT

Both the House and Senate considered bills to mitigate the impact of Medicare provisions of the Balanced Budget Act of 1997 (BBA 97) provisions on health care providers. These measures were considered in the context of stringent federal budget limitations. On November 5, 1999, the House passed the *Medicare Balanced Budget Refinement Act of 1999 (H.R. 3075)*. On October 26, 1999 the Senate Finance Committee reported the *Medicare and Medicaid Budget Correction and Refinement Act of 1999 (S. 1788)*. On November 18, 1999, the House passed the conference report on H.R. 3194 the District of Columbia appropriations bill. This measure incorporates the agreement reached by House and Senate negotiators on the Medicare provisions. This report summarizes the major provisions of the agreement. It will be updated as additional legislative actions occur.

Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP): Changes to Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) Provisions

Summary

On August 5, 1997, the President signed into law the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33). This legislation included a number of Medicare provisions. At the time of enactment, the Congressional Budget Office (CBO) estimated that Medicare spending would be reduced by \$116.4 billion over 5 years (FY1998-FY2002) and \$393.8 billion over 10 years (FY1998-FY2007). The BBA was expected to achieve the target savings both by slowing the rate of growth in payments to hospitals, physicians, and other providers and by establishing new prospective payment systems (PPSs) and other new payment methodologies for skilled nursing facilities, home health agencies, and other service categories. In addition, the measure established the Medicare+Choice program which expanded private plan options available to Medicare beneficiaries and modified the way payments are made to health maintenance organizations (HMOs).

In March 1999, and subsequently in July 1999, CBO lowered its Medicare spending estimates. The estimates made since enactment of BBA 97 reflect a number of factors, many of which are only indirectly related to the BBA provisions. These include an improved economic forecast, heightened anti-fraud and abuse initiatives, a slowdown in payments to providers, and lower projected enrollment in the Medicare+Choice program.

A number of health care provider groups have stated that actual Medicare payment reductions resulting from BBA 97 are larger than were intended when BBA 97 was enacted. Some groups further contend that beneficiary access to care has been adversely affected as a result. It is difficult to determine the actual impact of the legislation due to the limited data that are currently available and the fact that a number of the provisions have not been fully implemented. The Medicare Payment Advisory Commission (MedPAC) and the General Accounting Office (GAO) have reviewed existing information and find that, in general, BBA 97 provisions have not impeded beneficiary access to care. However, they caution that continued review of the implementation of the law is warranted.

Both the House and Senate considered bills to mitigate the impact of BBA provisions on Medicare providers. On November 5, 1999, the House passed the *Medicare Balanced Budget Refinement Act of 1999 (H.R. 3075)*. On October 26, 1999, the Senate Finance Committee reported the *Medicare and Medicaid Budget Correction and Refinement Act of 1999 (S. 1788)*. On November 18, 1999, the House passed the conference report on H.R. 3194 the District of Columbia appropriations bill. This measure incorporates the agreement reached by House and Senate negotiators on the Medicare provisions. This report summarizes the major provisions of the agreement. This report will be updated as additional legislative actions occur.

Contents

Introduction	1
Impact of BBA 97	1
Pending Legislation	4
Summary of The Medicare, Medicaid, And SCHIP Balanced Budget Refinement Act of 1999	6
Title I — Provisions Relating to Part A	6
Subtitle A — Adjustments to PPS Payments for Skilled Nursing Facilities (SNFs)	6
Subtitle B — PPS Hospitals	7
Subtitle C — PPS-Exempt Hospitals	7
Subtitle D — Hospice Care	8
Subtitle E — Other Provisions	9
Subtitle F — Transitional Provisions	9
Title II — Provisions Relating to Part B	10
Subtitle A — Hospital Outpatient Services	10
Subtitle B — Physician Payments	11
Subtitle C — Other Services	11
Title III — Provisions Relating to Parts A and B	13
Subtitle A — Home Health Services	13
Subtitle B — Direct Graduate Medical Education	14
Subtitle C — Technical Corrections	14
Title IV — Rural Provider Provisions	14
Subtitle A — Rural Hospitals	14
Subtitle B — Other Rural Provisions	16
Title V — Provisions Relating to Part C (Medicare+Choice Program) and Other Medicare Managed Care Provisions	17
Subtitle A — Provisions to Accommodate and Protect Medicare Beneficiaries	17
Subtitle B — Provisions to Facilitate Implementation of the Medicare+Choice Program	17
Subtitle C — Demonstration Projects and Special Medicare Populations	19
Subtitle D — Medicare+Choice Nursing and Allied Health Professional Education Payments	21
Subtitle E — Studies and Reports	21
Title VI — Medicaid	21
Title VII — State Children’s Health Insurance Program (SCHIP)	23

Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP): Changes to Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) Provisions

Introduction

On August 5, 1997, the President signed into law the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33). This legislation included Medicare provisions that were intended to slow the rate of growth in that program's spending. At the time of enactment, the Congressional Budget Office (CBO) estimated that Medicare spending would be reduced by \$116.4 billion over 5 years (FY1998-FY2002) and \$393.8 billion over 10 years (FY1998-FY2007). The BBA was expected to achieve the target savings both by slowing the rate of growth in payments to hospitals, physicians, and other providers and by establishing new prospective payment systems (PPSs) and other new payment methodologies for skilled nursing facilities, home health agencies, and other service categories. In addition, the measure established the Medicare+Choice program which expanded private plan options available to Medicare beneficiaries and modified the way payments are made to health maintenance organizations (HMOs).¹

In March 1999, CBO revised its budget projections. It lowered its Medicare spending estimates by an additional \$80 billion over the FY1998-FY2002 period and \$229 billion over the FY1998-FY2007 period. In July 1999, CBO projected a further reduction of \$11 billion over the FY1998-FY2002 period and \$21 billion over the FY1998-FY2007 period. The estimates made since enactment of BBA 97 reflect a number of factors, many of which are only indirectly related to the BBA provisions. These include an improved economic forecast, heightened anti-fraud and abuse initiatives, a slowdown in payments to providers, and lower projected enrollment in the Medicare+Choice program.²

Impact of BBA 97

A number of health care provider groups have stated that actual Medicare payment reductions resulting from BBA 97 are larger than were intended when BBA

¹ For a description of BBA 97, see CRS Report 97-802, *Medicare Provisions in the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33)*, by Jennifer O'Sullivan, Celinda Franco, Beth Fuchs, Bob Lyke, and Richard Price.

² For a discussion of changes in Medicare spending since BBA 97, see CRS Report RS20238, *Trends in Medicare Spending After the Balanced Budget Act*, by Hinda Chaikind.

97 was enacted. Some groups further contend that beneficiary access to care has been adversely affected as a result. In addition, some Medicare+Choice (M+C) organizations, which are either terminating their program participation or reducing their service areas, attribute these actions to reductions in Medicare payment rates and other BBA changes.

It is difficult to determine the actual impact of the legislation due to the limited data that are currently available.³ On October 1, 1999, the Ways and Means Health Subcommittee held a hearing on the impact of BBA 97 provisions. Witnesses from both the Medicare Payment Advisory Commission (MedPAC) and the General Accounting Office (GAO) testified on the information available to date.

MedPAC reported that it is difficult to sort out the effects of multiple changes in payment policies as well as the introduction of new prospective payment systems. It noted that many of the BBA changes have yet to be fully phased-in and that data to evaluate the impact of recent changes are not available in many cases. MedPAC also noted that it was difficult to isolate the effects of changes in Medicare policy from other changes in the health care system. The following are some of MedPAC's key findings by service category:

- *Hospitals — Inpatient Services.* MedPAC testified that while industry reports somewhat overstate the negative impact of BBA on hospital margins, the reports do reflect the overall direction. As was intended by BBA, the law reverses a 6-year trend of Medicare payments rising more rapidly than the cost of treating Medicare patients. MedPAC has not seen convincing evidence that the changes to date have affected either quality or access to inpatient care, but it will continue to monitor developments. MedPAC cited its March 1999 report which concluded that the FY2000 update included in BBA was appropriate; however, it recognized factors pointing to the need for caution in specifying future updates. It also questioned whether the unusually low rate of cost growth observed in recent years can be sustained without adverse effects on quality.
- *Hospitals — Outpatient Services.* MedPAC reports that hospitals have not felt the impact of BBA provisions because the PPS that was to be implemented in 1999 will not be implemented until mid-2000. MedPAC has increased its savings estimates of the impact of PPS but suggests that certain hospitals may counter some of the reduction by coding services more accurately. Given that implementation of PPS could have a larger impact on some hospitals than others, it recommended that the Secretary of the Department of Health and Human Services (HHS) closely monitor the use of care to ensure that access to appropriate care is not compromised. It also suggested that consideration be given to phasing in the system.
- *Home Health Agencies (HHAs).* MedPAC cited the findings from a recent GAO study which showed that although 14% of HHAs closed between October 1997 and January 1999 there were more agencies in existence at the

³ For further information see: CRS Report RL30300, *Medicare Beneficiary Access to Care: The Effects of the New Prospective Payment Systems on Outpatient Hospital Care, Home Health Care, and Skilled Nursing Facility Care*, by Carolyn Merck.

beginning of FY1999 than at the beginning of FY1996. Hospital discharge planners and others interviewed by GAO reported few access problems. However, GAO noted that beneficiaries who are more costly than average may face difficulties in the future as agencies change their behavior in response to the interim payment system (IPS) established by BBA 97. The IPS among other things, established a new methodology for limiting annual Medicare payments to individual agencies through per beneficiary limits. MedPAC's survey of HHAs contained findings that were consistent with the claim that the IPS has hampered access. However, it notes that changes in payment policy were occurring at the same time that HCFA was implementing other policies intended to reduce fraud and abuse (including stepped up in-depth case reviews by intermediaries). It also cited the lack of clear eligibility and coverage guidelines. It is therefore difficult to interpret the findings. In its June report, MedPAC was concerned about the tight timetable for implementation of the new PPS system. It recommended that Congress explore the feasibility of excluding, on a budget neutral basis, a small percentage of patients who have intense service needs (e.g., 2%) from the aggregate per beneficiary limits.

- *Skilled Nursing Facilities (SNFs)*. MedPAC cited a survey of hospital discharge planners by the Office of the Inspector General (OIG) of HHS. The OIG report stated that serious problems in placing beneficiaries are not apparent, although some SNFs are changing their admitting practices in response to the new payment system. The OIG noted that half of those surveyed reported that they have begun requesting more clinical information about patients and are often assessing patients more directly before making admissions decisions. The survey further reported that some medically complex patients had become harder to place. This is consistent with MedPAC's concerns that payment weights under the new PPS do not adequately account for the service needs of certain patients, particularly those who require relatively high levels of nontherapy ancillary services and supplies. Its March 1999 report recommended a refinement in the classification system. HCFA has undertaken a review of this potential problem.
- *Physicians*. A survey of beneficiary access to physicians' services indicated few problems. However, MedPac suggested that technical changes were needed in the sustainable growth rate system (that determines annual updates in physician payments) in order to avoid access problems in the future.
- *Medicare+Choice (M+C) Plans*. While Congress intended that the M+C program expand beneficiaries' health plan options to include preferred provider organizations, provider sponsored organizations, private fee-for-service plans and medical savings accounts, this has not occurred. However, enrollment in M+C plans (typically HMOs) has continued to grow. MedPAC states that M+C payment levels alone do not appear to have had much impact on either encouraging new plans to enter the market or encouraging existing plans to leave the market. MedPAC's March report recommended that the Secretary work with organizations offering plans to identify specific regulation or policy changes which could reduce the burden of compliance without compromising the objectives of the program. It further recommended delaying the filing date for the adjusted community rate proposals and giving M+C organizations the flexibility to tailor their benefit packages within their service areas. Finally, it supported phasing-in the risk adjustment payment mechanism.

The GAO testimony from October 1, 1999 included the following observations:

- *Home Health Agencies.* As noted in the MedPAC testimony (above) GAO has found little evidence to date of impaired access to care. GAO points out, however, that the PPS system is a more appropriate tool for controlling program spending than the IPS because it can align payments with patient needs. GAO notes that a number of PPS design issues remain and that the payment system will likely require continued adjustments even after its implementation next year.
- *Skilled Nursing Facilities.* GAO reports that some business decisions unrelated to the PPS have contributed to fiscal difficulties for some corporations operating SNFs. While overall SNF payment rates are likely to prove sufficient or even generous, the distribution may be out of balance. The current case mix adjustment method may not adequately ensure that providers serving high cost beneficiaries are paid enough. A potential access problem could result if Medicare underpays for high cost patients.
- *Outpatient Therapy Services.* For the vast majority of patients, the caps are unlikely to curtail access. Whether caps restrict access for a small share of nursing home residents is less straightforward. A needs-based system could better target payments toward patients who genuinely require more services than allowed under the caps.
- *Medicare+Choice Plans.* BBA provisions addressed the long recognized problem of excess payments to plans. The net effect of the new provisions has been modest and, on average, has likely removed only a portion of the excess payments built into the base rates. Further, plan withdrawals are attributable to a number of factors in addition to changes in M+C payment rates. Critical to making M+C payment modifications is the establishment of an appropriate base rate and risk adjustment mechanism that pays more for beneficiaries with serious health problems and less for relatively healthy persons.

Pending Legislation

Both the House and Senate considered bills to mitigate the impact of BBA provisions on providers. These measures were considered in the context of stringent federal budget limitations.

On November 5, 1999, the House passed the *Medicare Balanced Budget Refinement Act of 1999 (H.R. 3075)*. This measure is the bill reported by the House Ways and Means Committee on November 2, 1999, with some modifications as agreed to in discussions between the Ways and Means Committee and Commerce Committee (which shares jurisdiction over a portion of Medicare). The Congressional Budget cost estimates for the Ways and Means bill were \$10.5 billion over 5 years (FY2000-FY2004) and \$17.2 billion over 10 years (FY2000-FY2009); an estimate of the House-passed bill is not available.

On October 26, 1999, the Senate Finance Committee ordered reported the *Medicare and Medicaid Balanced Budget Correction and Refinement Act of 1999 (S. 1788)*. This measure had a cost estimate (including the non-Medicare provisions) of \$11.9 billion over 5 years and \$15.7 billion over 10 years.

On November 17, 1999, House and Senate negotiators reached agreement on the Medicare provisions. The agreement also included provisions related to the State Children's Health Insurance Program (SCHIP) and Medicaid. CBO has estimated the cost of this package at \$16 billion over the FY2000-FY2004 period and \$27 billion over the FY2000-FY2009 period. The agreement was introduced as H.R. 3496, the *Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999*. It was incorporated by reference into the conference agreement, on H.R. 3194, the District of Columbia Appropriations Act. The House passed the measure on November 18, 1999. This report summarizes the Medicare, Medicaid, and SCHIP portions of the bill.

Summary of The Medicare, Medicaid, And SCHIP Balanced Budget Refinement Act of 1999

Title I — Provisions Relating to Part A

Subtitle A — Adjustments to PPS Payments for Skilled Nursing Facilities (SNFs).

Sec. 101. Temporary Increase in Payment for Certain High Cost Patients

The agreement increases federal per diem PPS payments by 20% for 15 categories of Medicare patients in SNFs starting April 1, 2000, and increases the federal rates for all categories of patients by 4.0% in FY2001 and FY2002.

Sec. 102. Authorizing Facilities to Elect Immediate Transition to Federal Rate

The agreement permits SNFs to elect, on or after December 15, 1999, to receive Medicare payments based 100% on the federal per diem rate rather than partially on a federal per diem rate and partially on a pre-PPS facility specific rate.

Sec. 103. Part A Pass-Through for Certain Ambulance Services, Prostheses, and Chemotherapy Drugs

The agreement requires that certain ambulance services for dialysis patients, certain prostheses, and certain chemotherapy drugs for SNF patients be paid for by Medicare in addition to SNF PPS per diem amounts starting April 1, 2000 and then should be paid with a budget neutral adjustment to total payments beginning in FY2001.

Sec. 104. Provision for Part B Add-ons for Facilities Participating in the NHCMQ Demonstration Project

The agreement includes the cost of Part B services in the computation of the facility specific component of the SNF per diem payment during the transition to the federal per diem PPS for SNFs that had participated in the Nursing Home Case Mix and Quality demonstration, including updates of the SNF market basket increase minus 1 percentage point.

Sec. 105. Special Consideration for Facilities Serving Specialized Patient Populations

The agreement provides that from enactment until September 30, 2001, PPS payments to certain SNFs will be based 50% on the facility specific rate and 50% on the federal per diem rate (rather than moving to 100% at the federal rate) if the SNF was in operation before July 1, 1992, and if at least 60% of the SNF's patients in cost reporting periods beginning in 1998 were immuno-compromised secondary to an infectious disease (with other diagnoses).

Sec. 106. MedPAC Study on Special Payment for Facilities Located in Hawaii and Alaska

The agreement requires the Secretary to study and report within 18 months of enactment on the need for additional payments under the SNF PPS for facilities in Alaska and Hawaii.

Sec. 107. Study and Report Regarding State Licensure and Certification Standards and Respiratory Therapy Competency Examinations

The agreement requires the Secretary to study and report within 18 months of enactment on the variations in State licensure and certification standards regarding providers of respiratory therapy in SNFs and the need for Medicare to require examinations for, or certification of, workers providing respiratory therapy.

Subtitle B — PPS Hospitals.

Sec. 111. Modification in Transition for Indirect Medical Education (IME) Percentage Adjustment

The agreement provides that the IME adjustment would be frozen at 6.5% through FY2000, reduced to 6.25% in FY2001 and then to 5.5% in FY2002 and subsequent years. The agreement also provides for a special adjustment to achieve the 6.5% IME payment for the first six months of FY2000.

Sec. 112. Decrease in Reductions for Disproportionate Share Hospitals; Data Collection Requirements

The agreement freezes the reduction in the DSH payment formula to 3% in FY2001, changes the reduction to 4% in FY2002, and requires the Secretary to collect hospital cost data on uncompensated inpatient and outpatient care, including non-Medicare bad debt and charity care as well as Medicaid and indigent care charges for cost reporting periods beginning on or after October 1, 2001.

Subtitle C — PPS-Exempt Hospitals.

Sec. 121. Wage Adjustment of Percentile Cap for PPS-exempt Hospitals Percentage Adjustment

The agreement adjusts the labor-related portion of the 75% cap to reflect differences between the wage-related costs in the hospital's area and the national average of such costs within the same class of PPS-exempt hospitals beginning for cost reporting periods on or after October 1, 1999.

Sec. 122. Enhanced Payments for Long-Term Care and Psychiatric Hospitals Until Development of Prospective Payment Systems (PPS) for those Hospitals

The agreement provides for an increase to the amount of continuous bonus payments to the eligible long-term care and psychiatric providers from 1% to 1.5% for cost reporting periods beginning on or after October 1, 2000, and before

September 30, 2001, and 2% for cost reporting periods beginning on or after October 1, 2001, and before September 30, 2002.

Sec. 123. Per Discharge Prospective Payment System (PPS) for Long-Term Care Hospitals

The agreement requires the Secretary to report to the appropriate Congressional committees by October 1, 2001 on a discharge-based PPS with an adequate patient classification system for long-term care hospitals which would be implemented in a budget neutral fashion for cost reporting periods beginning on or after October 1, 2002.

Sec. 124. Per Diem Prospective Payment System (PPS) for Psychiatric Hospitals

The agreement requires the Secretary to report to the appropriate Congressional committees by October 1, 2001 on a per-diem based PPS with an adequate patient classification system for psychiatric hospitals and units which would be implemented in a budget neutral fashion for cost reporting periods beginning on or after October 1, 2002.

Sec. 125. Refinement of Prospective Payment System (PPS) for Inpatient Rehabilitation Hospitals

The agreement requires the Secretary to base a PPS on discharges, establish classes of patient discharges of rehabilitation facilities by functional-related groups, based on impairment, age, co-morbidities, 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 submit a study to Congress not later than 3 years after PPS implementation on its impact on utilization and access.

Subtitle D — Hospice Care.

Sec. 131. Temporary Increase in Payment for Hospice Care

The agreement increases payment rates to hospices by 0.5% in FY2001 and by 0.75% in FY2002.

Sec. 132. Study and Report to Congress Regarding Modification of the Payment Rates for Hospice Care

The agreement requires the GAO to study the cost factors used to determine hospice payment rates and amounts and report to Congress within 1 year of enactment.

Subtitle E — Other Provisions.**Sec. 141. MedPAC Study on Medicare Payment for Non-Physician Health Professional Clinical Training in Hospitals**

The agreement requires MedPAC, within 18 months of enactment, to submit to Congress a study of Medicare payment policy with respect to professional clinical training of different types of non-physician health care professionals (such as nurses, nurse practitioners, allied health professionals, physician assistants, and psychologists).

Subtitle F — Transitional Provisions.**Sec. 151. Exception to CMI Qualifier for One Year**

The agreement deems that Northwest Mississippi Regional Medical Center meets the case mix index criteria for classification as a referral center for FY2000.

Sec. 152. Reclassification of Certain Counties and Areas for Purposes of Reimbursement Under the Medicare Program

The agreement provides that Iredell County, NC is to be considered part of Charlotte-Gastonia Rock Hill NC-SC metropolitan statistical area (MSA) and Orange County, NY is to be considered part of the large urban area of New York, NY for the purposes of Medicare inpatient PPS in FY2000 and FY2001. In addition, Lake County, Indiana and Lee County, Illinois are deemed to be considered part of the Chicago, Illinois MSA; Hamilton-Middletown, Ohio is deemed to be considered part of the Cincinnati, Ohio-Kentucky-Indiana MSA; Brazoria County, Texas is deemed to be considered part of the Houston, Texas MSA; and Chittenden County is deemed to be considered part of the Boston-Worcester-Lawrence-Lowell-Brockton, Massachusetts-New Hampshire MSA. For FY2001, these reclassifications should be treated as a decision of the Medicare Geographic Reclassification Review Board.

Sec. 153. Wage Index Correction

The agreement requires the Secretary to recalculate and apply the Hattiesburg, MS MSA wage index for FY2000 using FY1996 wage and hour data for Wesley Medical Center without adjusting the wage indices in any other areas.

Sec. 154. Calculation and Application of Wage Index Floor for a Certain Area

The agreement provides that the Secretary will calculate and apply the wage index for the Allentown-Bethlehem-Easton MSA for FY2000 and FY2001 as if Lehigh Valley Hospital were classified in such area and, for FY2000 not adjust the wage index for any other area.

Sec. 155. Special Rule for Certain Skilled Nursing Facilities

The agreement provides that PPS payments for certain facilities in Baldwin or Mobile County, Alabama are to be based on 100% of the facility specific component of the SNF PPS rates for cost reporting periods starting in FY2000 or FY2001.

Title II — Provisions Relating to Part B**Subtitle A — Hospital Outpatient Services.****Sec. 201. Outlier Adjustment and Transitional Pass-Through for Certain Medical Devices, Drugs, and Biologicals**

The agreement permits the Secretary to provide for 2 to 3 years of payments in addition to hospital outpatient PPS payments (“pass-through”) for certain devices, drugs, and biologicals. It also allows additional payments to hospitals for certain high cost cases for which costs for each covered service exceed a fixed multiple of the PPS amount, plus pass-through payments, plus additional amounts. Such payments cannot exceed a certain portion of all outpatient payments and must be budget neutral. The agreement extends the 5.8% reduction for hospital operating costs and 10% for capital-related costs until the outpatient PPS is implemented. The agreement instructs the Secretary to design the PPS so that payments to hospitals will reflect pre-BBA beneficiary coinsurance amounts (i.e., without regard to copayments pegged at 20% of median hospital charges).

Sec. 202. Establishing a Transitional Corridor for Application of OPD PPS

The agreement provides payments in addition to PPS payments to hospitals during the first 3 years of the PPS if their payments are less than their pre-PPS payments in 1996 (determined according to a certain formula), but as if the formula-driven overpayment correction in BBA had been in effect in 1996. The additional payments are a specified percentage of the difference between old and new payment levels. The agreement temporarily holds certain rural hospitals harmless from payment reductions under the PPS and holds cancer hospitals harmless from such reductions permanently; requires BBA 97 beneficiary copayment amounts to be unaffected by these provisions.

Sec. 203. Study and Report to Congress Regarding the Special Treatment of Rural and Cancer Hospitals in Prospective Payment System for Hospital Outpatient Department Services

The agreement requires MedPAC to report to Congress within 2 years of enactment on the appropriateness of and method for covering certain rural and cancer hospitals under the PPS.

Sec. 204. Limitation on Outpatient Hospital Copayment for Procedure to the Hospital Deductible Amount

The agreement limits the amount for which a Medicare beneficiary can be billed for an outpatient procedure to the Medicare deductible amount for an inpatient stay (\$776 in 2000), and it provides funds to compensate hospitals for the difference.

Subtitle B — Physician Payments.

Sec. 211. Modification of Update Adjustment Factor Provisions to Reduce Update Oscillations and Require Estimate Revisions

The agreement makes technical changes to limit oscillations in the annual update to the conversion factor beginning in 2001 and provides that the sustainable growth rate is calculated on a calendar year basis. The Secretary is required to conduct a study on the utilization of physician services under the fee-for-service program.

Sec. 212. Use of Data Collected by Organizations and Entities in Determining Practice Expense Relative Values

The agreement requires the Secretary, in determining practice expense relative values, to establish by regulation a process under which the Secretary would accept for use and would use, to the maximum extent practicable and consistent with sound data practices, data collected by outside organizations and entities.

Sec. 213. GAO Study on Resources Required to Provide Safe and Effective Outpatient Cancer Therapy

The agreement requires the GAO to study and determine the physician and nonphysician resources necessary to provide safe outpatient cancer therapy services and the appropriate rates for such services.

Subtitle C — Other Services.

Sec. 221. Revision of Provisions Relating to Therapy Services

The agreement suspends for two years (2000 and 2001) application of the caps on physical therapy and occupational therapy services. The Secretary is to conduct focused medical reviews of therapy services during 2000 and 2001, with emphasis on claims for services provided to residents of SNFs.

Sec. 222. Update in Renal Dialysis Composite Rate

The agreement updates the composite rate for payment by 1.2% for renal dialysis services furnished during CY2000 and an additional 1.2% for such services furnished in CY2001.

Sec. 223. Implementation of Inherent Reasonableness Authority

The agreement prohibits the Secretary from exercising inherent reasonableness authority until after both the GAO releases its report on the issue and the Secretary has issued final rule-making.

Sec. 224. Increase in Reimbursement for Pap Smears

The agreement sets the minimum payment for the test component of a Pap smear at \$14.60, and expresses the sense of Congress that HCFA should institute an appropriate increase for new cervical cancer screening technologies approved by the FDA.

Sec. 225. Refinement of Ambulance Services Demonstration Project

The agreement modifies the ambulance services demonstration project provision, added by BBA 97, to require the Secretary to publish a request for proposals by July 1, 2000, and to specify that the capitated rate is to be based on the most current data available.

Sec. 226. Phase-in of PPS for Ambulatory Surgical Centers

The agreement requires phasing-in over 3 years new ASC rates based on pre-1999 survey data (new rates based on 1994 data are currently scheduled to go into effect in July 2000).

Sec. 227. Extension of Medicare Benefits for Immunosuppressive Drugs

The agreement provides for an extension of the current 36-month limit on coverage of immunosuppressive drugs for persons exhausting their coverage in 2000 - 2005. In each calendar year there will be an extension, specified by the Secretary (as a number of months or partial months), applicable to persons exhausting their benefits in that year. The increase for persons exhausting benefits in 2000 is 8 months; the minimum increase for persons exhausting benefits in 2001 is 8 months. Total expenditures are limited to \$150 million over the 5 years.

Sec. 228. Temporary Increase in Payment Rates for Durable Medical Equipment and Oxygen

The agreement increases payment rates for durable medical equipment by 0.3% in 2001 and by 0.6% in 2002, but those increases will not be included in the base for calculating increases after 2002.

Sec. 229. Studies and Reports

The agreement requires the following studies: (1) MedPAC study on cost-effectiveness of covering services of a post-surgical recovery center; (2) Agency for Health Care Policy and Research (AHCPR) study comparing differences in the quality of ultrasound and other imaging services provided by credentialed individuals versus those provided by non-credentialed individuals; (3) MedPAC comprehensive study of the regulatory burdens placed on all classes of providers under fee-for-service Medicare and the associated costs; and (4) GAO monitoring of Department of Justice application of guidelines on use of False Claims Act in civil health care matters.

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; GAO Report on Costs of Compliance with OASIS Data Collection Requirements

The agreement provides home health agencies with \$10 per beneficiary for administration of the Outcome and Assessment Information Set (OASIS) questionnaire to new home health patients for services furnished during cost reporting periods in FY2000. One-half of the payment will be made in April 2000 and the remainder at cost report settlement. It requires GAO to study the costs of collecting these data and to report by April 1, 2000.

Sec. 302. Delay in Application of 15% Reduction in Payment Rates for Home Health Services until 1 Year after Implementation of Prospective Payment System

The agreement delays the 15% reduction required under the PPS by the BBA regarding payments to home health agencies until 12 months after implementation of the PPS and requires the Secretary to report within 6 months of implementation of the PPS on the need for the 15% or other reduction.

Sec. 303. Increase in Per Beneficiary Limits

The agreement requires that per beneficiary limits under the BBA 97 home health interim payment system be increased by 2% in cost reporting periods starting in FY2000 for those home health agencies for which the per beneficiary limit is below the national median; the increase will not be included in the base for determining PPS amounts.

Sec. 304. Clarification of Surety Bond Requirements

The agreement establishes the lesser of \$50,000 or 10% of a home health agency's Medicare payments in the previous year as the annual amount of an agency's surety bond requirement, and it requires the bond to be in effect for 4 years or longer if ownership changes. Prior periods covered by a bond may be counted and Medicare and Medicaid bond requirements are to be coordinated.

Sec. 305. Refinement of Home Health Agency Consolidated Billing

The agreement excludes durable medical equipment, including oxygen and oxygen supplies, from the home health consolidated billing program.

Sec. 306. Technical Amendment Clarifying Applicable Market Basket Increase for PPS

The agreement clarifies that the increase in the home health PPS in FY2002 *and* FY2003 will be the market basket increase minus 1.1 percentage point.

Sec. 307. Study and Report to Congress Regarding the Exemption of Rural Agencies and Populations from Inclusion in the Home Health Prospective Payment System

The agreement requires MedPAC to study and report within 2 years of enactment on the feasibility and advisability of excluding rural home health agencies and beneficiaries living in rural areas from the home health PPS.

Subtitle B — Direct Graduate Medical Education.**Sec. 311. Use of National Average Payment Methodology in Computing Direct Graduate Medical Education (DGME) Payments**

The agreement changes the methodology for Medicare's direct graduate medical education (DGME) payments to teaching hospitals to incorporate a national average amount based on FY1997 hospital-specific per resident amounts. In FY2001, hospitals would receive no less than 70% of a geographically adjusted national average amount. Hospitals with per resident amounts above 140% of the geographically adjusted national average amount would have payments frozen at current levels for FY2001 and FY2002, and in FY2003-FY2005 would receive an update of the Consumer Price Index (CPI) minus 2 percentage points. Hospitals with per resident amounts between 70% and 140% of the geographically adjusted national average would continue to receive payments based on their hospital-specific per resident amounts updated for inflation.

Sec. 312. Initial Residency Period for Child Neurology Residency Training Programs

The agreement provides that the period of initial residency for individuals enrolled in child neurology training programs will be the period of initial residency for pediatrics plus 2 years. MedPAC is required to report to Congress on the appropriateness of extending this policy to other combined residencies by March 2001.

Subtitle C — Technical Corrections.**Sec. 321. BBA Technical Corrections**

The agreement provides for technical corrections to the Social Security Act.

Title IV — Rural Provider Provisions**Subtitle A — Rural Hospitals.****Sec. 401. Permitting Reclassification of Certain Urban Hospitals as Rural Hospitals**

The agreement requires the Secretary to treat certain urban hospitals as rural hospitals no later than 60 days after their application for such treatment if the hospitals: (1) are located in a rural census tract of a metropolitan statistical area (as

determined by the most recent Goldsmith Modification, originally published in the Federal Register on February 27, 1992); (2) are located in an area designated by State law or regulation as a rural area or designated by the State as rural providers; or (3) meet other criteria as the Secretary specifies.

Sec. 402. Update of Standards Applied for Geographic Reclassification for Certain Hospitals

The agreement updates existing criteria used to designate outlying rural counties as part of metropolitan statistical areas (MSAs).

Sec. 403. Improvements to the Critical Access Hospital (CAH) Program

The agreement applies the 96-hour length of stay limitation on an average annual basis rather than on a per case basis; permits for-profit hospitals, state-designated hospitals that have closed within the past 10 years, and downsized facilities that are state-licensed health centers or health clinics to be CAHs; specifies the payment methods for outpatient critical access hospital services, and clarifies CAHs' ability to participate in Medicare swing-bed program.

Sec. 404. 5-Year Extension of Medicare Dependent Hospital (MDH) Program

The agreement extends the Medicare Dependent Hospital program through FY2006.

Sec. 405. Rebasing for Certain Sole Community Hospitals

The agreement permits sole community hospitals that are now paid using the federal rate to transition over time to payment based on their hospital-specific FY1996 costs.

Sec. 406. One-year Sole Community Hospital Payment Increase

The agreement updates the FY2000 target amount by the market basket for discharges from sole community hospitals occurring in FY2001.

Sec. 407. Increased Flexibility in Providing Graduate Physician Training in Rural and Other Areas

The agreement permits hospitals to increase the number of primary care residents that it counts in the base year limit by up to 3 full-time equivalent residents if those individuals were on maternity, disability, or a similar approved leave of absence. Hospitals located in rural areas are permitted to increase their resident limits by 30% for direct and indirect medical education payments. In addition, non-rural facilities that operate separately accredited rural training programs in rural areas, or that operate accredited training programs with integrated rural tracks, may receive direct graduate medical education and indirect medical education payments for cost reporting periods beginning on April 1, 2000 and for discharges occurring on or after April 1, 2000 respectively. The agreement also includes the Senate provision

regarding an exception to the count of residents to include those who participated in GME at a Veterans Affairs (VA) facility and were subsequently transferred.

Sec. 408. Elimination of Certain Restrictions with Respect to Hospital Swing Bed Program

The agreement eliminates the existing requirement that states review the need for swing beds through the Certificate of Need (CON) process and removes other constraints on length of stay.

Sec. 409. Grant Program For Rural Hospital Transition to Prospective Payment

The agreement permits rural hospitals with fewer than 50 beds to apply for grants not to exceed \$50,000 to pay for data systems required to meet BBA 97 amendments, including the costs associated with purchase of computer software and hardware, education and training of hospital staff, and costs related to the implementation of PPS systems.

Sec. 410. GAO Study on Geographic Reclassification

The agreement requires GAO to submit a report to Congress no later than 18 months after enactment on the current laws and regulations for geographic reclassification of hospitals under Medicare.

Subtitle B — Other Rural Provisions.

Sec. 411. MedPAC Study of Rural Providers

The agreement requires MedPAC to conduct a study on rural providers, evaluate the adequacy and appropriateness of the categories of special Medicare payments (and payment methodologies) for rural hospitals, and their impact on beneficiary access and quality of health services and submit a report to Congress no later than 18 months of enactment.

Sec. 412. Expansion of Access to Paramedic Intercept Services in Rural Areas

The agreement expands the coverage of medically necessary, advanced life support (ALS) services provided by a paramedic intercept service provider in a rural area to include areas designated as rural areas by any State law or regulation or those located in a rural census tract of a metropolitan statistical area (as determined under the most recent Goldsmith Modification, originally published in the *Federal Register* on February 27, 1992).

Sec. 413. Promoting Prompt Implementation of Informatics, Telemedicine, and Education Demonstration Project

The agreement requires the Secretary to award without additional review the diabetes mellitus telemedicine demonstration project no later than 3 months after enactment to the best technical proposal as of the bill's enactment date.

Title V — Provisions Relating to Part C (Medicare+Choice Program) and Other Medicare Managed Care Provisions

Subtitle A — Provisions to Accommodate and Protect Medicare Beneficiaries.

Sec. 501. Changes in Medicare+Choice Enrollment Rules

The agreement establishes a special election period for persons in a plan which has notified the individual of an impending termination and permits these persons to choose a Medigap plan within 63 days of receiving a notice from their plan rather than waiting for the contract to end. The agreement also establishes a continuous open enrollment period for institutionalized beneficiaries. Further, a plan leaving a service area may offer enrollees the option to continue to receive all their basic services from plan providers in another service area.

Sec. 502. Change in Effective Date of Elections and Changes of Elections of Medicare+Choice Plans

The agreement specifies that any enrollment changes made after the 10th of a month do not take effect until the beginning of the second calendar month thereafter.

Sec. 503. 2-Year Extension of Medicare Cost Contracts

The agreement extends the cost contract program through 2004.

Subtitle B — Provisions to Facilitate Implementation of the Medicare +Choice Program.

Sec. 511. Phase-In of New Risk Adjustment Methodology; Studies and Reports on Risk Adjustment

The agreement: 1) changes the phase-in of the new risk adjustment method based on health status to a blend of 10% new health status method/90% old demographic method in 2000 and 2001, and not more than 20% health status in 2002; 2) provides for a MedPAC study and report on the new risk adjustment procedure; and 3) provides for a study and report by the Secretary regarding reporting of encounter data.

Sec. 512. Encouraging Offering of Medicare+Choice Plans in Areas Without Plans

The agreement provides for payment of a new entry bonus of 5% of the monthly Medicare+Choice payment rate in the first 12 months and 3% in the subsequent 12 months to organizations that offer a plan in a payment area without a Medicare+Choice plan since 1997, or in an area where all organizations have announced their withdrawal from the area as of October 13, 1999.

Sec. 513. Modification of 5-Year Re-Entry Rule for Contract Terminations

The agreement reduces the exclusion period from 5-years to 2-years for organizations seeking to re-enter the Medicare+Choice program after withdrawing. Specific exceptions are permitted where there is a change in payment policy. Nothing affects the Secretary's authority to provide additional exceptions including those specified in HCFA's Operational Policy Letter #103 (which permits an exception in areas served by 2 or fewer plans).

Sec. 514. Continued Computation and Publication of Medicare Original Fee-For-Service Expenditures on a County-Specific Basis

The agreement provides for the publication of various payment-related information for the original Medicare fee-for-service program for each Medicare+Choice payment area.

Sec. 515. Flexibility to Tailor Benefits Under Medicare+Choice Plans

The agreement allows organizations to vary premiums, benefits, and cost-sharing across individuals enrolled in the plan so long as these are uniform within segments comprising 1 or more Medicare+Choice payment areas.

Sec. 516. Delay in Deadline for Submission of Adjusted Community Rates

The agreement provides for submission of adjusted community rates by July 1 instead of May 1.

Sec. 517. Reduction in Adjustment in National Per Capita Medicare+Choice Growth Percentage for 2002

The agreement provides for a reduction in the national per capita Medicare+Choice growth percentage of 0.3 percentage points in 2002 instead of the 0.5 percentage point reduction now scheduled in law.

Sec. 518. Deeming of Medicare+Choice Organization to Meet Requirements

The agreement requires the Secretary within 210 days of receiving an application from a private accrediting organization, to determine whether such organization's processes meets the requirements for M+C plan accreditors. If it does, the Secretary would be required to deem that a M+C plan accredited by such organization met certain standards required of M+C plans. A private accreditation organization could elect to deem one or more of the following standards required of M+C plans: quality assurance, confidentiality of records, antidiscrimination, access to services, information on advance directives, and provider participation.

Sec. 519. Timing of Medicare+Choice Health Information Fairs

The agreement permits HCFA to conduct the health information campaign during the fall season, rather than just November.

Sec. 520. Quality Assurance Requirements for Preferred Provider Organization Plans

The agreement requires preferred provider organizations to meet the same quality assurance requirements as are applicable to private fee-for-service plans and non-network MSAs. MedPAC is required to study appropriate quality improvement standards that should apply to each type of M+C plan (including each type of coordinated care plans) and to the original Medicare program.

Sec. 521. Clarification of Non-Applicability of Certain Provisions of Discharge Planning Process to Medicare+Choice Plans

The agreement specifies that a Medicare+Choice discharge planning evaluation is not required to include information on the availability of home health services provided by individuals or entities that do not have a contract with the organization. Further, the plan may specify or limit the provider or providers of post-hospital home health services or other post-hospital services.

Sec. 522. User Fee for Medicare+Choice Organizations Based on Number of Enrolled Beneficiaries

Specifies that the total amount of funds available in a fiscal year to the Secretary to carry out annual beneficiary education functions is limited to \$100 million. The agreement specifies that the aggregate amount of user fees that can be imposed on M+C plans, to fund these activities, will be restricted and proportionate to the percentage of Medicare beneficiaries enrolled in M+C plans. A Medicare+Choice plan's share of the total is the same proportion as its share of the **total** Medicare population. The remainder of these activities must be funded through standard appropriations processes.

Sec. 523. Clarification Regarding the Ability of a Religious Fraternal Benefit Society to Operate Any Medicare+Choice Plan

The agreement permits religious fraternal benefit societies to restrict enrollment in any of their Medicare+Choice plans (not just coordinated care plans) to their members.

Sec. 524. Rules Regarding Physician Referrals for Medicare+Choice Program

The agreement clarifies that there is an exception for Medicare+Choice coordinated care plans to both the ownership and compensation prohibitions of the self-referral law.

Subtitle C — Demonstration Projects and Special Medicare Populations.

Sec. 531. Extension of Social Health Maintenance Organization Demonstration (SHMO) Project Authority

The agreement extends the Medicare waivers for SHMOs until 18 months after the Secretary submits a report with a plan for integration and transition of SHMOs

into an option under Medicare+Choice. It requires the Secretary to submit a final report 21 months after the integration and transition report. Six months after the Secretary's final report, MedPAC is required to submit a report with recommendations. The agreement specifies that no enrollment limit may be imposed under the project, other than the aggregate limit on enrollment at all sites, which remains not less than 324,000.

Sec. 532. Extension of Medicare Community Nursing Organization Demonstration Project

The agreement extends the Community Nursing Organization demonstration project for 2 years but limits total federal expenditures for it to the amount that would be spent if the demonstration were not in operation; it requires the Secretary to report to Congress on the results of the demonstration by July 1, 2001.

Sec. 533. Medicare+Choice Competitive Bidding Demonstration Project

The agreement delays implementation of the Medicare +Choice Competitive Bidding Demonstration project until January 1, 2002 or, if later, 6 months after Competitive Pricing Advisory Committee (CPAC) submits reports on (a) incorporating original fee-for-service Medicare into the demonstration; (b) quality activities required by participating plans; (c) the viability of expanding the demonstration project to a rural site; and (d) the nature of the benefit structure required from plans that participate in the demonstration. The Secretary is also required, subject to recommendations by CPAC, to allow plans that make bids below the established government contribution rate, to offer beneficiaries rebates on their Part B premiums.

Sec. 534. Extension of Medicare Municipal Health Services Demonstration Projects

The agreement extends the Medicare Municipal Health Services Demonstration Project for 2 years, through 2002.

Sec. 535. Medicare Coordinated Care Demonstration Project

The agreement specifies that funding for the coordinated care demonstration project to be located in the District of Columbia is to come from Medicare trust fund.

Sec. 536. Medigap Protections for PACE Program Enrollees

The agreement extends certain Medigap guaranteed issue protections to PACE enrollees over age 65 whose PACE enrollment is discontinued under circumstances parallel to those which would permit guaranteed issue if Medicare+Choice enrollment was discontinued.

Subtitle D — Medicare+Choice Nursing and Allied Health Professional Education Payments.

Sec. 541. Medicare+Choice Nursing and Allied Health Professional Education Payments

The agreement provides that hospitals with approved nursing and allied health professional training programs would receive additional payments to reflect utilization of Medicare+Choice enrollees. In no case would the total payment under this section exceed \$60 million.

Subtitle E — Studies and Reports.

Sec. 551. Report on Accounting for VA and DOD Expenditures for Medicare Beneficiaries

The agreement requires the Secretaries of HHS, DOD, and VA to submit to Congress a report no later than April 1, 2001 on the use of health services furnished by DOD and VA to Medicare beneficiaries, including both Medicare+Choice enrollees and Medicare fee-for-service beneficiaries.

Sec. 552. Medicare Payment Advisory Commission Studies and Reports

The agreement requires MedPAC to: 1) conduct a study and report to Congress, on the development of a payment methodology under Medicare+Choice for frail elderly beneficiaries enrolled in specialized programs; and 2) submit to Congress a report on specific legislative changes that would make MSA plans a viable option under the M+C program.

Sec. 553. GAO Studies, Audits, and Reports

The agreement requires GAO to conduct: 1) a study of Medigap policies, and 2) an annual audit of the Secretary's expenditures for providing M+C information to beneficiaries.

Title VI — Medicaid

Sec. 601. Increase in DSH Allotments for Certain States and the District of Columbia

The agreement makes technical corrections to the table included in the Balanced Budget Act of 1997 establishing limits on payments to hospitals treating a disproportionate share of uninsured and low-income patients. These technical corrections affect Minnesota, New Mexico, Wyoming, and the District of Columbia for fiscal years 1999 through 2002.

Sec. 602. Removal of Fiscal Year Limitation on Certain Transitional Administrative Costs Assistance

The agreement extends beyond fiscal year 2000 the availability of a fund of \$500 million created to assist with the transitional costs of new Medicaid eligibility activities resulting from welfare reform, and allows these funds to be used for costs incurred after the first three years following welfare reform.

Sec. 603. Modification of the Phase-Out of Payment for Federally Qualified Health Centers (FQHCs) Services and Rural Health Clinics (RHCs) Services Based on Reasonable Costs

The agreement slows the phase-out of the cost-based system of reimbursement for services provided by FQHCs and RHCs and authorizes a study of the impact of reducing or modifying payments to such providers.

Sec. 604. Parity in Reimbursement for Certain Utilization and Quality Control Services; Elimination of Duplicative Requirements for External Quality Review of Medicaid Managed Care Organizations

The agreement provides that states will receive enhanced matching payments for medical and utilization reviews for Medicaid fee-for-service when conducted by certain entities similar to peer review organizations. The agreement also eliminates duplicative requirements for external review and requires the Secretary of Health and Human Services (HHS) to certify to Congress that the external review requirements are fully implemented.

Sec. 605. Inapplicability of Enhanced Match under the State Children's Health Insurance Program to Medicaid DSH Payments

The agreement clarifies that Medicaid disproportionate share hospital (DSH) payments are matched at the Medicaid federal matching percentage and not at the enhanced federal matching percentage authorized under Title XXI.

Sec. 606. Optional Deferment of the Effective Date for Outpatient Drug Agreements

The agreement allows rebate agreements entered into after the date of enactment of this act to become effective on the date on which the agreement is entered into, or at state option, any date before or after the date on which the agreement is entered into.

Sec. 607. Making Medicaid DSH Transition Rule Permanent

The agreement extends a technical provision included in the Balanced Budget Act of 1997 related to allocation of DSH funds among California's hospitals.

Sec. 608. Medicaid Technical Corrections

The agreement makes technical corrections to cross-references in Title XIX.

Title VII — State Children’s Health Insurance Program (SCHIP)

Sec. 701. Stabilizing the State Children’s Health Insurance Program Allotment Formula

To provide greater stability in the distribution of federal funds, the agreement modifies the allotment distribution formula set forth in the Balanced Budget Act of 1997 by establishing floors and ceilings to limit the amount a state’s allocation can fluctuate from one year to the next.

Sec. 702. Increased Allotments for Territories under the State Children’s Health Insurance Program

The agreement provides additional allotments for the commonwealths and territories for fiscal years 2000 through 2007.

Sec. 703. Improved Data Collection and Evaluations of the State Children’s Health Insurance Program

The agreement provides funding for the collection of data to produce reliable annual state-level estimates of the number of uninsured children, and a federal evaluation of SCHIP to identify effective outreach and enrollment practices for both SCHIP and Medicaid, barriers to enrollment, and factors influencing beneficiary drop-out. The agreement also requires: (1) an inspector general audit and GAO report on enrollment of Medicaid-eligible children in SCHIP, (2) states to report annually the number of deliveries to pregnant women and the number of infants who received services under the Maternal and Child Health Services Block Grant or who were entitled to SCHIP benefits, and (3) the Secretary of HHS to establish a clearinghouse for the consolidation and coordination of all Federal databases and reports regarding children’s health.

Sec. 704. References to SCHIP and State Children’s Health Insurance Program

With respect to any references to the program established in Title XXI of the Social Security Act, the agreement requires that the Secretary of HHS use the term State Children’s Health Insurance Program and SCHIP instead of Children’s Health Insurance Program and CHIP.

Sec. 705. SCHIP Technical Corrections

The agreement requires technical corrections to selected sections of Title XXI.

