TITLE I -- BENEFICIARY PROVISIONS

Section 101. Acceleration of Reduction of Beneficiary Copayment for Hospital Outpatient Services.

Current Law

Prior to the Balanced Budget Act of 1997 (hereafter referred to as "BBA 97"), hospital outpatient departments could bill Medicare beneficiaries for 20% of the hospital's charges for a procedure or service, regardless of the amount Medicare eventually approved for that care. Under this arrangement, beneficiary copayments for hospital outpatient department services could be as much as 50% or more of the Medicare approved amounts. BBA 97 sought to bring beneficiary cost sharing for outpatient hospital services gradually into line with that required for other Part B care by freezing the dollar amount hospitals may charge beneficiaries for each type of outpatient procedure at 20% of the median of all hospital charges (by procedure) in 1996, updated to the date of implementation of the outpatient PPS (August 1, 2000). Over time, the "frozen" dollar amounts hospitals may charge beneficiaries will come to equal 20% of Medicare's approved amount under the PPS, and Medicare's payment will be 80%. However, Medicare Payment Advisory Commission (MedPAC) estimated that, for some outpatient services, it could take up to 40 years for beneficiary payments to equal 20% of Medicare approved amounts under the PPS.

The Medicare, Medicaid, S-CHIP Balanced Budget Refinement Act of 1999 (hereafter referred to as "BBRA 99") limited beneficiary copayments for hospital outpatient services to the amount of the hospital inpatient deductible ($776 in 2000). Beneficiary copayments for eight outpatient procedures currently exceed this amount and therefore would be subject to the limitation.

Explanation of Provision

The limitation on the beneficiary copayment to the hospital inpatient deductible applies to total copayments charged to a beneficiary for all covered outpatient care received by the beneficiary within a year.

Starting in January, 2001, the Secretary of Health and Human Services (hereafter referred to as "Secretary") will reduce the effective copayment rate for outpatient services to a maximum rate of 60% and then gradually reduce the effective coinsurance rate by 5 percentage points each year from 2002 through 2004 until the maximum rate is 45% in 2004. As stated in BBA 97, hospitals may waive any increase in coinsurance that may have arisen from the implementation of the outpatient prospective payment system (PPS).

Medigap insurers must disclose annually to their enrollees the amount by which their premiums have decreased and the methodology they used to calculate the decrease as a result of this provision. They shall provide the information to the Secretary, who will make the

information available to the public, and to the Comptroller General. The Comptroller General will work with the National Association of Insurance Commissioners (NAIC) to evaluate the extent to which premiums for supplemental policies reflect the acceleration of the reduction in beneficiary coinsurance for hospital outpatient services and result in savings to beneficiaries. The Comptroller General will report to the Congress by April 1, 2004.

Effective Date

Effective January 1, 2001.

Section 102. Coverage of Medical Nutrition Therapy Services for Beneficiaries With Diabetes or a Renal Disease.

Current Law

BBA 97 required the Secretary of HHS to request the National Academy of Sciences to analyze the expansion or modification of preventive and other benefits provided to Medicare beneficiaries. The Secretary was required to submit a report to Congress on specific findings related to several benefit categories. One category included in the required study was "nutrition therapy services, including parenteral and enteral nutrition and including the provision of such services by a registered dietitian." The Academy's Committee on Nutrition Services for Medicare Beneficiaries, Food and Nutrition Board, transmitted a report on nutrition therapy early this year.

The report contained several key recommendations. The Committee recommended that nutrition therapy, upon referral from a physician, should be a reimbursable Medicare benefit. It noted that current evidence suggests that nutrition therapy is effective as part of a comprehensive approach to the management and treatment of many conditions affecting the Medicare population including dyslipidemia, hypertension, heart failure, diabetes, and kidney failure. The Committee also noted that the registered dietician is currently the single identifiable group of health care professionals with standardized education, clinical training, continuing education, and national credentialing requirements necessary to be directly reimbursed as a provider of nutrition therapy.

Explanation of Provision

The provision would establish Medicare coverage for medical nutrition therapy services for beneficiaries who have diabetes or a renal disease.

Medical nutrition therapy services would be defined as nutritional diagnostic, therapy and counseling services for the purpose of disease management which are furnished by a registered dietician or nutrition professional, pursuant to a referral by a physician. The term registered dietician or nutrition professional means an individual who 1) has completed a baccalaureate or higher degree with completion of academic requirements of a program in nutrition or dietetics; 2) has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietician or nutrition professional; and 3) is either licensed or certified as a dietician or nutrition professional by the state in which the services are performed, or, in a state which does

not provide for such licensure or certification, meets criteria established by the Secretary. Persons licensed or certified as dieticians or nutrition specialists on the date of enactment would not be required to meet the training requirements under 1 and 2.

The provision would specify that the amount paid for medical nutrition therapy services would equal to 80% of the lesser of the actual charge for the service or 80% of the amount that would be paid under the physician fee schedule if such services were provided by a physician. Assignment would be required for all claims.

Effective Date

Applies to services furnished on or after January 1, 2001.

Section 103. Coverage of Screening Colonoscopy for Average Risk Individuals.

Current Law

BBA 97 authorized coverage of, and established frequency limits for, colorectal cancer screening tests. A covered test is any of the following procedures furnished for the purpose of early detection of colorectal cancer: (1) screening fecal-occult blood test (for persons over 50, no more than annually); (2) screening flexible sigmoidoscopy (for persons over 50, no more than one every 4 years); (3) screening colonoscopy for high-risk individuals (limited to one every 2 years); and (4) other procedures as the Secretary finds appropriate for the purpose of early detection of colorectal cancer. The Secretary was required to publish, within 90 days of enactment, a determination on the coverage of screening barium enema. Under the regulation, barium enemas, as an alternative to either a screening flexible sigmoidoscopy or a screening colonoscopy, are covered in accordance with the same screening parameters established for those tests.

Explanation of Provision

The provision would authorize coverage for screening colonoscopies for all individuals, not just those at high risk. For persons not at high risk, payments could not be made for such procedures if performed within 10 years of a previous screening colonoscopy or within 4 years of a screening flexible sigmoidoscopy.

Effective Date

Applies to colorectal cancer screening services provided on or after January 1, 2001.

Section 104. Coverage of Annual Screening Pap Smear and Pelvic Exams.

Current Law

Medicare authorizes coverage for a screening Pap smear once every 3 years. BBA 97 authorized coverage every 3 years for a screening pelvic exam which includes a clinical breast examination. Coverage was authorized on a yearly basis for both Pap smears and screening pelvic exams for women at high risk of developing cervical or vaginal cancer. Coverage was also authorized on a yearly basis for a woman of childbearing age who had a positive test in any of the preceding 3 years.

Explanation of Provision

The provision modifies current law to provide for annual pelvic exams and allows all women to have annual pap smears for three years. If all three pap tests are negative the beneficiary would return to a once every three year schedule. If any of the initial three tests are positive the beneficiary would be entitled to annual benefits as a high risk patient.

Effective Date

Applies to items and services furnished on or after January 1, 2001.

Section 105. Coverage of Screening for Glaucoma.

Current Law

Medicare does not cover routine screenings for glaucoma.

Explanation of Provision

The provision would add Medicare coverage for annual glaucoma screenings for persons determined to be at high risk for glaucoma, individuals with a family history of glaucoma, and individuals with diabetes or myopia. A screening for glaucoma would be defined as a dilated eye examination with an intraocular pressure measurement and a direct opthalmoscopy or slit-lamp biomicroscopic examination for the early detection of glaucoma. The service would have to be furnished by or under the supervision of an optometrist or ophthalmologist who is legally authorized to perform such services in the state where the services are furnished. There would be no deductible or coinsurance applied to these services.

Effective Date

Applies to services furnished on or after January 1, 2001.

Section 106. Modernization of Screening Mammography Benefit.

Current Law

Currently Medicare pays for screening mammographies under a statutorily prescribed reimbursement rate that is indexed to the Medical Economics Index (MEI). The law makes no distinction between types of screening mammographies, nor is the Secretary provided any discretion to modify payments for screening mammographies that utilize new or more costly technologies.

Explanation of Provision

In 2001, the Secretary would be authorized to make payments equal to 150% of the current physician fee schedule amount for bilateral diagnostic mammography (approx. $127) for certain screening mammography procedures that the Secretary determines results in: 1) a significant increase or decrease in the resources used in the test or in the manufacture of the affiliated equipment; 2) a significant improvement in the performance of the test or equipment; and 3) a significant advance in medical technology that is expected to significantly improve the treatment of Medicare beneficiaries.

For years after 2001, payment of screening mammography would be incorporated in the physician fee schedule. Finally, the provision instructs the Secretary to expedite the consideration of whether a new HCPCS code is appropriate for screening mammography that uses a new technology.

Effective Date

Provisions authorizing the payment for new technologies would take effect for services provided on or after January 1, 2001. Payments under the physician fee schedule would begin January 1, 2002.

Section 107. Preservation of Coverage of Drugs and Biologicals under Part B of the Medicare Program

Current Law

Section 1862(s) of the Social Security Act defines covered "medical and other health services" for purposes of coverage under Medicare Part B. The definition includes:

> (2)(A) services and supplies (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) furnished as incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills...

The phrase "cannot be self-administered" is defined in the Medicare Carrier's Manual as follows:

> Whether a drug or biological is of a type which cannot be self-administered is based on the usual method of administration of the form of that drug or biological as furnished by the physician. Thus, where a physician gives a patient pills or other oral medication, these are excluded from coverage since the form of the drug given to the patient is usually self-administered. Similarly, if a physician gives a patient an injection which is usually self-injected (e.g., insulin or calcitonin), this drug is excluded from coverage, unless administered to the patient in an emergency situation (e.g., diabetic coma). Where, however, a physician injects a drug which is not usually self-injected, this drug is not subject to the self-administrable drug exclusion (regardless of whether the drug may also be available in oral form) since it is not self-administrable in the form in which it was furnished to the patient.

Individual Medicare carriers have reportedly applied different policies when considering whether a drug or biological can or cannot be self-administered. Some carriers have based the determination on the typical means of administration while others have assessed the individual patient's ability to administer the drug.

On August 13, 1997, HCFA issued a memorandum to Medicare carriers which was intended to clarify program policy. The memorandum stated that the inability to self-administer is to be based on the typical means of administration of the drug, not on the individual patient's ability to administer the drug. The memorandum stated that: "The individual patient's mental or physical ability to administer any drug is not a consideration for this purpose." The memorandum went on to note that certain drugs that are generally self-administered may not be self-administered under certain limited circumstances such as when the patient first learns how to administer the drug. Coverage in these limited situations is at the discretion of the Medicare carrier; i.e. the carrier determines in these instances whether it is medically necessary for the physician or staff to administer the drug. The carrier could not consider the patient's condition such as a mental or physical disability.

As a result of this memorandum, certain patients (for example, patients with multiple sclerosis) no longer had Medicare coverage for certain drugs. However, implementation of this policy directive was halted for FY2000 by a provision in the Consolidated Appropriations Act. The provision prohibits the use of any funds to carry out the August 13, 1997 transmittal or to promulgate any regulation or other transmittal or policy directive that has the effect of imposing (or clarifying the imposition of) a restriction on the coverage of injectable drugs beyond those applied on the day before issuance of the transmittal. HCFA issued a Program Memorandum in April 2000 which suspended application of the August 13, 1997 memorandum. It noted that each carrier or intermediary must establish its own policies individually and could not establish model policies as a group.

Explanation of Provision

Section 107 would replace the current phrase in Section 1862(a)(2) relating to self-administered drugs and biologicals. The new language would permit coverage of "drugs and biologicals which are not usually administered by the patient."

Effective Date

This provision applies to drugs and biologicals administered on or after October 1, 2000.

Sec. 108. Elimination of Time Limitation on Medicare Benefits for Immunosuppressive Drugs.

Current Law

Medicare currently provides limited coverage of immunosuppressive drugs for beneficiaries who undergo organ transplant surgery. Prior to 1999, beneficiaries were eligible for only 36 months of these benefits following their surgery. The BBRA provided $150 million for FY2000 - FY2004 to expand the time limit applicable to this benefit. Specifically, BBRA provided that the benefit would be expanded from 36 months to 44 months for those whose 36 months of benefits expired during 2000. Similarly, for those whose 36 months of benefits were scheduled to expire in 2001 the law provided that they would receive at a minimum 8 months of additional benefits. For beneficiaries losing benefits in 2002, 2003 or 2004, the BBRA provided that they would be provided additional months of coverage based on the Secretary's actuarial estimates of how many additional months could be provided for those exhausting their prior benefits in such years given the statutory constraint of $150 million in new spending.

Explanation of Provision

The provision eliminates all time limitations from the current benefit for all aged and disabled Medicare beneficiaries.

Effective Date

The provision is effective for drugs provided on or after the date of enactment.

Section 109. Imposition of Balanced Billing Limits on Prescription Drugs.

Current Law

Medicare's recognized payment amount for drugs (not paid on a cost or prospective payment basis) equals 95% of the average wholesale price. Beneficiaries are liable for the 20% coinsurance, and in addition may be liable for balance billing charges.

Certain practitioners under Medicare (such as nurse practitioners or clinical psychologists) are required to bill for all services on an assignment-related basis. This means that they are required to accept Medicare's recognized payment amount as payment in full, except for any required deductible and coinsurance amounts. Balance billing is prohibited.

Explanation of Provision

The provision would specify that payment for drugs under Part B must be made on the basis of assignment.

Effective Date

The provision would apply to items furnished on or after January 1, 2001.

Section 110. Study on Medicare Coverage of Routine Thyroid Screening.

Current Law

Medicare does not cover routine thyroid screenings.

Explanation of Provision

The provision would require the Secretary to request the National Academy of Sciences, and as appropriate in conjunction with the United States Preventive Services Task Force, to analyze the addition of a new preventive benefit. The benefit would be coverage of routine thyroid screening using a thyroid stimulating hormone test. The analysis would consider the short term and long term benefits, and cost to Medicare, of adding such coverage for some or all beneficiaries. The Secretary would be required to submit a report to Congress on the findings within two years of enactment. The Secretary would provide funding for the study from funds appropriated to HHS for FY 2001 and 2002.

Effective Date

Enactment.

Section 111. Demonstration Project for Disease Management for Severely Chronically Ill Medicare Beneficiaries.

Current Law

No provision.

Explanation of Provision

The Secretary would be required to conduct a demonstration project to illustrate the impact on costs and health outcomes of applying disease management to Medicare beneficiaries with diagnosed, advanced-stage congestive heart failure, diabetes, or coronary heart disease. Participation in the project would be voluntary. Medicare beneficiaries would be eligible to participate in the project only if (1) they meet specific medical criteria demonstrating the appropriate diagnosis and the advanced nature of their disease; (2) their physicians approved of their participation in the project; and (3) they are not enrolled in a Medicare + Choice plan. In no

case would the number of participants in the project exceed 30,000. A beneficiary who is enrolled in the project would be eligible for disease management services related to their chronic health condition. In addition, contractors providing disease management services would be responsible for providing beneficiaries enrolled in the project with prescription drugs.

The projects would be carried out through contracts with up to 3 disease management organizations. The Secretary would not enter into such a contract with an organization unless it demonstrates that it can produce improved health outcomes and reduce aggregate Medicare expenditures. These organizations would be paid a negotiated fee established so that there is a net reduction in Medicare expenditures. The organization would guarantee the net reduction through an appropriate arrangement with a reinsurance company or otherwise. Payments to the organizations would be made in appropriate proportion from the Medicare trust funds. The project would last for no longer than 3 years.

The Secretary would submit an interim report to Congress no later than 2 years after the date the project is first implemented and a final report no later than 6 months after the project is completed. The reports would include information on the project's impact on costs and health outcomes as well as recommendations on the cost-effectiveness of extending or expanding the project.

Effective date

Enactment.

Section 112. MedPAC Study on Consumer Coalitions.

Current Law

No provision

Explanation of Provision. The provision would require MedPAC to conduct a study that examines the use of consumer coalitions in the marketing of Medicare+Choice plans. A consumer coalition would be defined as a non-profit community-based organization that provides information to beneficiaries about their health options under Medicare and negotiates with Medicare+Choice plans on benefits and premiums for beneficiaries who are members of the coalition or otherwise affiliated with it.

The study would examine: 1) the potential for increased efficiency in Medicare through greater beneficiary knowledge of health care options, decreased marketing costs of such organizations, and creation of a group market; 2) the implications of Medicare+Choice plans and Medigap plans offering Medicare beneficiaries in the same geographic location different benefits and premiums based on their affiliation with a consumer coalition; 3) how coalitions should be governed, how they should be accountable to the Secretary of HHS, and how potential conflicts of interest should be avoided; and 4) how such coalitions should be funded. The Commission would be required to submit a report to Congress, within one year of enactment, on the study.

The report would include a recommendation on whether and how a demonstration project might be conducted for the operation of consumer coalitions under Medicare.

Effective Date. Enactment.

TITLE II -- PROVISIONS RELATING TO PART A

Subtitle A -- Inpatient Hospital Services

Section 201. Revision of Acute Care Hospital Payment Update for 2001.

Current Law

The Health Care Financing Administration (HCFA) measures price increases that affect the costs of goods and services purchased by acute care hospitals using an input price index or market basket. Periodically, HCFA re-bases and revises the market basket. Each year, Medicare's operating payments to hospitals are increased or updated by a factor that is determined in part by the projected increase in the hospital market basket index (MBI). BBA 97 established Medicare's update factor for acute hospitals as the MBI minus 1.1 percentage points for FY 2001 and FY 2002 and the MBI for subsequent years. BBRA 99 established that sole community hospitals (SCH) would receive the full MBI for FY 2001.

Medicare pays for inpatient services furnished in acute care hospitals using a prospective payment system (PPS). Simply, hospital discharges are classified into one of approximately 500 diagnosis-related groups (DRGs) depending upon the medical condition of the patient. Each year, HCFA uses Medicare charge data to construct a weight for each DRG that reflects its relative treatment costs. DRG classifications are adjusted annually as well. Both the annual DRG reclassification and recalibration of the relative weights must be done in a manner that ensures that aggregate payments to hospitals are not affected. A hospital's base DRG payment for a given Medicare patient is calculated by multiplying the DRG weight by a standardized amount per case (which is essentially the average cost of a Medicare case in an average nonteaching hospital).

Explanation of Provision

All hospitals would receive the full MBI for FY 2001. In order to implement this increase for hospitals (other than SCHs), those hospitals would receive the MBI minus 1.1 percentage points (the current statutory provision) for discharges occurring on or after October 1, 2000 and before April 1 2001; these non-SCH hospitals would receive the MBI plus 1.1 percentage points for discharges occurring on or after April 1, 2001 and before October 1, 2001.

The Secretary is directed to consider the prices of blood and blood products purchased by hospitals in the next rebasing and revision of the hospital market basket to determine whether those prices are adequately reflected in the market basket index.

The Secretary would be able to adjust the standardized amount in future fiscal years to correct for increases in the aggregate Medicare payments caused by adjustments to the DRG weighting factors in a previous fiscal year (or estimates that such adjustments for a future fiscal years) that did not take into account coding improvements or changes in discharge classifications and did not accurately represent increases in the resource intensity of patients treated by PPS hospitals.

Effective Date

Enactment. The case mix adjustment is effective for discharges occurring on or after October 1, 2001.

Section 202. Increase in Reimbursement for Bad Debt for Qualified Medicare Beneficiaries.

Current Law

Medicare currently pays 55% of the bad debt incurred by hospitals in caring for indigent Medicare beneficiaries.

Explanation of Provision

The provision would increase the percentage of bad debt paid by Medicare 1 percentage point each year for five years, starting in FY2001, for those individuals for whom the hospital can demonstrate to the Secretary are classified as Qualified Medicare Beneficiaries (QMBs).

Effective Date

This provision is effective beginning with cost reports starting in FY 2001.

Section 203. Additional Modification in Transition for Indirect Medical Education (IME) Payment Adjustment.

Current Law

BBA 97 reduced the indirect medical education (IME) payment adjustment from 7.7% for each 10% increase in teaching intensity to 7.0% in 1998; 6.5% in 1999; 6.0% in 2000; and 5.5% in 2001 and subsequent years. BBRA 99 changed the IME adjustment to 6.5% in 2000, 6.25% in 2001 and 5.5% in 2002 and subsequent years.

Explanation of Provision

Teaching hospitals would receive 6.25% IME payment adjustment (for each 10% increase in teaching intensity) for discharges occurring on or after October 1, 2000 and before April 1, 2001. The IME adjustment would increase to 6.75% for discharges on or after April 1, 2001 and before October 1, 2001, for an average of 6.5% for FY 2001. The IME adjustment would be 6.25% in 2002 and 5.5% in 2003 and in subsequent years.

Effective Date

Enactment.

Section 204. Decrease in Reductions for Disproportionate Share Hospital (DSH) Payments.

Current Law

Certain hospitals receive an additional Medicare payment because they treat a large number of poor Medicare or Medicaid patients. Different formulas are used to establish a hospital's disproportionate share hospital (DSH) threshold and payment adjustment, depending upon the hospital's location, number of beds and status as a rural referral center or sole community hospital. BBA 97 included reductions in the DSH payment formula amounts of 3% in FY 2000; 4% in FY 2001; 5% in FY 2002 and 0% in FY 2003 and subsequently. BBRA 99 changed those reductions in the DSH payment formula amounts to 3% in FY 2000 and FY 2001; 4% in FY 2002 and 0% in FY 2003 and subsequently.

Explanation of Provision

Reductions in the DSH payment formula amounts would be 2% in FY 2001, 3% in FY 2002, and 0% in FY 2003 and subsequently. To implement the FY 2001 provision, DSH amounts for discharges occurring on or after October 1, 2000 and before April 1, 2001, would be reduced by the percentages in effect prior to enactment of this provision. DSH amounts for discharges occurring on or after April 1, 2001 and before October 1, 2001 would be reduced by only 1 percentage point.

Effective Date

Enactment.

Section 205. Increase in Base Payment to Puerto Rico Acute Care Hospitals.

Current Law

Under Medicare's prospective payment system, a separate standardized amount is used to set payments for hospitals in Puerto Rico. BBA 97 provides for an adjustment of the Puerto Rico

rate from a blended amount based on 25% of the federal amount and 75% of the local amount to a blended amount based on a 50/50 split between federal and local amounts.

Explanation of Provision

For discharges on or after October 1, 2000, hospitals in Puerto Rico would receive payment based on a blended amount of 75% of the federal amount and 25% of the local amount. Notwithstanding this change, the current 50/50 split between federal and local amounts for discharge occurring on or after October 1, 2000 and before April 1, 2001 would be maintained. Discharges occurring on or after April 1, 2001 and before October 1, 2001 would be paid based on 100% of the federal amount.

Effective Date

Enactment.

Section 206. Wage Index Improvements.

Current Law

Under Medicare's inpatient acute hospital prospective payment system (PPS), hospitals can request reclassification from one geographic location to another for the purpose of using the other area's standardized amount, wage index, or both. Hospitals seeking reclassification submit requests each year to the Medicare Geographic Classification Review Board (MGCRB). Hospital MGCRB applications for wage index reclassification use average hourly data published in the prior year's final regulation implementing PPS. These annual applications are evaluated using published criteria, but generally depend on average hourly wage comparisons of the specific hospital to that of the area in which it is located as well as to that in the area to which it seeks to be reclassified.

Explanation of Provision

For FY 2001 or any fiscal year thereafter, a MGCRB decision to reclassify a PPS hospital for use of a different area's wage index would be effective for three fiscal years. The MGCRB would establish procedures whereby a hospital may elect to terminate this reclassification decision before the end of such period. For FY 2003 and subsequently, MGCRB would base any comparison of the average hourly wage of the hospital with the average hourly wage for hospitals in the area using data from the each of the two immediately preceding surveys as well as data from the most recently published hospital wage survey.

The Secretary would establish a process (based on the process used to compute and apply the geographic wage index for the physician fee schedule) where a single wage index is computed for all geographic areas in the state for the purposes of Medicare hospital PPS. The process would be established by October 1, 2001 for reclassifications beginning in FY 2003. If the

Secretary applies a statewide geographic index, an application by an individual hospital would not be considered.

The Secretary would also collect occupational data for PPS hospitals in order to construct an occupational mix adjustment for the hospital area wage index. Data would be collected every three years; the first complete data collection effort would occur no later than September 30, 2003 for application beginning October 1, 2004.

Effective Date

The three-year reclassification provision is effective for FY 2001 reclassifications. The provision mandating reclassification based on three years of data is effective for FY 2003 reclassifications. The statewide wage index provision is available for FY 2002 reclassifications. Collection of the occupational data should be completed by the end of FY 2003, for application for FY 2005 reclassifications.

Section 207. Limitation to Residents in Allopathic and Osteopathic Medicine in Application of Resident Limits.

Current Law

BBA 97 established limits on the number of full-time equivalent (FTE) residents that could be counted for both direct and indirect medical education reimbursement. Generally, the total number of FTE residents in allopathic and osteopathic medicine in an urban teaching hospital could not exceed the number of resident FTEs included in its cost report period ending on or before December 30, 1996; rural teaching hospitals could not exceed 130% of that count. Moreover, direct and indirect graduate medical education payments are based on a three-year rolling average count of actual resident FTEs (the current cost reporting period and the two preceding cost reporting periods.)

Explanation of Provision

The three-year rolling average count for calculating direct graduate medical education and indirect medical education payments would only include residents in allopathic and osteopathic medicine.

Effective Date

Cost reporting periods beginning on or after October 1, 2000.

Section 208. Payment for Inpatient Services in Rehabilitation Hospitals.

Current Law

BBA 97 required the Secretary to develop a prospective payment system (PPS) for rehabilitation hospitals and distinct-part units with PPS rates to be phased-in between October 1, 2000 and before October 1, 2002. The PPS system will be fully implemented by October 1, 2002. For FY 2001 and 2002, total payments for rehabilitation hospitals are to equal 98% of the amounts of payments that would have been made if PPS had not been enacted.

Explanation of Provision

For FY 2001, total payments for rehabilitation hospitals would equal 100% of the amounts of payments that would have been made if PPS had not been enacted. Total payments in 2002 would equal 98% of the amounts of payments that would have been made if PPS had not been enacted. A rehabilitation facility would be able to make a one-time election not later than 30 days before its first cost reporting period for which the PPS applies.

Effective Date

August 5, 1997 (as if it had been enacted as part of BBA 97).

Section 209. Payment for Inpatient Services of Psychiatric Hospitals.

Current Law

BBA 97 established caps for target amounts for certain PPS-exempt providers including psychiatric hospitals. Generally, Medicare payments to a psychiatric hospitals are based on the lowest of a facility's actual costs, target amount, or cap. National caps were set at the 75th percentile of FY 1996 updated target amounts for each class of provider, such as psychiatric hospitals. Psychiatric hospitals may also receive additional bonus or relief payments depending upon the relationship of its costs to its cap. New providers are reimbursed differently. BBRA 99 increased the amount of bonus payments; required an adjustment to the labor-related portion of the national cap (the 75 percentile calculation); and requires the Secretary to report to the appropriate Congressional committees on a per-diem based prospective payment system (PPS) for psychiatric hospitals and distinct-part units which would be implemented in a budget-neutral fashion for cost reporting periods beginning on or after October 1, 2002.

Explanation of Provision

The provision allows for an additional incentive payment in FY 2001. For cost reporting periods beginning on or after October 1, 2000 and before October 1, 2001, psychiatric hospitals would be eligible for an incentive payment of 3% of the target amount.

Effective Date

Enactment affecting cost reporting periods beginning on or after October 1, 2000 and before October 1, 2001.

Section 210. Payment for Inpatient Services of Long-Term Care Hospitals.

Current Law

BBA 97 established caps for target amounts for certain PPS-exempt providers including long-term hospitals. Generally, Medicare payments to a long term care hospital are based on the lowest of a facility's actual costs, target amount, or cap. National caps were set at the 75th percentile of FY 1996 updated target amounts for each class of provider, such as long term hospitals. A long term hospitals may also receive additional bonus or relief payments depending upon the relationship of its costs to its cap. New providers are reimbursed differently. BBRA 99 increased the amount of the bonus payments; required an adjustment to the labor-related portion of the national cap (the 75-percentile calculation); and required that the Secretary implement a discharge-based prospective payment system (PPS) for long term hospitals by October 1, 2002.

Explanation of Provision

For cost reporting periods beginning on or after October 1, 2000, a long term hospital would have its national cap increased by 2%. Long term hospitals not subject to the national cap would have their targets increased by 25%. Neither these payments nor the increased bonus payments provided by BBRA 99 would be factored into the development of the PPS for long term hospitals. When developing the PPS for inpatient long term hospitals, the Secretary is instructed to examine the feasibility and impact of basing payment on the existing (or refined) acute hospital DRGs and using the most recently available hospital discharge data for long term care hospitals. If the Secretary is unable to implement a long term hospital PPS by October 1, 2002, the Secretary would be required to implement a PPS for these hospitals that bases payment on existing DRGs.

Effective Date

Enactment.

Subtitle B -- Adjustments to PPS Payments for Skilled Nursing Facilities

Section 221. Elimination of Reduction in Skilled Nursing Facility (SNF) Market Basket Update in 2001.

Current Law

The unadjusted federal per diem rate under the SNF PPS is updated in FY 2000 by the SNF market basket index (MBI) increase during the period July 1, 1998, through Sept 30, 1999 (the "initial period" of the SNF PPS), minus one percentage point. It is increased in FY 2001 and FY 2002 by the rate for the previous year increased by the SNF MBI increase minus one percentage point, and, in subsequent years, it increased by the full percentage change in the SNF MBI.

Explanation of Provision

The federal per diem rate for FY 2001 is increased over the rate in effect in the previous year by the full MBI increase, and, for FY 2002, it is increased by the MBI increase minus one percentage point. However, in the period October 1, 2000, through March 31, 2001, the rate determined under current law shall be in effect, and for the period April 1, 2001, through September 31, 2001, it will be the amount in effect in FY 2000 plus one percentage point. These increases are in addition to the temporary increase of 20% for certain Resource Utilization Groups (RUGs) provided in BBRA 99.

The Comptroller General is required to report to Congress by July 1, 2002, on the adequacy of Medicare SNF payment rates and the extent to which Medicare contributes to the financial viability of those facilities.

The Secretary is required to conduct a study and to report to Congress by January 1, 2005, on different systems for categorizing patients in Medicare SNFs to account for relative resource utilization by residents with different needs, including recommendations for appropriate changes in law.

Effective Date

Enactment.

Section 222. Increase in Nursing Component of PPS Federal Rate.

Current Law

The Medicare PPS for SNF care is a schedule of daily "per diem" rates for patients falling into 44 different resource utilization groups (RUGs). SNF residents in the different groups use different mixes of nursing care, therapy services, and other services. Each RUG payment amount is composed of an amount for nursing care, for therapy, and for other costs. On July 31, 2000, HCFA published the RUG rates for urban and rural SNFs for FY 2001.

Explanation of Provision

The nursing component of each RUG is increased by 5% for SNF care furnished after April 1, 2001, and before October 1, 2002.

The Comptroller General is required to conduct an audit of nurse staffing ratios in a sample of SNFs and to report to Congress by August 1, 2002, based on that audit. The report shall assess the effect of the added 5% payment on nurse staffing ratios and recommend whether the additional payment should be continued.

Effective Date

Enactment.

Section 223. Application of SNF Consolidated Billing Requirement Limited to Part A Covered Stays.

Current Law

Under the consolidated billing requirement of BBA 97, SNFs and all nursing homes that include a Medicare-certified SNF component must submit to Medicare all claims for all the services provided to their residents who are enrolled in traditional fee-for-service Medicare. Thus, the requirement applies to claims on behalf of beneficiaries who are long-term care residents of a nursing home that has a SNF component as well as those who are residents in the SNF. This requirement is referred to as "consolidated billing." (The law includes a list of services that are excluded from the consolidated billing requirement; excluded providers may bill Medicare directly.) The consolidated billing requirement also pertains to Medicare covered services regardless of whether the resident does or does not qualify for SNF care under Medicare Part A. The requirement means that non-excluded service or care providers who furnish covered services to SNF residents may not bill Medicare directly, but must submit their claim to the SNF for payment. If the item or service is covered by Medicare, but is not included in the SNF PPS, Medicare makes the payment to the SNF, and the SNF is responsible for paying the provider.

The consolidated billing requirement went into effect in July 1998 (implementation of the SNF PPS) for some, but not all, SNF residents. Consolidated billing has been implemented only for services to those SNF residents who are in a Medicare Part A covered stay, and has not been implemented for Medicare Part B covered services for beneficiaries who are SNF residents whose stay is not covered under Medicare (which includes those who are long-term care residents of the non-SNF component of the facility). Since January 1999, consolidated billing has been in operation for physical, occupational, and speech therapy services. When HCFA is ready to expand implementation of consolidated billing to other items and services, it will publish a notice in the federal register 90 days prior to implementation.

Explanation of Provision

The consolidated billing requirement would apply only to services and items furnished to SNF residents in a Medicare part A covered stay and to therapy services furnished in part A and part B covered stays.

The Inspector General of HHS shall monitor part B payments to SNFs on behalf of residents who are not in a part A covered stay.

Effective Date

The consolidated billing restriction is effective January 1, 2001.

Section 224. Adjustment of Rehabilitation RUGS to Correct Anomaly in Payment Rates.

Current Law

BBRA 99 increased Medicare payments to SNFs by 20% for 15 of 44 resource utilization groups (RUGs). Payments for certain "ultra high" therapy RUGs were not increased, although payment to "medium" therapy groups were increased.

Explanation of Provision

Certain federal per diem payments are increased by 6.7% to ensure that Medicare payments for SNF residents with "ultra high" and "high" rehabilitation therapy needs are appropriate in relation to payments for residents needing "medium" or "low" levels of therapy. The 20% additional payment is removed from certain RUGs to make the provision budget neutral.

The Inspector General of HHS shall review and report to Congress by October 1, 2001, regarding whether under the RUG payment structure as in effect under the BBRA 99 includes incentives for the delivery of inadequate care.

Effective Date

The changes in Medicare federal per diem payment rates are effective for SNF services furnished on or after April 1, 2001.

Section 225. Establishment of Process for Geographic Reclassification.

Current Law

No provision.

Explanation of Provision

The Secretary may establish a process for geographic reclassification of skilled nursing facilities based upon the method used for inpatient hospital patients. The Secretary may implement the process upon completion of the data collection necessary to calculate an area wage index based on the wages paid by skilled nursing facilities.

Effective Date

Enactment.

Subtitle C -- Hospice Care

Section 231. Full Market Basket Increase for 2001.

Current Law

Hospice daily payment rates for routine home care, continuous home care, inpatient respite care, and general inpatient care are updated annually by the increase in the hospital market basket index (MBI). The BBA 97 reduced these updates to the market basket increase minus one percentage point for FY 1998 through FY 2002. However, the BBRA 99 increased the rates otherwise in effect for FY 2001 by 0.5 percentage point and for FY 2002 by 0.75 percentage point.

Aggregate annual payments to individual hospices are capped at an amount equal to $15,313 times the number of persons served in the period November 1, 1999, through October 31, 2000. The cap is not applied to individual patients. The cap is adjusted annually by the percentage change in the medical care component of the Consumer Price Index for Urban Consumers (CPI-U).

Explanation of Provision

For the period October 1, 2000, through March 31, 2001, the daily payment rates are computed according to BBRA 99; from April 1, 2001, through September 30, 2001, payments are computed based on the MBI increase plus one percentage point.

Effective Date

Enactment. (A conforming amendment to BBRA 99 is effective as if enacted with the BBRA 99.)

Section 232. Clarification of Physician Certification.

Current Law

To be eligible for hospice care under Medicare, a beneficiary must elect hospice treatment, and the individual's attending physician and the medical director of the hospice program providing the care must certify in writing that the individually is terminally ill. "Terminally ill" is defined in law as an individual whose life expectancy is six months or less.

Explanation of Provision

The physician's or medical director's certification of terminal illness shall be based on their clinical judgment regarding the normal course of the individual's illness.

Effective Date

Effective for certifications made on or after the date of enactment.

Section 233. MedPAC Report on Access to, and Use of, Hospice Benefit.

Current Law

No provision.

Explanation of Provision

MedPAC shall examine the factors affecting the use of Medicare hospice benefits, including delay of entry into the hospice program and urban and rural differences. A report on the study shall be submitted to Congress 18 months after enactment.

Effective Date

Enactment.

Subtitle D -- Other Provisions

Section 241. Relief From Medicare Part A Late Enrollment Penalty For Group Buy-In for State and Local Retirees.

Current Law

Almost all persons age 65 or over are automatically entitled to Part A. These individuals (or their spouses) established entitlement during their working careers by paying the hospital insurance tax on earnings covered by either the social security or railroad retirement systems. Persons not automatically entitled to Part A may obtain coverage by paying the Part A premium. The 2000 monthly premium is $301.

Persons not automatically entitled to Part A include some state and local employees. BBA 97 specified that the premium amount is zero for certain public employees. A person covered under this provision is one who was receiving cash benefits under a qualified state or local government retirement system on the basis of employment of at least 40 calendar quarters. For each of the preceding 84 months, the individual must have been enrolled in Part A and not have had his or her premium paid by a governmental entity.

Explanation of Provision

The provision would exempt certain state and local retirees from the Part A delayed enrollment penalties. These would be groups of persons for whom the state or local government elected to pay the delayed Part A enrollment penalty for life. The groups would be all of the individuals in one or more broad classes of employees who retire prior to a specified date, but not later than January 1, 2002. The amount of the delayed enrollment penalty which would otherwise

be assessed would be reduced by an amount equal to the total amount of Medicare payroll taxes paid by the employee and the employer on behalf of the employee.

Effective Date

Applies to premiums beginning with July 1, 2001.

TITLE III -- RURAL PROVIDER PROVISIONS

Subtitle A -- Rural Hospitals

Section 301. Equitable Treatment for Rural Disproportionate Share Hospitals.

Current Law

Medicare gives hospitals that serve a large number of poor Medicare or Medicaid patients an additional payment, called a disproportionate share (DSH) payment. Different formulas are used to establish a hospital's eligibility threshold and payment depending upon the hospital's location (urban or rural), bed size and status as a rural referral center or sole community hospital.

Explanation of Provision

For discharges occurring on or after April 1, 2001, all hospitals would be eligible to receive DSH payments when their DSH percentage (threshold amount) exceeds 15%. The DSH payment formulas for sole community hospitals (SCHs), rural referral centers (RRC), rural hospitals that are both SCHs and RRCs, small rural hospitals and urban hospitals with less than 100 beds would be modified.

Effective Date

Enactment.

Section 302. Extension of Option to Use Rebased Target Amounts to All Sole Community Hospitals.

Current Law

Sole community hospitals (SCHs) are hospitals that, because of factors such as isolated location, weather or travel conditions, or absence of other hospitals, are the sole source of acute inpatient service reasonably available in a geographic area. Prior to BBRA 99, SCHs were paid

on the basis of their hospital-specific target amount calculated using updated FY 1982 or FY 1987 costs or paid using the federal national standardized amount, whichever resulted in higher Medicare payment. BBRA 99 permitted SCHs paid on the basis of hospital-specific target amounts to transition to target amounts calculated using FY 1996 costs.

Explanation of Provision

Any SCH would be able to elect payment based on hospital-specific updated FY 1996 costs if this target amount resulted in higher Medicare payments. There would be a transition period with Medicare payment based completely on updated FY 1996 hospital specific costs for discharges occurring after FY 2003.

Effective Date

Discharges after April 1, 2001.

Section 303. Updating Criteria for Medicare Dependent Hospitals.

Current Law

Medicare dependent hospitals (MDHs) are small rural hospitals that treat a relatively high proportion of Medicare patients. Generally, a MDH is located in a rural area, has 100 beds or less, is not classified as a sole community hospital, and had a least 60% of its days or discharges during FY 1987 attributable to Medicare Part A beneficiaries.

Explanation of Provision

The MDH criteria would be updated to permit an otherwise qualifying small rural hospital to be classified as an MDH if at least 60% of its days or discharges were attributable to Medicare Part A beneficiaries in at least two of the three cost reporting periods beginning during FY 1996, FY 1997, or FY 1998.

Effective Date

Discharges occurring on or after April 1, 2001.

Section 304. Other Rural Hospital Provisions.

Current Law

BBRA 99 instructed MedPAC to conduct a study of rural providers to examine the adequacy and appropriateness of the categories of special Medicare payments and payment methodologies. The study is due no later than 18 months after enactment.

Explanation of Provision

MedPAC is instructed to include in its analysis the impact on volume on the per unit cost of rural hospitals with psychiatric units and include in its report a recommendation on whether special treatment is warranted.

Effective Date

Enactment.

Subtitle B -- Critical Access Hospitals

Section 311. Clarification of No Beneficiary Cost-Sharing for Clinical Diagnostic Laboratory Tests Furnished by Critical Access Hospitals.

Current Law

Generally, outpatient services in critical access hospitals (CAHs) are paid on a reasonable cost basis and are not subject to certain Medicare reimbursement limits. Medicare beneficiaries do not have to pay coinsurance for clinical diagnostic laboratory tests. BBRA 99 included provisions to limit beneficiary coinsurance for clinical diagnostic laboratory tests furnished by CAHs. As drafted, however, BBRA 99 changed the basis of payment for these laboratory services in CAHs from cost-based reimbursement to payment based on the 80% of the clinical laboratory fee schedule and obligated CAHs to collect 20% coinsurance from beneficiaries.

Explanation of Provision

Medicare beneficiaries would not be liable for any coinsurance, deductible, copayment, or other cost sharing amount with respect to clinical diagnostic laboratory services furnished as an outpatient critical access hospital (CAH) service. Conforming changes that clarify that CAH is reimbursed on a reasonable cost basis for outpatient clinical diagnostic laboratory services are also included.

Effective Date

Provision applying to Medicare beneficiary cost sharing amounts is effective for services furnished on or after the enactment of BBRA 99. Conforming amendments clarifying CAH cost-based reimbursement are effective for cost reporting periods beginning on or after October 1, 2000.

Section 312. Assistance with Fee Schedule Payment for Professional Services Under All-Inclusive Rate.

Current Law

A critical access hospital (CAH) is a very small rural hospital, remote from other providers or designated as an essential provider by the state, that has an average length of patient stay of less than 96 hours (4 days). Medicare pays a CAH for outpatient services based on reasonable costs or, at the election of an entity, pays the CAH a facility fee based on reasonable costs plus an amount based on Medicare's fee schedule for professional services.

Explanation of Provision

Medicare would pay a CAH for outpatient services based on reasonable costs or, at the election of an entity, would pay the CAH a facility fee based on reasonable costs plus an amount based on 110% of Medicare's fee schedule for professional services.

Effective Date

The effective date is for items and services furnished on or after April 1, 2001.

Section 313. Exemption of Critical Access Hospital Swing Beds from SNF PPS.

Current Law

Swing beds are beds in certain small rural hospitals (with less than 100 beds) that may be used to provide either acute care or long-term services. BBA 97 implemented a prospective payment system for skilled nursing facilities (SNFs) over a transition period with rural swing bed providers to be covered by this new payment system no earlier than July 1999.

Explanation of Provision

Swing beds in critical access hospitals (CAH) would be exempt from the SNF prospective payment system. CAHs would be paid for covered SNF services on a reasonable cost basis.

Effective Date

Cost reporting periods beginning on or after enactment.

Section 314. Payment in Critical Access Hospitals for Emergency Room On-Call Physicians.

Current Law

Medicare pays a critical access hospital (CAH) for outpatient services based on reasonable costs or, at the election of an entity, pays the CAH a facility fee based on reasonable costs plus an

amount based on Medicare's fee schedule for professional services. Certain Medicare payment principles are not applied to CAHs when determining Medicare's reimbursement amount.

Explanation of Provision

When determining the allowable, reasonable cost of outpatient CAH services, the Secretary would recognize amounts for the compensation and related costs for on-call emergency room physicians who are not present on the premises, are not otherwise furnishing services, and are not on-call at any other provider or facility. The Secretary would define the reasonable payment amounts and the meaning of the term "on-call."

Effective Date

Cost reporting periods beginning on or after October 1, 2001.

Section 315. Treatment of Ambulance Services Furnished by Certain Critical Access Hospitals.

Current Law

Medicare pays for ambulance services on a reasonable cost basis when furnished by a provider and on a reasonable charge basis when furnished by a supplier. BBA 97 requires that HCFA establish a national fee schedule to pay for ambulance services and requires that covered ambulance services be paid based on the lower of the actual billed charge or the ambulance fee schedule amount. HCFA is in the process of implementing the ambulance fee schedule which was the product of a negotiated rulemaking process.

Explanation of Provision

Ambulance services provided by a critical access hospital (CAH) or provided by an entity that is owned or operated by a CAH would be paid on a reasonable cost basis if the CAH or entity is the only provider or supplier of ambulance services that is located within a 35-mile drive of the CAH.

Effective Date

Cost reporting periods beginning on or after October 1, 2001.

Section 316. Clarification of Critical Access Hospital Criteria.

Current Law

To qualify as a critical access hospital (CAH), a rural hospital can have no more than 15 acute care beds or, if the hospital operates swing beds, no more than 25 beds as long as no more

than 15 of those beds are occupied by acute care patients at any time. Any bed in a unit of the facility that is licensed as a distinct-part skilled nursing facility when the hospital applies to the State for designation as a critical access hospital shall not be counted.

Explanation of Provision

A facility would not be designated as a CAH if it had a distinct part rehabilitation unit or distinct part psychiatric unit.

Effective Date

August 5, 1997 (as if it had been enacted as part of BBA 97)

Subtitle C -- Other Rural Provisions

Section 321. Assistance for Providers of Ambulance Services in Rural Areas.

Current Law

Payment for ambulance services provided by freestanding suppliers is currently based on reasonable charge screens. Hospital or other provider-based ambulance services are paid on a reasonable cost basis. Payment cannot exceed what would be paid to a freestanding supplier. The reasonable costs or charges cannot exceed costs or charges recognized in a prior year, increased by the CPI-U minus one percentage point.

BBA 97 provided for the implementation of a fee schedule, effective January 1, 2000. The aggregate amount of payments in 2000 could not exceed what would otherwise be paid under the prior system. Increases in subsequent years are to equal the CPI increase, except that there is a one percentage point reduction in 2001 and 2002.

Implementation of the fee schedule has been delayed until at least January 1, 2001.

Explanation of Provision

The provision would make additional payments to providers of ground ambulance services for trips, originating in a rural area or in a rural census tract of a metropolitan statistical area, that are greater than 17 miles and up to 50 miles. The rate per mile would be not less than one-half of the payment established for the first 17 miles of a trip originating in a rural area (one-half of the $2.50 payment for miles one through 17 would equal $1.25 in 2001). The payments would be made for services furnished on or after January 1, 2001 and before January 1, 2004.

The provision would require the Comptroller General to conduct a study of the costs of efficiently providing ambulance services for trips originating in rural areas. The Comptroller General would be required to submit a report to Congress, not later than June 30, 2002, on the

results of the study together with recommendations on steps that should be taken to assure access to ambulance services for trips originating in rural areas. The Secretary would be required to take these findings into account when establishing the fee schedule, beginning with 2004.

Effective Date

The assistance for mileage rates provision would apply to services furnished on or after January 1, 2001. The report requirement would be effective on enactment.

Section 322. Treatment of Certain Physician Pathology Services Under Medicare.

Current Law

The final rule for the Medicare physician fee schedule issued November 2, 1999, required hospitals to bill for the technical component of pathology services furnished to its inpatients. Based on comments received, HCFA decided to delay implementation of this rebundling requirement until January 1, 2001, to allow hospitals and independent laboratories sufficient time to negotiate arrangements.

Regulations implementing the hospital outpatient prospective payment system require hospitals to provide directly or under arrangements all services furnished to hospital outpatients. If a specimen (e.g., tissue, blood, urine) is taken from a hospital outpatient, the facility or technical component of the diagnostic test must be billed by the hospital. Thus, independent laboratories cannot bill for the technical component of pathology services furnished to outpatients. On August 11, 2000, HCFA issued a program memorandum (Transmittal No. AB-00-73) which delayed implementation of the rebundling requirement until January 1, 2001.

Explanation of Provision

The provision would permit independent laboratories, under a grandfather arrangement to continue, for a 3-year period, direct billing for the technical component of pathology services provided to hospital inpatients and hospital outpatients. Laboratories covered under the grandfather provision would be those which had an arrangement with a hospital for direct billing in effect on July 22, 1999. The provision would also permit, for the same three-year period, direct billing for lab services provided to patients of hospitals located in rural areas with less than 100 beds. The provision would not apply to services furnished to Medicare+Choice (M+C) enrollees or enrollees in plans integrating acute and long-term services.

The Comptroller General would be required to conduct a study of the effect of these provisions on hospitals and laboratories and access of fee-for-service beneficiaries to the technical component of physician pathology services. The report would be due to Congress by April 1, 2003. It would include recommendations on whether the provisions should continue after the 3-year period for either (or both) inpatient and outpatient hospital services and whether the provision should be extended to other hospitals.

Effective Date

The direct billing provision would apply to services furnished during the three-year period beginning January 1, 2001. The report requirement is effective upon enactment.

Section 323. Funding for Grant Program for Rural Hospital Transition to Prospective Payment.

Current Law

Under the Medicare Rural Hospital Flexibility Program established as part of Title XVIII, the Secretary may award grants to rural hospitals to cover the implementation costs associated with data systems needed to meet the BBA 97 requirements.

Explanation of Provision

$25 million would be appropriated from the Part A Trust fund for these grants. These amounts would remain available for this purpose until spent.

Effective Date

Enactment.

Section 324 Expansion of Medicare Payment for Telehealth Services.

Current Law

BBA 97 provided for reimbursement from Medicare Part B for professional consultation via telecommunications systems with physicians and practitioners for beneficiaries residing in rural areas.

Explanation of Provision

The provision would limit application of the BBA 97 provision to services provided during the January 1, 1999, to July 1, 2001 period. Starting on July 1, 2001, it would establish revised payment provisions for services that are provided via a telecommunications system by a physician or practitioner at a distant site to an eligible beneficiary. An eligible beneficiary would be a person receiving services at an originating site in a designated health professional shortage area located in a rural area.

The provision would require the Secretary to make payments for telehealth services to the physician or practitioner at the distant site in an amount equal to the amount that would have been paid to such physician or practitioner if the service had been furnished to the beneficiary without

the use of a telecommunications system. Services covered under the provision would include payments for professional consultations, office visits, office psychiatry services, including any service identified, as of July 1, 2000, by the following HCPCS codes: 99241-99275, 99201-99215, 90804 - 90809, and 90862. Nothing would be construed as requiring or prohibiting the physician or practitioner at the distant site from sharing a portion of the fee with the physician or practitioner at the originating site.

Except for psychiatric services, an eligible telehealth beneficiary would have to be presented at the originating site by a physician, practitioner, or registered nurse for the furnishing of a service via a telecommunications system. Further, a referring physician or practitioner at the originating site would not be prohibited from presenting an eligible telehealth individual.

A facility fee would be paid to the originating site. This fee would equal $20 for the period July 2001 through December 2002, increased by the percentage increase in the Medicare Economic Index (MEI) in future years. An originating site would be defined as: the physician's or practitioner's office, rural health clinic, federally qualified health center, or a critical access hospital. Fee sharing would be neither required nor prohibited between the physician or practitioner at the distant and originating sites. Payment for a registered nurse who serves as a telepresenter would be made by the distant site physician or practitioner or by the orginating stie that employs the nurse. Balance billing limits apply on beneficiary charges.

The provision would require the Comptroller General to conduct a study to identify additional services and originating sites that are appropriate for payment via a telecommunications system. The study would evaluate and make recommendations on the use of store-and-forward technology, the extent and appropriateness of fee splitting among physicians and practitioners, and whether a telepresenter should be required. The report, together with recommendations, would be transmitted to Congress within three years of enactment.

Effective Date

Enactment.

Section 325. Expanding Access to Rural Health Clinics

Current law

BBA 97 extended the per visit payment limits that had existed for independent rural health clinics to provider-based rural health clinics except for those clinics based in small rural hospitals with fewer than 50 beds.

Explanation of Provision

Provider-based rural health clinics based in small urban hospitals with fewer than 50 beds would be exempt from the per visit payment limits as well.

Effective date

Enactment applied to services furnished on or after October 1, 2000.

TITLE IV -- PROVISIONS RELATING TO PART B

Subtitle A -- Hospital Outpatient Services

Section 401. Revision of Hospital Outpatient PPS Payment Update.

Current Law

The hospital outpatient department PPS is a schedule of fees for groups of related types of care and services. The fee schedule is updated annually based on the hospital market basket increase. In CY 2000, CY 2001, and CY 2002, the outpatient department fee schedule increase is equal to the hospital market basket (MBI) increase percentage minus one percentage point.

The hospital outpatient department PPS reflects a certain mix of services and relative frequency of use of services. A conversion factor converts the relative use weights into payment amounts. The conversion factor is updated periodically based on the rate of increase in the hospital market basket index.

Explanation of Provision

For services furnished on or after July 1, 2001 and before January 1, 2002, PPS payments for hospital outpatient department services shall be increased by the MBI increase plus 1 percentage point.

If the Secretary determines that adjustments to the factor used to convert the relative utilization weights into payment amounts have, or are likely to, result in hospitals' changing their coding or classification of covered services, thereby changing aggregate payments, the Secretary may adjust the conversion factor in later years to eliminate the effect of coding or classification changes.

Effective Date

Enactment. The adjustment for case mix change will be effective January 1, 2002.

Section 402. Clarifying Process and Standards for Determining Eligibility of Devices for Pass-Through Payments Under Hospital Outpatient PPS.

Current Law

BBRA 99 provided that, for a defined period of time of two to three years, the Secretary of HHS is required to provide additional payments for costs of certain "current innovative" devices, drugs, and biologicals, and certain "new" high cost devices, drugs, and biologicals used in hospital outpatient department care. These payments are referred to as "pass-through payments" because they would pass through the hospital outpatient PPS and be paid separately from the underlying PPS payments associated with the procedure in which the pass-through item is used. "Current" is defined as something for which Medicare is paying under outpatient services on the first day of the PPS; "new" is defined as something for which Medicare was not paying on an outpatient basis on December 31, 1996.

A pass-through for the cost of current innovative products apply to (1) orphan drugs; (2) certain cancer therapy drugs, biologicals, and brachytherapy; and (3) radiopharmaceutical drugs and biological products.

A pass-through of costs for "new" medical devices, drugs, and biologicals is required if the costs of those items is "not insignificant" in relation to the fee schedule amount payable for the service.

Explanation of Provision

Through public rule-making procedures, the Secretary is required to establish criteria for defining special payment categories under the hospital outpatient PPS for new medical devices. The Secretary would be required to promulgate, through the use of a program memorandum, initial categories that would encompass each of the individual devices that the Secretary has designated as qualifying for the pass-through payments to date. In addition, similar devices not so designated because they were payable under Medicare prior to December 31, 1996 would also be included in the initial categories. The Secretary would be required to create additional new categories in the future to accommodate new technologies meeting the not insignificant cost test established in BBRA 99. Once the categories are established, pass through payments currently authorized under Section 1833(t)(b) of the Social Security Act would proceed on a category-specific, rather than device-specific, basis. These payments are designated as "category-based pass-through payments." These payments would continue to be made for the 2 to 3-year payment period originally specified in BBRA 99, and for each given category, would begin when the first such payment is made for any device included in a specified category. At the conclusion of this transitional payment period, categories would sunset and payment for the device would be included in the underlying PPS payment for the related service.

Effective Date

Enactment.

Section 403. Application of OPD PPS Transitional Corridor Payments to Certain Hospitals that Did Not Submit a 1996 Cost Report.

Current Law

BBRA 99 provides payments in addition to PPS payments to a hospital during the first three years of the PPS if its PPS payments are less than the hospital's "pre-BBA 97 amount." The pre-BBA 97 amount is defined as the ratio of the hospital's reimbursement for cost reporting periods ending in 1996 to the hospital's reasonable costs for cost reporting periods ending in 1996.

During the first year of the outpatient PPS, a hospital would receive an additional amount equal to 80% of the first 10% of the difference between its payments under the prior system and under the PPS, 70% of the next 10% of reduced payments, and 60% of the next 10%. If PPS payments are less than 70% of prior levels, the additional sum is 21% of the pre-BBA 97 amount. During the second year, the payments as a proportion of reduced payments would change to 70% of the first 10% and 60% of the second 10%. If PPS payments are less than 80% of prior amounts the additional sum is 13% of the pre-BBA 97 amount. In the third year, the payment would be 60% of the first 10% of reduced payments, and if the PPS payments are less than 90% of the prior amounts, the additional payment is 6% of the pre-BBA 97 amount. These additional payments would be made through 2003.

BBRA 99 included a temporary hold harmless provision for small rural hospitals under the PPS and a permanent hold harmless provision for cancer hospitals under the PPS. For services furnished before January 1, 2004, by rural hospitals with not more than 100 beds, Medicare payments will equal 100% of the hospitals' pre-BBA 97 outpatient payment amounts if their PPS amount is less than the pre-BBA 97 amount. On a permanent basis, Medicare payments to cancer hospitals will equal 100% of their pre-BBA 97 amount if their PPS amount is less than their pre-BBA 97 amount. Pre-BBA 97 amount is defined as the amount equal to the product of the reasonable cost of the hospital for such services for the portions of the hospital's cost reporting period (or periods) occurring in the year and the base OPD payment-to-cost ratio for the hospital.

Explanation of Provision

For determining the pre-BBA 97 amount for hospitals that did not have a Medicare cost reporting period ending in 1996, the pre-BBA 97 amount is based on the cost reporting period ending before 2001 in which the hospital submitted a cost report.

Effective Date

Effective as if enacted with the BBRA 99.

Section 404. Application of Rules for Determining Provider-Based Status for Certain Entities.

Current Law

Hospitals may provide outpatient services at a facility that is not co-located with the main hospital or "provider" facility but that is financially part of the same business. That is, the

outpatient department is administered financially and clinically by the main provider. Such facilities are referred to as "provider based" entities. (Provider based entities may also be a physician's practice, a SNF, or a home health agency.) There are certain financial advantages for having provider-based status. Although the Medicare law lists the types of facilities that are regarded as providers of services, it does not use or define the term "provider-based." The hospital outpatient PPS regulations promulgated by HCFA in April 2000 include new criteria and procedures for distinguishing between provider-based facilities and free standing facilities. Because these are new rules, some facilities that previously had provider-based status might not meet the criteria and could lose their provider-based status.

On September 20, 2000, HCFA wrote to hospital associations that the new regulations pertaining to definition of provider based entities would be delayed for three months.

Explanation of Provision

The provision grandfathers existing arrangements for two years beginning October 1, 2000. If a facility or organization requests approval for provider-based status on October 1, 2000, and before October 1, 2002, it may not be treated as if it did not have such status during the period of time the determination is pending. In making such status determination on or after October 1, 2000, HCFA shall treat the applicant as satisfying any requirements for geographic location if it satisfies geographic location requirements in regulations or is located not more than 35 miles from the main campus of the hospital.

An applicant facility or organization shall be treated as satisfying all requirements for provider-based status if it is owned or operated by a unit of State or local government or is a public or private nonprofit corporation that is formally granted governmental powers by a unit of State or local government, or is a private hospital that, under contract, serves certain low income households or has a certain disproportionate share adjustment.

These provisions are in effect during a two-year period beginning on October 1, 2000.

Effective Date

Enactment.

Section 405. Treatment of Children's Hospitals Under Prospective Payment System.

Current Law

Children's hospitals are subject to the hospital outpatient prospective payment system.

Explanation of Provision

The BBRA 99 provides special "hold harmless" payments to ensure that cancer hospitals would receive no less under the hospital outpatient PPS than they would have received, in

aggregate, under the "pre-BBA" system, that is, the pre-PPS payment system. This hold harmless protection is extended to children's hospitals.

Effective Date

The provision is effective as if included in the BBRA 99.

Subtitle B -- Other Services

Section 411. One-Year Extension of Moratorium on Therapy Caps; Report on Standards for Supervision of Physical Therapy Assistants.

Current Law

BBA 97 established annual payment limits for all outpatient therapy services provided by non-hospital providers. The limits applied to services provided by independent therapists as well as to those provided by comprehensive outpatient rehabilitation facilities (CORFs) and other rehabilitation agencies. The limits did not apply to outpatient services provided by hospitals.

There were two per beneficiary limits. The first was a $1,500 per beneficiary annual cap for all outpatient physical therapy services and speech language pathology services. The second was a $1,500 per beneficiary annual cap for all outpatient occupational therapy services. Beginning in 2002, the amount would increase by the Medicare Economic Index (MEI).

BBRA 99 suspended application of the therapy limits in 2000 and 2001. (In the absence of additional legislation, the caps would be imposed again beginning in 2002.) During this time, the Secretary is required to conduct focused medical reviews of therapy claims with emphasis on claims for services provided to residents of SNFs. The Secretary is also required to study utilization patterns in 2000 compared to those in 1998 and 1999. The study (which must be based on a statistically significant number of claims) will look at nationwide patterns as well as patterns by region, types of setting, and diagnosis or condition. The Secretary is required to report the results of this study to Congress by June 30, 2001, together with any legislative recommendations deemed appropriate.

Explanation of Provision

The provision would extend the moratorium on the therapy cap and the requirement for focused reviews for one year through 2002. The provision would also require the Secretary to conduct a study on the implications of eliminating the "in the room" supervision requirement for Medicare payment for physical therapy assistants who are supervised by physical therapists and the implications of this requirement on the physical therapy cap. The report would be due to Congress within 18 months of enactment.

Effective Date

Enactment.

Section 412. Update in Renal Dialysis Composite Rate.

Current Law

Dialysis services are offered in three outpatient settings: hospital-based facilities, independent facilities, and the patient's home. There are two methods for reimbursement. Under Method I, facilities are reimbursed a prospectively set amount, known as the composite rate, for each dialysis session, regardless of whether the services are provided at the facility or the patient's home. The composite rate is derived from audited cost data and adjusted for the national proportion of patients dialyzing at home versus in a facility, and for area wage differences. Adjustments are made to the composite rate for hospital-based dialysis facilities to reflect higher overhead costs.

Beneficiaries electing home dialysis may choose not to be associated with a facility and may make independent arrangements with a supplier for equipment, supplies, and support services. Reimbursement to these suppliers, known as Method II, is made on the basis of reasonable charges, limited to 100% of the median of the composite rate. An exception is made for patients on continuous cycling peritoneal dialysis; in these cases the limit is 130% of the median hospital composite rate.

The composite rate is not routinely updated. BBRA 99 provided for an increase in the composite rate. For CY2000, the increase is 1.2% above the rate in effect on December 31, 1999. For CY2001, the rate is 1.2% above the amount in effect on December 31, 2000.

Explanation of Provision

The provision would modify the BBRA 99 provision to specify that the composite rate increase for 2001 is 2.4%.

The provision would require the Secretary to collect data and develop an end-stage renal disease (ESRD) market basket whereby the Secretary could estimate before the beginning of a year the percentage increase in costs for the mix of labor and non-labor goods and services included in the composite rate. In developing the index, the Secretary could take into account the technology used in furnishing dialysis services, the manner or method of furnishing those services, and the amounts by which payments for all services billed by the facility exceed the aggregate allowable audited costs. The Secretary would submit a report on the index to Congress by July 1, 2003 together with recommendations on the appropriateness of an annual or periodic update mechanism for dialysis services.

The provision would require the Secretary to develop a system which includes in the composite rate, to the maximum extent feasible, payment for clinical diagnostic lab tests and drugs (not including erythropoietin). Included would be those tests and drugs that are routinely used in furnishing dialysis to beneficiaries but are currently billed separately by the facilities. The report

on the ESRD market basket would also include a report on this new system and recommendations for incorporating it into payment for dialysis services.

The Comptroller General would be required to study the access of beneficiaries to dialysis services. The study would address the following issues: whether there is a sufficient supply of facilities to furnish dialysis services; whether Medicare payment levels are appropriate, taking into account audited costs of facilities for all services furnished, to ensure continued access to services; and improvements in access (and quality of care) that may result from the increased use of long nightly and short daily hemodialysis modalities. The report would be due to Congress by January 1, 2003.

Effective Date

Enactment.

Section 413. Payment for Ambulance Services.

Current Law

Payment for ambulance services provided by freestanding suppliers is currently based on reasonable charge screens. Hospital or other provider-based ambulance services are paid on a reasonable cost basis. Payment cannot exceed what would be paid to a freestanding supplier. The reasonable costs or charges cannot exceed costs or charges recognized in a prior year, increased by the CPI-U minus one percentage point.

BBA 97 provided for the implementation of a fee schedule, effective January 1, 2000. The aggregate amount of payments in 2000 could not exceed what would otherwise be paid under the prior system. Increases in subsequent years are to equal the CPI increase, except that there is a one percentage point reduction in 2001 and 2002.

Implementation of the fee schedule has been delayed until at least January 1, 2001.

Explanation of Provision

The provision would eliminate the 1.0 percentage point reduction for 2001.

Effective Date

Applies to services furnished on or after January 1, 2001.

Section 414. Ambulatory Surgical Centers.

Current Law

Medicare payments for ambulatory surgical centers are currently based on a fee schedule since such services were covered by the program in 1982. BBA 97 mandated an update of the consumer price index for all urban consumers (CPI-U) minus 2.0 percentage points in 1998 through 2002. In June, 1998, HCFA published proposed rules rebasing, regrouping and revising ASC rates based on cost survey data from 1994. BBRA 99 requires the new rates to be phased-in over 3 years.

Explanation of Provision

The provision would require HCFA to revise the payment system with 1999 (or more recent) cost survey data and would eliminate the minus 2.0 percentage point reduction to the update for 2001 upon the implementation of the new payment system.

Effective Date

Upon enactment.

Section 415. Full Update for Durable Medical Equipment.

Current Law

Durable medical equipment (DME) is reimbursed on the basis of a fee schedule, and covered items are classified into five groups for purposes of determining the fee schedule amounts. The DME fee schedule is updated annually by the consumer price index for all urban consumers (CPI-U). BBA 97 froze payment for DME at the 1997 level for the years 1998 through 2002. BBRA 99 increased payment rates for FY 2001 to 0.3% over FY 2000 rates and FY 2002 levels to 0.6% over FY 2000 rates.

Explanation of Provision

For 2001, the payments for covered DME are increased by the full CPI-U for the 12- month period ending June 2000. No increase is authorized for 2002.

Effective Date

Effective as if enacted with BBRA 99.

Section 416. Full Update for Orthotics and Prosthetics.

Current Law.

BBRA 97 established in law an update of 1% for covered orthotics and prosthetics fee schedule amounts for 1998 through 2002. For years 2003 and beyond, the fee schedule amounts were to be updated at urban consumer price index.

Explanation of Provision

The provision would provide a full update for 2001, and retain the scheduled update of 1% for 2002.

Effective Date

Enactment.

Section 417. Establishment of Special Payment Provisions and Requirements for Prosthetics and Certain Custom Fabricated Orthotic Items.

Current Law.

Medicare DME coverage under part B includes prosthetic and orthotic devices that are reasonable and medically necessary. In certain cases, upgraded items may be covered.

Explanation of Provision.

Certain prosthetics or custom fabricated orthotics are covered if furnished by a qualified practitioner and fabricated by a qualified practitioner or qualified supplier. The Secretary is to establish a list of such items in consultation with experts.

Not later than 6 months from enactment, the Comptroller General shall submit to Congress a report on: the Secretary's compliance with the Administrative Procedures Act with regard to HCFA Ruling 96-1; certain impacts of that ruling; the potential for fraud and abuse in provision of prosthetics and orthotics under special payment rules and for custom fabricated items; the effect on Medicare and Medicaid payments if that ruling were overturned.

Effective Date.

Within 1 year of enactment, the Secretary shall promulgate regulations to provide these items, using negotiated rulemaking procedures under subchapter II of chapter 5 of title 5 U.S.C.

Section 418. Revised Part B Payment for Drugs and Biologicals and Related Services.

Current Law

Generally, Medicare does not pay for most outpatient prescription drugs. However, the program does pay for certain drugs provided incident to a physician's service, as well as some immunosuppressive drugs prescribed for transplant patients and certain oral cancer drugs. BBA 97 specified that, in any case where payment is not made on a cost or prospective payment basis, the rate of reimbursement was to be equal to 95% of the average wholesale price (AWP) for the drug. Recent investigations by the Department of Health and Human Services Office of the

Inspector General, the General Accounting Office, and the Department of Justice have found that the current methodology, in many cases, results in payments to physicians and other suppliers of covered drugs which are substantially in excess of the supplier's actual acquisition costs.

The Department of Justice, as part of recent Medicaid investigations, has obtained data on actual wholesale prices from catalogues used by drug wholesalers. In May 2000, HHS announced that it was forwarding this information to Medicare carriers. Effective October 1, 2000, carriers were expected to use this information when calculating AWPs for 40 drugs. Some physicians, particularly oncologists, stated that while Medicare payments for the drugs may have been high, Medicare payments for administration of the drugs are substantially below actual costs. As a result of this concern, HHS announced in September 2000, that revised payment policy would not be applied to chemotherapy and certain other drugs.

BBRA 99 required GAO to conduct a nationwide study to determine the physician and non-physician clinical resources necessary to provide safe outpatient cancer therapy services and the appropriate payment rates for such services. In making this determination GAO is required to: 1) determine the adequacy of practice expense relative value units associated with the use of those clinical resources; 2) determine the adequacy of work units in the practice expense formula; and 3) assess various standards to assure the provision of safe outpatient cancer therapy services. GAO is required to submit a report to Congress on this study. The report is to include recommendations regarding practice expense adjustments, including the development and inclusion of adequate work units to assure the adequacy of payment amounts for safe outpatient cancer therapy services. The study is to include cost estimates for the recommendations.

Explanation of Provision

The provision would require the GAO to conduct a broader study on the difference between the average acquisition costs of covered drugs and biologicals and the associated payments made for such drugs and biologicals currently under the AWP reimbursement methodology. In addition, the GAO would be required to survey and evaluate the adequacy of other payments (if any) currently made to physicians and other suppliers of drugs under the Medicare program to compensate them for the related costs of handling and administering such drugs. Based on its findings, the GAO would be required to submit recommendations to the Secretary for revising the current payment methodology for drugs and biologicals and for related services. GAO would be required to design its recommendations so as to ensure that beneficiaries would maintain appropriate access to covered drugs and related services.

In making such recommendations the GAO would be instructed to evaluate the adequacy of practice expense values now recognized in CPT codes physicians commonly employ to seek reimbursement for the administration of drugs and biologicals. Moreover, GAO would consider the potential need for additional payments to non-physicians suppliers of drugs for the costs they incur in the provision of different drugs. In devising the recommendations, GAO would be required to consider the methods and amounts of reimbursements provided by large group health plans for similar drugs and biologicals, and related administration services, and the potential effects any change in payment methodologies might have on the delivery of Medicare benefits in hospital outpatient departments and other related settings. Before making any recommendations,

the GAO would be required to consult with current providers of Medicare covered drugs and biologicals as well as other entities involved in the distribution of such items.

The provision would require coordination of the new study with the study required under BBRA. The results of both studies, and the GAO's recommendations for changes in the reimbursement methodology, would be required to be submitted to Congress and to the Secretary within six months of the date of enactment. Upon receipt of the GAO's recommendations, the Secretary would be required to make revisions, based on such recommendations, to the payment methodology for covered drugs and biologicals. In addition, the Secretary could make adjustments to physician reimbursements or provide for additional payments to other suppliers for the costs of handling and administering such items, if deemed appropriate. In implementing such revisions, the total payments for covered drugs and any new payments established for the handling and administration of such drugs could not exceed the estimated aggregate expenditures that would be made for covered drugs under current law.

Finally, the provision precludes the Administrator of HCFA from taking interim administrative actions that would affect the payments for covered drugs and biologicals until such time as the GAO has completed its study and made its recommendations.

Effective Date

Enactment.

TITLE V -- PROVISIONS RELATING TO PARTS A AND B

Subtitle A -- Home Health Services

Section 501. One-Year Additional Delay in Application of 15 Percent Reduction on Payment Limits for Home Health Services.

Current Law

BBA 97 required implementation of a home health care prospective payment system (PPS) and specified that the PPS be designed so that in the first 12 months of operation, the aggregate amount of Medicare PPS payments would equal the total payments that would have been paid under the interim payment system had it remained in effect that year but with a 15% across-the-board reduction in Medicare payments to home health agencies. The home health PPS was originally scheduled for implementation in FY 1999 but was delayed until October 1, 2000 (FY 2001). BBRA 99 delayed the 15% reduction until 12 months after October 1, 2000 (thus the reduction would go into effect on October 1, 2001), and it required the Secretary to report on the

need for a 15% or other reduction 6 months after implementation of the PPS. (This report is due by March 1, 2001.)

Explanation of Provision

The provision requires that the aggregate amount of Medicare payments to home health agencies in the second year of the PPS (FY 2002) shall equal the aggregate payments in the first year of the PPS, updated by the market basket index (MBI) increase minus 1.1 percentage points. The 15% reduction to aggregate PPS amounts would be delayed until October 1, 2002.

The Comptroller General is required to submit, by April 1, 2002, a report analyzing the need for the 15% or other reduction. The requirement for such report by the Secretary is vitiated.

Effective Date

Enactment.

Section 502. Restoration of Full Home Health Market Basket Update for Home Health Services for Fiscal Year 2001.

Current Law

P.L. 105-277 (the FY 1999 Omnibus Appropriations bill) specified that per visit limits and per beneficiary limits under the home health interim payment system (IPS) are to be updated by the home health market basket index (MBI) increase minus 1.1 percentage points in FY 2000 through FY 2003. (At the time that legislation was passed, it was unclear that the PPS would be ready for implementation during that time period.) The PPS rates are to be updated in FY 2002 and FY 2003 by the MBI minus 1.1 percentage points, and, in subsequent years, by the full MBI increase. The PPS is scheduled for implementation on October 1, 2000, and it is to be "budget neutral" to the IPS in that year (i.e., total payments under the PPS will be the same in the aggregate as payments under the IPS would have been had it been in effect in that year).

The home health PPS includes a factor to reflect the mix and intensity of home health services provided to Medicare beneficiaries. Beneficiaries are categorized into one of 80 home health resource groups (HHRGs), each of which carries a standard payment for a 60-day episode of care for a beneficiary. The standard payment is computed using the average national cost-per-visit (computed and weighted by visit type, that is, skilled nursing, physical therapy, etc.) multiplied by the national average number of visits (by type) in a 60-day period. The payments under this system are updated periodically.

Explanation of Provision

For cost reporting periods beginning in FY 2001, any updates to home health payments (including the update to interim payment system rates) would be equal to the full MBI increase.

This increase in that year would raise the base for the first year of the PPS and all subsequent years.

If the Secretary determines that updates to the PPS system for a previous fiscal year (or estimates of such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments due to changes in coding or classification of beneficiaries' service needs that do not reflect real changes in case mix, the Secretary may adjust PPS amounts to eliminate the effect of such coding or classification changes.

Effective Date.

Market basket updates are effective upon enactment. Case mix adjustments are effective for home health cases closed after October 1, 2001.

Section 503. Temporary Extension of Periodic Interim Payments.

Current Law

Effective with implementation of the home health PPS, BBA 97 repealed periodic interim payments (PIP) under which certain home health agencies with consistent Medicare payment experience received biweekly payments based on past payment levels.

Explanation of Provision

Those home health agencies who were receiving PIP as of September 30, 2000, shall continue to receive those payments until December 1, 2000. The agencies shall receive payments in each of November and December 2000 equal to the amount they received in October 2000. The amounts will be included in the agency's last settled cost report before implementation of the PPS.

Effective Date

Enactment.

Section 504. Use of Telehealth in Delivery of Home Health Services.

Current Law

No provision.

Explanation of Provision

The provision would clarify that the telecommunications provisions should not be construed as preventing a home health agency from providing a service, for which payment is made under

the prospective payment system, via a telecommunications system, provided that the services do not substitute for home health services ordered by a physician as part of a plan of care or are not considered a home health visit for purposes of eligibility or payment.

Effective Date

Enactment.

Section 505. Study on Costs to Home Health Agencies of Purchasing Nonroutine Medical Supplies.

Current Law

The home health PPS establishes payments for 60-day episodes of care. PPS rates are based on the average cost per home care visit (by type of home health service), including the average cost for routine and nonroutine medical supplies. These supplies are bundled into the home health PPS payments. (Supplies that fall under Medicare's durable medical equipment fee schedule are excluded from the PPS.)

Routine supplies include items such as dressings, blood-drawing supplies, and protective gloves, masks, and gowns. These items are generally carried by all home health workers to all their visits.

Nonroutine medical supplies include catheters, catheter supplies, ostomy bags and supplies related to ostomy care, covered osteoporosis drugs, and certain other items. They are used only for specific patients. Prior to the PPS, these costs were paid for by Medicare separately from routine visit reimbursement rates.

Explanation of Provision

Not later than November 1, 2002, the Secretary shall submit to Congress a report regarding the variation in prices home health agencies pay for nonroutine supplies, the volume of supplies used, and what effect the variations have on the provision of services. The Secretary shall make recommendations on whether Medicare payment for those supplies should be made separately (using a fee schedule) from the home health PPS.

Effective Date

Enactment.

Section 506. Treatment of Branch Offices; GAO Study on Supervision of Home Health Care Provided in Isolated Rural Areas.

Current Law

Prior to BBA 97, home health agency (HHA) payments were based on the HHA's billing location. Thus, an agency headquartered in an urban area would be paid according to rates for urban areas, even though that agency had provided some of its billable visits through branch offices serving rural communities. BBA 97 required HHAs to submit payment claims on the basis of the location in which the service was provided. The home health PPS payments are based on the location in which the care is furnished.

In order to ensure that branch offices of HHAs are adequately supervised, HCFA regional offices have established "time and distance" standards on how far a branch office may be from an agency's main office. The purpose of time and distance standards is to establish a basis for determining the ability of a home health agency to supervise and control branch offices and to monitor care to patients. These policies vary by regional office. Because these definitions are not in federal regulations, they have not been subject to public rule-making requirements under the Administrative Procedure Act.

Explanation of Provision

The provision clarifies that neither time nor distance between a home health agency parent office and a branch office shall be the sole determinant of a home health agency's branch office status. The Secretary may include forms of technology in determining "supervision" for purposes of determining a home health agency's branch office status.

Not later than January 1, 2002, the Comptroller General shall submit to Congress a report regarding the adequacy of supervision and quality of home health services provided by home health agency branch offices and subunits in isolated rural areas, and make recommendations on whether national standards for supervision would be appropriate in assuring quality.

Effective Date

Enactment.

Subtitle B -- Direct Graduate Medical Education

Section 511. Increase in Floor for Direct Graduate Medical Education Payments.

Current Law

Medicare pays hospitals for its share of the direct costs of graduate medical education (GME) based on a count of the residents trained by the hospital and an updated per resident training cost. BBRA 99 established that a national average per resident amount should be used to compute direct GME payments to acute hospitals for cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2005. Generally, a hospital with a per resident amount below 70% of the geographically adjusted national average per resident amount will be increased to that amount. Those teaching hospitals with per resident amounts above 140% of the

national average adjusted for their locality will not receive an inflation update for FY 2001 and FY 2002 and then will receive a lower update than other hospitals (CPI-U minus 2 percentage points) for FY 2003 to FY 2005.

Explanation of Provision

A hospital's approved per resident amount for cost reporting periods beginning during FY 2002 would not be less than 85% of the locality adjusted national average per resident amount.

Effective Date

Enactment.

Section 512. Change in Distribution Formula for Medicare+Choice-Related Nursing and Allied Health Education Costs.

Current Law

BBRA 99 authorizes hospitals that operate approved nursing and allied health professional training programs to receive additional payments to reflect utilization of Medicare+Choice (M+C) enrollees. As specified by the Secretary, the payment amount is calculated based on the proportion of physician direct graduate medical education (GME) payments for M+C enrollees to the total physician GME payments multiplied by the Secretary's estimate of total reasonable cost reimbursement for approved nursing and allied health professional training programs. This payment cannot exceed $60 million. Hospitals receive these allied health payments in proportion to the amount of Medicare reasonable cost reimbursement for nursing and allied health programs received in the second preceding fiscal year to the total paid to all hospitals in that cost reporting period.

Explanation of Provision

A hospital would receive these nursing and allied health payments in proportion to its relative cost of allied and nursing health programs and M+C utilization in comparison to that in all other hospitals. Specifically, a hospital's payments would be calculated by the product of its Medicare reasonable cost reimbursement for allied and health programs multiplied by the number of M+C inpatient days in this hospital divided by the sum of the products in all other hospitals.

Effective Date

Portions of cost reporting periods occurring on or after January 1, 2001.

Subtitle C -- Changes in Medicare Coverage and Appeals Process

Section 521. Revisions to Medicare Appeals Process.

Current Law

Medicare beneficiaries and, in certain circumstances, providers and suppliers of health care services may appeal adverse determinations regarding claims for benefits under Part A and Part B. Section 1869 of the Social Security Act allows these parties who have been denied coverage of an item or service the right to appeal that decision through a series of administrative appeals and then into federal district court if the amounts of disputed claims in question meet certain thresholds at each step of the appeals process.

The procedures differ for Medicare Part A and Medicare Part B services. Generally, each part has its own initial appeals process which the beneficiary must exhaust before moving on to a hearing before an administrative law judge (ALJ), then to review by the Health and Human Services Department Appeals Board (DAB) and then possibly to federal court. Under Part A, an ALJ hearing is available for disputed amounts greater than $100 and judicial review is available for disputed amounts greater than $1,000. Under Part B, an ALJ hearing is available for disputed amounts greater than $500 and judicial review is available for amounts greater than $1,000. Generally, claims involving the delivery of similar or related services to the same individual or involving common issues of law and fact arising from services furnished to two or more individuals can be aggregated to reach the jurisdictional amount.

The Medicare statute establishes that provisions are not to be interpreted to prevent a beneficiary from being represented in an appeal by a person who supplied the service or item. However, this supplier or provider may not represent a beneficiary in an appeal to have the beneficiary's financial liability waived unless the supplier/provider has waived his rights for payment from the beneficiary for the services or items that are being appealed. The person may not impose any financial liability on the beneficiary in connection with such representation.

Medicare statute and regulations include provisions for an expedited appeal process where a party may request court review in place of an ALJ hearing or DAB review when all parties to the reconsidered decision (including the Secretary) concur that the only issue precluding a favorable determination is: 1) a statutory provision which the individual requesting review alleges to be unconstitutional; or 2) a regulation, national coverage decision under Section 1862(a)(1) of the Social Security Act, or a HCFA ruling which the individual alleges to be invalid. Expedited review does not apply to a challenge to a manual instruction, local medical policy, or a policy statement. Only agency determinations, such as regulations, HCFA rulings, and national coverage determinations, that are binding on the ALJ, can be appealed in such a fashion.

Explanation of Provision

The Secretary would promulgate regulations and make *initial determinations* with respect to Medicare Part A and Part B benefits including: (1) whether a beneficiary is entitled to Medicare benefits; (2) the amount of Medicare benefits available to a beneficiary; (3) any other initial determination with respect to a Medicare claim including those decisions that payment may not be made or may no longer be made for a service or item; those made by a utilization and quality

control peer review organization; or those made by contractors administering Medicare or Title XI (peer review). Generally, initial determinations would be concluded no later than 45-days from the date the Secretary receives a claim for benefits. Notice of the initial determination would be mailed to the individual filing the claim before the 45-day deadline.

In general, subject to time limits for filing an appeal, any individual dissatisfied with the initial determination would be entitled to a *reconsideration*. A request for a reconsideration must be initiated within 180 days of the date the individual receives the notice of the initial determination (or within additional time as permitted by the Secretary). In addition, if contested amounts are greater than $100, an individual would be able to appeal an adverse reconsideration decision by requesting a hearing by the Secretary pursuant to Section 205(b) of the Social Security Act. (Section 205(b) provides first for a hearing by an ALJ, then in certain circumstances, for a hearing before the DAB.) If the dispute is not satisfactorily resolved through this administrative process, and if contested amounts are greater than $1,000, the individual would be able to request judicial review of the Secretary's final decision as currently provided for in Section 205(g) of the Social Security Act. Aggregation of claims to meet these thresholds would be permitted.

An *expedited determination* would be available for a beneficiary who has received notice: 1) that a provider plans to terminate services and a physician certifies that failure to continue the provisions of the services is likely to place the beneficiary's health at risk; or 2) that the provider plans to discharge the beneficiary. In these instances, a beneficiary would be able to request, in writing or orally, an expedited determination or reconsideration. In cases where the moving party alleges there are no material facts in dispute, the Secretary would make an expedited determination of the substance of the matter in dispute and then render a decision expeditiously. The Secretary would be able to reopen or revise any initial determination or reconsideration under established guidelines.

The Secretary would enter into 3-year contracts with *qualified independent contractors* (QICs) to conduct reconsiderations of initial determinations. At a minimum, twelve QIC contracts would be awarded. These contracts would be renewable for subsequent 3-year periods. QICs would be entities or organizations that are independent from those Medicare contractors that make initial determinations and would meet requirements as established by the Secretary. QICs would have sufficient training and expertise in medical science and legal matters to review initial determinations. Reviews concerning medical necessity determinations would include consideration of facts and circumstances by a panel of physicians or other appropriate health care professionals. National coverage determinations or local coverage determinations that are developed in accordance with specified due process requirements would be binding on a QIC's reconsideration. In the absence of such guidance, QICs would base reconsideration decisions on applicable valid medical science. Certain conflict of interest provisions would be applicable to physician employees of the QICs.

QICs would conduct and conclude a determination or reconsideration and then would mail the notice of the decision by not later than the end of the 45-day period from the date that a reconsideration request has been filed (on a timely basis). If the deadline for mailing the decision is missed, the appealing party would be able to request an ALJ hearing, notwithstanding any requirements for such a hearing.

QICs would conduct and conclude expedited reconsiderations and provide notice (by telephone and in writing) of the reconsideration results to the Medicare beneficiary, provider of services, and attending physician no later than 1 day after the medical or other records needed for reconsideration are received. The reconsiderations would be conducted regardless of whether the beneficiary would be charged for continued services or liable for payment. In such reconsideration the QIC would solicit the views of the beneficiary involved.

A QIC would promptly notify beneficiaries and Medicare claims processing contractors of determinations. QIC determinations would be in writing and would include a detailed explanation of the determination, discussion of the pertinent facts and applicable regulations. In the case of reconsidered medical necessity determinations, an explanation of the medical and scientific rationale for the decision would be provided as well. Each QIC would monitor its determinations to ensure consistency and keep accurate records of each decision made in order to identify: 1) specific claims that would give rise to appeals; 2) situations where provider, physician, or supplier education would be needed; 3) situations where changes to national or local policies would be needed; and 4) situations where changes in local medical review policies would be needed. Each contractor would submit these records at least annually to the Secretary. The Secretary would establish a methodology under which a QIC would make available all determinations to fiscal intermediaries, carriers, peer review organizations (PROs), Medicare+Choice organizations and other entities under contract to make initial determinations under Medicare or peer review statutes. All QICs and their employees would not be liable under criminal or civil law for any authorized duties or activities provided that due care was exercised. These limitations on liability would also be extended to external review contractors resolving beneficiary appeals under Part C.

Pursuant to the provisions of Section 205(b), a beneficiary could appeal the decision of a QIC to an ALJ. The QIC would prepare such information as required for an appeal and participate in the hearings as required by the Secretary. The ALJ would render a decision no later than 90 days after the date a request for hearing has been timely filed, but the party requesting the hearing would be able to ask that the 90-day deadline be waived. The DAB would conduct and conclude a review of the ALJ decision and make a decision or remand the case back to the ALJ for reconsideration by no later than 90 days after the date a hearing has been requested (if the request is submitted on a timely basis). In cases where the ALJ decision is not rendered within the 90-day deadline, the appealing party would be able to request a DAB hearing.

The existing protections with respect to suppliers and providers representing beneficiaries would be retained. A provider or supplier would not be prohibited from representing a beneficiary solely on that basis. Any provider or supplier representing the beneficiary would have to waive their right to payment from the beneficiary with respect to the services or items being appealed. These representatives may not impose a financial liability on the beneficiary. Other existing requirements with respect to representatives of beneficiaries would apply as well. A beneficiary's right to appeal would be able to be assigned to a provider or supplier upon the beneficiary's written consent on a standard form.

The Secretary would perform outreach activities to inform beneficiaries, providers, and suppliers of their appeal rights and procedures including use of the toll-free telephone number to respond to inquiries about the status of appeals. The Secretary would provide each QIC and ALJ

continuing education regarding Medicare or PRO policies so that informed appeal decisions would be made.

The Secretary would submit to Congress an annual report including information on the number of appeals for the previous year, identifying issues that require administrative or legislative actions, and including recommendations for change as necessary. The report would also contain an analysis of the consistency of the QIC determinations as well as the cause for any identified inconsistencies. Not less often than every five years, the Secretary would survey a valid sample of Medicare beneficiaries, providers and suppliers to determine whether these individuals or entities are satisfied with the appeals process as well as related education and training efforts. The Secretary would submit a report to Congress on the results for the survey which would include recommendations for administrative or legislative actions.

Effective Date

Enactment.

Section 522. Revisions to Medicare Coverage Process.

Current Law

Generally, Medicare benefits are only payable if they are "reasonable and necessary." Medicare coverage policy specifies when, and under what circumstances, particular items and services are "reasonable and necessary." Medicare coverage policies are issued at the national level through the development of National Coverage Determinations (NCDs), and by local carriers and fiscal intermediaries.

Significant statutory limitations have been imposed on the review of NCDs. Specifically, an ALJ may not review a national coverage determination, except to decide whether the determination has been applied correctly to the claim at issue. A court shall not set aside or invalidate a national coverage determination, because public rulemaking provisions contained in the Administrative Procedure Act or Section 1871(b) of the Social Security Act have not been followed. Further, any case in which a court determines that the record is incomplete or otherwise lacks adequate information to support the validity of a national coverage determination is remanded back to the Secretary for additional proceedings to supplement the record. The court may not determine that an item or service is covered in the particular case except upon review of the supplemented record.

Explanation of Provision

The provision would clarify when and under what circumstances Medicare coverage policy could be challenged. The prohibition of an ALJ review of a national coverage decision would be retained. However, an administrative level of review would be added. An aggrieved party could file a complaint concerning a national coverage decision. The decision would be reviewed by the Department Appeals Board (DAB) of HHS. The DAB would be required to review the record

and to permit discovery and the taking of evidence to evaluate the reasonableness of the determination. In reviewing the determination, the DAB could only defer to the reasonable findings of fact, reasonable interpretations of law, and reasonable application of fact to law by the Secretary. A DAB decision would constitute the final HHS action. It would be subject to judicial review.

The provision would permit an aggrieved party to file a complaint concerning a local coverage determination. In this case, the determination would be reviewed by an ALJ. The requirements placed on the ALJ review would be the same as those outlined for the DAB review of national coverage decisions. The determination could be reviewed by the DAB. A DAB decision would constitute the final HHS action. It would be subject to judicial review.

The provision would also permit an affected party to submit a request to the Secretary to issue a national coverage or noncoverage determination if one has not been issued. The Secretary would have 90 days to respond. The response would take one of the following forms: 1) a national coverage determination with or without limitations; 2) a national noncoverage determination; 3) a determination that no such determination is appropriate; or 4) a notice that states that the Secretary has not completed review, an identification of the remaining steps and a deadline by which the Secretary will complete the review and issue a determination.

The provision would specify that an action seeking review of a national or local coverage determination could be initiated only by one (or more) of the following aggrieved persons or classes of persons: 1) beneficiaries who are in need of the item or services that are the subject of the coverage determination; and 2) persons, or classes of persons, who make manufacture, offer, supply, make available, or provide such items and services that may be marketed for the intended use that is the subject of the determination.

The provision would require that hearings by the Secretary regarding coverage policy be made public and that all coverage determinations be made available on the Internet site of the Department of Health and Human Services. In addition, the provision would require that the public be afforded notice and opportunity to comment on any proposed change in coverage policy, that such a determination be on the record and based on applicable medical, technical and scientific evidence, and be accompanied by a clear statement specifying the basis for such determination. The Secretary would be required to make available to the public any non-proprietary data that was relied upon in making such determinations. Finally, the provision would: 1) require the Secretary to report annually to Congress on the timeliness with which national coverage determinations made in the previous year were completed and implemented; and 2) clarify that persons named to any advisory committee established by the Secretary to assist in the development of coverage policy would have the authority to fully participate in the advisory panels deliberations and be able to directly advise the Secretary on the matters considered.

Effective Date

Enactment.

Subtitle D -- Veterans Subvention Demonstration Project

Section 531. Veterans Access to Services Under the Medicare Program.

Current Law

Medicare does not pay for services provided at VA facilities with one exception: as determined by the Secretary of Health and Human Services (HHS), Medicare will pay for services provided to the general public if the VA is acting as community institution or agency. For example, Medicare would pay for dialysis services provided by a VA facility to end-stage renal disease patients who were not veterans. In addition, Medicare payment cannot be made for items or services that a provider is obligated by law or contract to render at the public expense.

BBA 97 authorized the Secretaries of the Department of Defense (DoD) and HHS to establish a 3-year managed care demonstration project where HHS would reimburse DoD from Medicare trust funds for health care services furnished to certain Medicare-eligible military retirees or dependents. BBA 97 also instructed the Secretary of HHS and the Secretary of Veterans Affairs (VA) to jointly submit to Congress a detailed implementation plan for a VA subvention demonstration project modeled after this DoD demonstration project no later than 12 months after its start.

With respect to veterans' medical benefits, the Eligibility Reform Act of 1996 required the VA to establish and operate a system of annual patient enrollment to manage access to VA health care services within available resources. VA medical benefits are available to veterans on the basis of a priority system which determines the relative access to VA services. There are seven priority categories, with the highest priority given to veterans with service-connected disabilities. The VA is required to maintain capacity for veterans with special disabilities including treatment with spinal cord injury, blindness, amputation, and mental illness. Each year, the VA must enroll veterans in those priority categories for which there are sufficient resources to provide care that is timely and acceptable in quality.

Explanation of Provision

In general, certain Medicare-eligible veterans would receive Medicare covered Part B benefits from VA facilities; after meeting a maintenance of effort target, the VA would receive Medicare payments not to exceed that which would have otherwise been expended for such services under Medicare, up to a capped amount. Medicare reimbursement to the VA is capped at $30 million in the first fiscal year, $40 million in the second fiscal year and $60 million in the third fiscal year. Veterans would participate on a voluntary basis. The VA could enroll both "Category A Medicare-eligible veterans" (generally, those with the higher VA service priorities) and "Category C Medicare-eligible veterans" (generally, those who receive VA care to the extent resources permit) who are entitled to Part A and enrolled in Part B. Priority would be given to Category A enrollees. The VA would be able to establish enrollment fees and copayment requirements on a sliding income scale for Category C Medicare-eligible veterans only.

The VA demonstration project would be implemented in no more than 6 geographic areas according to a negotiated agreement between the administering Secretaries (the Secretary of HHS and the Secretary of VA). The agreement would include: 1) a description of the benefits to be provided; 2) a description of the eligibility rules for participating in the project; 3) a description of the project's enrollment process (which is to be administered in the same general fashion as the VA enrollment process); 4) a description of how the demonstration project would satisfy Medicare requirements; 5) a description of how reimbursement and maintenance of effort requirements would be implemented; 6) a statement that the Secretary of HHS would have access to all VA data that is determined to be necessary for independent estimates, audits of maintenance of effort and reconciliation; 7) a description of any Medicare requirements that are waived; 8) a requirement that the VA maintain marketing and outreach efforts to Category A Medicare-eligible veterans; 9) a description of the required data match procedures; and 10) a VA statement that the VA health benefits provided to Medicare-eligible veterans will not be reduced by this project.

The minimum benefits provided under the project would include at least all Medicare Part B health care services. VA would be able to enter into contracts with private entities for the provision of care under the demonstration. However, VA outpatient clinics would be used to provide services in the demonstration project to the extent feasible. No VA facilities could be constructed, renovated, or expanded with funds from this project.

Each site selected under the project would be required to: 1) have sufficient technology and infrastructure to meet data collection requirements; 2) have a sufficiently large number of Category A and Category C Medicare-eligible veterans residing in the area to assure sufficient demand for the program; 3) have the capacity to manage the project successfully; and 4) be geographically remote or inaccessible from a VA medical center that is closest to the residences of the Medicare-eligible veterans living in the area. The administering Secretaries would be instructed to consider designating at least one site in an area near a VA facility that no longer furnishes inpatient hospital care and, if feasible, one site in a rural area. The administering Secretaries would establish a data matching program to identify and compare veterans who are eligible for Part A and enrolled in Part B. The data match would occur no later than February 1, 2001.

The project could be implemented no earlier than October 1, 2001 and would be subject to the following requirements: 1) certification by the HHS Inspector General, submitted no later than April 1, 2001, that a data matching program has been established and a successful data match has occurred; 2) certification by the HHS Inspector General that the VA has improved its information management system to permit the VA to identify the project's costs for providing services; and 3) a VA report submitted to Congress and to the Controller General, no later than 90 days before implementation, on the steps that will be taken to maintain a level of health care services provided at the participating VA site. The project would be implemented through regulations that would take effect on an interim basis, after notice and pending opportunity for public comment.

Although the demonstration project would be required to meet applicable conditions of participation and other requirements for receiving Medicare payments except the prohibition of payments to Federal providers of services and Medicare secondary payer requirements would not apply. The Secretary of HHS is authorized to waive any requirement or approve alternative ways

of meeting such requirements if the waiver reflects the unique status of the VA as an agency of the federal government or is necessary to carry out the demonstration project.

Payments under the demonstration would not exceed an amount that would have been expended under Medicare Part B for such services if otherwise provided. Periodic payments from the Part B Trust Fund would be made, but not to exceed $30 million in the first fiscal year, $40 million in the second fiscal year, and $60 million in the third fiscal year. Any participating VA facility is required to maintain the level of effort for space available care to Medicare-eligible veterans.

The administering Secretaries, in conjunction with the Comptroller General, would closely monitor the Medicare expenditures under the demonstration project for Category A and Category C Medicare-eligible veterans in comparison with those expenditures that would have been made for such veterans if the demonstration project had not been conducted. The VA would be required to maintain the overall level of effort with respect to these categories of veterans by reference to an established base year. The Comptroller General would submit to Congress and the administering Secretaries an annual report on the extent, if any, that Medicare costs increased during the preceding fiscal year because of the demonstration. If so, the Secretaries would be required to take necessary steps to recoup Medicare funds and prevent any such future increases.

The Comptroller General would be required to conduct an evaluation of the demonstration project and would submit annual reports to Congress and the administering Secretaries. The first report would be submitted not later than 12 months after the date that the VA first provides services. The evaluation would include an assessment of the following: 1) any Medicare savings or costs resulting from the project; 2) VA's cost of providing care to Category A and Category C Medicare-eligible veterans; 3) an analysis of the project's impact on overall accessibility to VA medical care and the unintended effects (if any) upon VA's enrollment system; 4) VA compliance with Medicare requirements; 5) the number of participants in the demonstration project; 6) a list of health insurance plans and programs that were the primary payers for the participants prior to the demonstration and a distribution of the participants prior enrollment in such plans; 7) any impact of the project on private health providers and Medicare beneficiaries who are not enrolled in the project; 8) an assessment of the access to care and quality of care for Medicare-eligible veterans; 9) an analysis of whether and in what manner, easier access to care from VA medical centers affects the number of Category A and Category C Medicare-eligible veterans receiving Medicare health care; 10) an assessment of the impact on the access to care for Category A and Category C Medicare-eligible veterans who did not participate in the project and for Medicare beneficiaries generally; 11) a description of the difficulties (if any) experienced by VA in managing the demonstration project; 12) any other additional elements contained in the agreement; and 13) any additional elements that the Comptroller General determines is appropriate.

Not later than 6 months after the date of the final report from the Comptroller General, the administering Secretaries would submit a report to Congress containing their recommendations concerning the Medicare cost associated with this demonstration project, whether to discontinue the project, and whether the terms of the project should be continued or modified with respect to Medicare-eligible veterans.

Effective Date

Enactment.

Subtitle E -- Improving Access to New Technologies

Section 541. Process for Making and Implementing HCPCS Coding Modifications.

Current Law

There are 3 levels of codes used under Medicare fee schedules. These are known as HCPCS Level I, HCPCS Level II, and HCPCS Level III, where HCPCS is the HCFA Common Procedure Coding System. Level I codes are Current Procedural Terminology (CPT) codes which are predominantly codes used for physician services. HCPCS Level II codes encompass a variety of services including ambulance services, drugs, and durable medical equipment, as well as some temporary codes for physician services. Level III codes are local codes, created by local carriers or fiscal intermediaries to meet temporary coding needs. Recommendations for changes in Level I codes are made by the CPT Editorial Panel which is convened several times each year by the American Medical Association. Requests for modifications of HCPCS Level II codes are received and considered by the Alpha-Numeric Editorial panel, which consists of representatives from the Health Care Financing Administration, the Blue Cross and Blue Shield Association, and the Health Insurance Association of America. Currently, any changes in HCPCS Level II codes are implemented annually.

Explanation of Provision

The provision would require the Secretary to accept applications for HCPCS Level II code modifications from the public throughout the year and to make decisions with respect to such applications expeditiously. The Secretary would be required to assure that modifications to HCPCS Level II codes approved during the 3 months preceding the last month of a calendar quarter would be used in Medicare payment systems (including the fee schedule data base) not later than the first day of the following calendar quarter. The Secretary would be further required to assure that meetings of the Alpha-Numeric Editorial panel are open to the public and that the panel meets at least quarterly. The provision would also prohibit the Secretary from requiring a minimum period of marketing experience with respect to a drug or device as a condition of consideration or approval of a HCPCS Level II modification.

Effective Date

January 1, 2001.

Section 542. Establishment of Procedures for Medicare Coding and Payment Determinations for New Clinical Diagnostic Laboratory Tests and Other Items on a Fee Schedule.

Current Law

Medicare pays for clinical laboratory services on the basis of area wide fee schedules. For most older tests, the basis of these fee schedules amounts was charges submitted to carriers by suppliers of the tests in years prior to 1986. Since 1986, the law has set a cap -- or national limitation amount -- on the payment amount for a given test. BBA 97 froze the fee schedule for the 1998-2002 period. It also lowered the national limitation amount from 76% of the median to 74% of the median of all fee schedules for a test. Currently, there is no formal ongoing process for revising the codes used to account for and assign payments to new lab tests. Most new tests are either assigned to existing code and payment value, or if significantly different, may be assigned a "gap-filling" temporary code by local carriers. Payment amounts for these new gap-filled codes are established at the discretion of local carriers, and ultimately are incorporated into fee schedules nationwide at a reduced payment level using the application of the national limitation methodology described above.

Explanation of Provision

The provision would require the Secretary, within 1 year of enactment, to establish procedures for coding and payment determinations for new clinical diagnostic tests and durable medical equipment; such procedures would be consistent with those established for implementing coding modifications for HCPCS Level II codes. The Secretary would be required to provide for public participation at any hearing or any meeting at which a coding or payment determination is made.

The provision would also establish requirements relating to establishment of payment rates for lab tests assigned new or substantially revised codes on or after January 1, 2001. Specific rules would apply if the Secretary proposed to base the payment on the existing lab fee schedules (including the national limitation amount) for one or more similar tests. In this case, the Secretary would be required to publish, no later than July 1, of each year the Secretary's proposal and provide an opportunity for public comment.

For other new tests (that the Secretary is not proposing to base on existing schedules for similar tests), the payment for the first 3 years would be based on the prevailing charge level for the test for the area without any reductions or payment limitations that would otherwise apply to existing tests. The Secretary would be required to set the level for the base year at 60% of the prevailing charge, adjusted annually by the change in the consumer price index and other adjustments the Secretary determines are justified by technological changes. The national limitation amount for these new tests would be set at 100% of the median of all fee schedules.

The Secretary would be required to submit a report to Congress, within one year of enactment, that identifies the specific procedures used by the Secretary to adjust payments for lab tests and durable medical equipment which are classified to existing codes, but for which, because

of an advance in technology, there has been both a significant increase or decrease in the resources used and significant improvement in the performance of the test or equipment. The report would include recommendations for legislative changes as may be necessary to assure fair and appropriate payment levels.

Finally, in certain cases, the Secretary would be prohibited from assigning new clinical diagnostic lab tests to a code with a lower payment amount from the code recommended by the American Medical Association Common Procedure Terminology Editorial Panel. This prohibition would apply in cases where the Secretary made such assignment solely on the basis that the test that may be performed by a lab with a certificate of waiver under the Clinical Laboratory Improvement Act.

Effective Date

Enactment.

Section 543. Retention of HCPCS Level III Codes.

Current Law

There are 3 levels of codes used under Medicare fee schedules. These are known as HCPCS Level I, HCPCS Level II, and HCPCS Level III, where HCPCS is the HCFA Common Procedure Coding System. Level III codes are local codes developed by local carriers and fiscal intermediaries to address temporary coding needs. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provided that all electronic billing transactions between payers and providers must adhere to new standard formats and employ uniform diagnostic and treatment codes. This requirement is being phased-in over 2-3 years (depending on the size of the plan) beginning October 16, 2000.

Explanation of Provision

The Secretary would be required to maintain and continue the use of Level III HCPCS codes under the HCPCS coding system, as such system was in effect on August 16, 2000, through December 31, 2003. Such codes would be made available to the public.

Effective Date

Enactment.

Section 544. Recognition of New Medical Technologies Under Medicare Inpatient Hospital PPS.

Current Law

Under current law the Secretary is required to make an annual estimation of the costs that will be incurred by hospitals due to the introduction of new technology in the next year when calculating the hospital update. This estimate, along with other retrospective measures of changes in the costs of inputs as surveyed by the hospital market basket, are used to update the per discharge payments provided for under the inpatient hospital prospective payment system. These updates benefit all hospitals equally, regardless of how quick they actually incorporate the new technology forecasted by the Secretary. Once new technology has been proliferated throughout the delivery system, the costs associated with it also cause the relative weights assigned to different diagnosis-related groups (DRGs), which are the basis for hospital payments, to change. However, due to delays in data collection and analysis, the reweighting of DRGs lags significantly behind the actual introduction of technologies which may impact the actual costs of providing related services.

Explanation of Provision

The Secretary would be required to submit a report to Congress no later than April 1, 2001 on potential methods for more rapidly incorporating new medical services and technologies used in the inpatient setting in the clinical coding system used with respect to payment for inpatient services. The Secretary would be required to identify the preferred methods for expediting these coding modifications in her report, and to implement such method by October 1, 2001.

The Secretary would implement a mechanism by October 1, 2001 to identify and provide additional payments to hospitals who utilize new medical services and technologies. This mechanism would be used to collect more accurate cost data on discharges associated with the new technology for a period of not less than two and not more than three years. The additional payments devised under the system would be set such that the amount paid adequately reflected the estimated average costs of such new service or technology. Finally, cost data derived in the transitional two to three year period would be used to more accurately assign a discharge associated with the new technology to the appropriate DRG, and allow for a more accurate re-calibration of the relative resource values assigned to the DRG and others in the inpatient PPS. Additional hospital payments could be made by means of a new technology group (DRG), an add-on payment, payment adjustment or other mechanism. However, separate fee schedules for additional new technology payments would not be permitted.

The Secretary would implement the new mechanism on a budget neutral basis. The total amount of projected additional payments under the mechanism would be limited to an amount not greater than the Secretary's annual estimation of the costs attributable to the introduction of new technology in the hospital sector as a whole (as estimated for purposes of the annual hospital update calculation).

For purposes of the new payment mechanism, a "new medical service or technology" would be one that met criteria specified by the Secretary after notice and opportunity for public comment.

The provision would require the Secretary to consult with groups representing hospitals, physicians, and manufacturers of new medical technologies before publishing related regulations implementing the new payment mechanism.

Effective Date

Enactment.

Subtitle F -- Other Provisions

Section 551. Extension of Advisory Opinion Authority.

Current Law

HIPAA required the Department of Health and Human Services, through the Office of the Inspector General (OIG) in consultation with the Department of Justice, to issue advisory opinions to outside parties who request guidance on the applicability of the anti-kickback statute, safe harbor provisions and other OIG health care fraud and abuse sanctions. The authority to issue this guidance expired on August 21, 2000.

Explanation of Provision

The OIG's authority to issue guidance would be made permanent.

Effective Date

Enactment.

Section 552. Change in Annual MedPAC Reporting Dates.

Current Law

The Medicare Payment Advisory Commission (MedPAC) is required to submit to Congress, by March 1 of each year, a report on Medicare payment policies. By June 1 of each year, MedPAC is required to submit a report to Congress which contains an examination of issues affecting the Medicare program.

Explanation of Provision

The provision would change the annual reporting dates to March 15 and June 15, respectively. The provision would also require on the record votes on recommendations contained in the reports.

Effective Date

Applies beginning with 2001.

Section 553. Development of Patient Assessment Instruments.

Current Law

No provision.

Explanation of Provision

The Secretary shall report to the Congress on the development of standard instruments for the assessment of the health and functional status of patients and make recommendations on the use of such standard instruments for payment purposes. The Secretary shall consult with the Medicare Payment Advisory Commission and the Agency for Healthcare Quality and Research and other organizations representing providers of services. The report shall be submitted to Congress no later than January 1, 2005.

Effective Date

Enactment.

TITLE VI -- MEDICARE+CHOICE REFORMS AND OTHER MANAGED CARE REFORMS

Subtitle A -- Medicare+Choice Payment Reforms

Section 601. Increase in National Per Capita Medicare+Choice Growth Percentage in 2001 and 2002.

Current Law

The national per capita Medicare+Choice (M+C) growth percentage is defined as the projected per capita increase in total Medicare expenditures minus a specific reduction set in law. In 1998, the reduction was 0.8 percentage points, from 1999 through 2001 it is 0.5 percentage points, and for 2002 the BBRA 99 set the reduction at 0.3 percentage points. There is no reduction after 2002. Starting with the 1999 M+C payments, adjustments have also been made for errors in the previous years' spending projections.

Explanation of Provision

This provision would eliminate the 0.5 percentage point reduction to the national per capita M+C growth percentage in 2001 as well as the 0.3 percentage point reduction in 2002.

Effective Date

Enactment.

Section 602. Modification of Budget Neutrality Adjustments.

Current Law

After preliminary M+C payment rates are determined for each payment area (typically a county), a budget neutrality adjustment is required by law to determine final payment rates. This adjustment is made so that estimated total M+C payments in a given year will be equal to the total payments that would be made if payments were based solely on area-specific rates. A budget neutrality adjustment may only be applied to the blended rates because rates cannot be reduced below the floor or minimum increase amounts. As a result of this limitation, it is not always possible to achieve budget neutrality.

Explanation of Provision

Beginning in 2001, the budget neutrality adjustment would not apply if it would result in a reduced M+C payment. Budget neutrality adjustments that raised M+C payments would continue to apply.

Effective Date

Enactment.

Section 603. Increase in Minimum Payment Amount.

Current Law

Each county is subject to a floor amount, designed to raise payments in certain counties more quickly than would otherwise occur. The minimum payment amount for aged M+C enrollees is $401.61 for 2000 and will be $415.01 for 2001. As required by law, each year this payment amount is increased by a measure of the national growth percentage. In 2001, payments for M+C organizations will be set at the floor amount in about one-third of all counties.

Explanation of Provision

The provision would set the minimum payment amount or floor payment for aged enrollees at $450 in 2001.

Effective Date

Enactment.

Section 604. Increase in Minimum Percentage Increase.

Current Law

The minimum increase rule protects counties that would otherwise receive only a small (if any) increase. In 1998, the minimum update for any payment area was 102% of its 1997 adjusted average per capita cost (AAPCC). For each subsequent year, it will be 102% of its annual M+C per capita rate for the previous year. All plans are subject to the same minimum increase.

Explanation of Provision

This provision would apply a 4% minimum update in 2001 and a 2% minimum update thereafter.

Effective Date

Enactment.

Section 605. Allowing Movement to 50:50 Percent Blend.

Current Law

The blended rate is defined as the weighted sum of: 1) a percentage of the annual area-specific M+C per capita rate for the year for the payment area; and 2) a percentage of the input-price adjusted annual national M+C per capita rate for the year.

The component of the blend represented by the national rate is a weighted average of all local area-specific rates. This component of the blend is adjusted to reflect differences in certain input prices, such as labor costs, by a formula stated in the law. BBA 97 allows the Secretary to change the method for making input-price adjustments in the future.

The blended per capita rate shifts county rates gradually away from solely local (generally county) rates, which reflect the wide variations in fee-for-service costs, toward a national average rate. Blending is designed to reduce payments in counties where the adjusted average per capita costs (AAPCCs) historically were higher than the national average rate, and to increase payments in counties where AAPCCs were lower.

Under current law, the percentage in the blend assigned to the area-specific rate is reduced in increments over 6 years from 90% in 1998 to 50% in 2003, while the corresponding percentage for the national component is increased from 10% to 50%. In 2001, the blended rate will be

based on 66% of the area-specific rate and 34% of the national, input-price adjusted rate. In 2002, the split will be 58% area-specific and 42% national. In 2003, the split will be 50%:50%. Each year, the blended rates may be raised or lowered to achieve budget neutrality.

Explanation of Provision

This provision would allow plans to move to the 50%:50% blend in 2001, 2 years sooner than is required under current law. Plans not making this election in 2001 could choose to move to the 50%:50% blend in 2002.

Effective Date

Enactment.

Section 606. Increased Payment for Areas with Two or Fewer Medicare+Choice Contracts.

Current Law

Plans are paid an administered monthly payment, called the M+C payment rate, for each enrollee. Under the M+C program, the per capita rate for a payment area is set at the highest of three amounts (the blend amount, the minimum or floor payment, and the minimum update), calculated according to formulas established in statute and updated by law.

Explanation of Provision

This provision would give plans in payment areas with no more than two M+C contracts (as of July 1 before the beginning of the following contract year) an additional 0.5 percentage point increase on top of their monthly payment. The provision would be effective for 4 years, 2002 through 2005. The provision would not affect the bonus payments established in BBRA 99.

Effective Date

Enactment.

Section 607. Permitting Higher Negotiated Rates in Certain Medicare+Choice Payment Areas Below National Average.

Current Law

Plans are paid an administered monthly payment, called the M+C payment rate, for each enrollee. Under the M+C program, the per capita rate for a payment area is set at the highest of three amounts, calculated according to formulas established in statute and updated by law.

Explanation of Provision

Beginning in 2004, this provision would introduce an element of negotiated pricing into the rates paid to plans by allowing them to negotiate their annual update with the Secretary. Only those plans with rates below the national average, the United States Per Capita Cost (USPCC), would be allowed to negotiate their updates.

Plans would negotiate with the Secretary by presenting data on costs, benefits and utilization. A plan would be required to submit its current audited adjusted community rate (ACR) to the Secretary. Plans could negotiate an update, up to a ceiling of the growth rate of the private insurance market, adjusted for the characteristics of the Medicare population and excluding the cost of items not covered by Medicare, as calculated by the Secretary. However, no plan would be permitted to negotiate a rate that exceeds the USPCC.

Effective Date

Enactment.

Section 608. 10-Year Phase in of Risk Adjustment.

Current Law

M+C payments are risk-adjusted to reflect variations in the cost of providing health care among Medicare beneficiaries. For example, if sicker and older patients all sign up for one M+C plan, risk adjustment is designed to compensate the plan for their above-average health expenses.

BBA 97 required the Secretary to develop a risk adjustment mechanism that uses variations in health status as well as demographic factors to account for variations in costs. Beginning in January 2000, the Health Care Financing Administration (HCFA) implemented a new risk adjustment mechanism built on 15 principal inpatient diagnostic cost groups (PIP-DCGs). Payments are adjusted based on inpatient data using the PIP-DCG adjuster and demographic factors, so that this system accounts for both demographic and health-status variations. Under this mechanism, the per capita payment made to a plan for an enrollee is adjusted if that enrollee had an inpatient stay during the previous year. Separate demographically-based payments are used for enrollees without a prior hospitalization, newly eligible aged persons, newly eligible disabled Medicare enrollees, and others without a medical history.

BBRA 99 slowed down the implementation of the Secretary's proposed phase-in schedule of this system, through 2002. In 2000 and 2001, 10% of payments will include risk adjustment using the PIP-DCG method and 90% will be based solely on the older demographic method. In 2002, up to 20% of the payments will be adjusted under the new system, with the remainder of the payment based on adjustments under the old method. After 2002, the splits are not set in law, although the Secretary originally planned to: 1) base 80% of payments on the PIP-DCG system in 2003; and 2) develop a new risk adjustment system for 2004 and beyond that would incorporate both inpatient and outpatient diagnoses.

Explanation of Provision

Until such time that risk adjustment is based on data from inpatient hospital and ambulatory settings, 10% of payments would be based on risk adjustment using the PIP-DCG method and 90% would be based solely on the older demographic method. Beginning with the first year that risk adjustment is based on data inpatient hospital and ambulatory settings, it would be phased in over 10 years, in equal increments.

Effective Date

Enactment.

Section 609. Transition to Revised Medicare+Choice Payment Rates.

Current Law

M+C organizations which choose not to renew their contract with HCFA or to reduce their service area must notify HCFA in writing by July 1 of the year in which the contract would end. For example, notification was due by July 3, 2000 (because July 1 fell on a Saturday) for contracts ending December 31, 2000.

Explanation of Provision

Within 2 weeks after the date of enactment of the Act, the Secretary must announce revised M+C capitation rates for 2001, due to changes from this Act. Plans that previously provided notice of their intention to terminate contracts or reduce their service area for 2001 would have 4 weeks after enactment of this Act to rescind their notice and submit an ACR. Further, any M+C organization that would receive higher capitation payments as a result of this Act must submit revised ACR information within three weeks after the date of enactment. Despite the issuance of revised rates, M+C organizations would continue to be paid on a fee-for-service basis for costs associated with coverage determinations that are made mid-year.

Effective Date

Enactment.

Section 610. Adjustment in Payment for Medicare+Choice Enrollees with End-Stage Renal Disease.

Current Law

M+C payment rates for end-stage renal disease (ESRD) beneficiaries are set using a similar method as that used for aged beneficiaries except that ESRD rates are calculated on a statewide basis. Currently M+C payments for these beneficiaries are risk-adjusted using the old,

demographic-only, system. The Secretary plans to develop a new risk adjustment system for 2004 and beyond that would incorporate both inpatient and outpatient diagnoses. At that time, payments for ESRD enrollees will be risk-adjusted incorporating the phased-in new system with data from all settings.

Explanation of Provision

This provision would require that ESRD rates be adjusted for age and other factors as determined appropriate by the Secretary. These separate rates will remain in effect until the Secretary implements a risk adjustment system using data from inpatient hospital stays and ambulatory sites.

Effective Date

January 1, 2001.

Section 611. Report on Inclusion of Certain Costs of The Department of Veterans Affairs and Military Facility Services in Calculating Medicare+Choice Payment Rates.

Current Law

No provision.

Explanation of Provision

The Secretary shall report to Congress by January 1, 2003 a method to phase-in the costs of military facility services furnished by the Department of Veterans Affairs or the Department of Defense to Medicare-eligible beneficiaries in the calculation of the area's M+C capitation payment.

Effective Date

Enactment.

Subtitle B -- Other Medicare+Choice Reforms

Section 621. Payments of Additional Amounts for New Benefits Covered During a Contract Term.

Current Law

National Coverage Determinations (NCDs) may occur during a contract year, therefore changing the requirements for covered services under the M+C program. If the Secretary determines that the NCD will result in significant increased costs to M+C plans already under contract to provide covered benefits for a given year, current law requires the Secretary to adjust payments to M+C orgaization accordingly.

Explanation of Provision

This provision modifies current law so that payment adjustments will also be made if a legislative change results in significant increased costs to M+C plans, using the same thresholds that apply to NCDs. In addition, it requires that cost projections and payment adjustments be based on an actuarial estimate provided by the Chief Actuary of the Health Care Financing Administration.

Effective Date

This provision is effective on the date of enactment and applies to determinations and changes in law occurring after such date.

Section 622. Restriction on Implementation of Significant New Regulatory Requirements Mid-Year.

Current Law

No provision.

Explanation of Provision

The provision precludes the Secretary from implementing, other than at the beginning of a calendar year, regulations under Section 1856(b) that impose new, significant regulatory requirements on M+C plans.

Effective Date

Enactment.

Section 623. Timely Approval of Marketing Material That Follows Model Marketing Language.

Current Law

Under current law the Secretary has 45 days to approve marketing material submitted for review by M+C plans. If the Secretary requests changes in the materials, and they are resubmitted, the Secretary may now take an additional 45 days to approve the revisions. Since

the plans commit to participate in the program July 1st, and nationwide beneficiary educational efforts begin in October, delays in the approval of plan specific marketing materials can inadvertently preclude a plan from being able to initiate its own marketing efforts in concert with the Secretary's annual beneficiary education campaign.

Explanation of Provision

The provision would require the Secretary to make decisions, within 10 days, approving or modifying marketing material used by M+C organizations, provided that the organization uses model language specified by the Secretary.

Effective Date

This provision applies to marketing material submitted on or after January 1, 2001.

Section 624. Avoiding Duplicative Regulation.

Current Law

Medicare law currently preempts State law or regulation from applying to M+C plans to the extent they are inconsistent with federal requirements imposed on M+C plans, and specifically, relating to benefit requirements, the inclusion or treatment of providers, and coverage determinations (including related appeals and grievance processes).

Explanation of Provision

This provision would specify that the term *benefit requirements* includes cost-sharing requirements. Second, the provision would preempt State laws and regulations affecting marketing materials, summaries and schedules of benefits, and other documentation regarding an M+C plan.

Effective Date

Enactment.

Section 625. Election of Uniform Local Coverage Policy For Medicare+Choice Plan Covering Multiple Localities.

Current Law

An M+C plan that operates in more than one local carrier or fiscal intermediary jurisdiction tracks and follow variances in local coverage policy within its service area.

Explanation of Provision

An M+C organization offering a plan in an area with more than one local coverage policy would be able to elect to have the local coverage policy for the part of the area that is most beneficial to M+C enrollees (as identified by the Secretary) apply to all M+C enrollees enrolled in the plan.

Effective Date

Enactment.

Section 626. Providing Choice for Skilled Nursing Facility Services Under the Medicare+Choice Program.

Current Law

No provision.

Explanation of Provisions

Would require Medicare+Choice plans to provide covered post-hospital extended care services through certain "home skilled nursing facilities" designated by an enrollee, if the following conditions are met: 1) the enrollee elects to receive such care through such designated facility; and 2) the facility has a contract with the M+C organization to provide such services, or agrees to accept substantially similar payment under the same terms and conditions that apply to similarly situated SNFs that are under contract with the M+C plan. A "home skilled nursing facility" would be defined as a SNF that otherwise meets the participation requirements for Medicare, and is a facility in which one of the following conditions applies: 1) the enrollee seeking benefits resided at the time of the admission to the hospital preceding the need for extended care services; 2) the SNF seeking to provide such services is affiliated with a continuing care retirement community which provided residence to the enrollee prior to such hospital admission; or 3) the enrollees spouse resides at the time of the enrollees discharge from such hospital.

Effective Date

Would apply with respect to M+C plan contracts entered into or renewed on or after the date of enactment.

Subtitle C -- Other Managed Care Reforms

Section 631. One-Year Extension of Social Health Maintenance Organization (SHMO) Demonstration Project.

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, capitated payment basis. The waivers have been extended on several occasions since then, and the Omnibus Budget Reconciliation Act of 1990 authorized a second generation of projects. BBA 97 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.

BBRA 99 extended the SHMO waivers until 18 months after the Secretary submits a report with a plan for integration and transition of SHMOs into an option under M+C. It required 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. It also specified 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.

Explanation of Provision

The waivers permitting operation of SHMOs are extended 30 months.

Effective Date

Enactment.

Section 632. Revised Terms and Conditions for Extension of Medicare Community Nursing Organization (CNO) Demonstration Project.

Current Law

The Community Nursing Organization (CNO) demonstration project was established as a social experiment to evaluate the ability of community nursing organizations to deliver coordinated community nursing and ambulatory care services to Medicare Part B beneficiaries for fixed capitated payments. Originally authorized in the Omnibus Budget Reconciliation Act (OBRA) of 1987, the project began operation in 1994 and was scheduled to operate through 1997. BBA 97 extended their operation through 1999, and BBRA 99 extended them through December 31, 2000.

The demonstrations have operated in four sites (one site is scheduled to close at the end of September 2000). The evaluation methodology included random assignment of beneficiaries to experimental and control groups. BBRA 99 required that the projects be budget neutral for the period after 1999, meaning the total cost of the capitated payments could not exceed traditional Medicare costs. This constraint required that the capitation payments be reduced starting in July 2000.

HCFA issued an evaluation report on May 3, 2000, which covered the experience of the projects through 1997. BBRA 99 requires that a report covering the period after that be published in July 2001.

Explanation of Provision

The requirement that the CNO capitated payments be reduced to ensure budget neutrality is eliminated. Through December 2001, the projects shall operate under the same terms and conditions applicable during 1999, but with modification to the capitation rates. From October 1, 2000, through December 31, 2000, the capitation rates are adjusted for inflation since 1999 and for changes in service packages, but reduced by 10% in projects in Arizona, Minnesota, and Illinois and by 15% in New York. In 2001, the rates shall be determined by actuarially adjusting the rates in the prior period for inflation, utilization, and changes to the service package. Adjustments are made to case management fees for certain frail enrollees. Requirements are imposed to create greater uniformity in clinical features among participating sites and to improve quality and enrollee satisfaction.

By July 1, 2001, the Secretary shall submit to the House Committees on Ways and Means and Commerce and the Senate Committee on Finance a report evaluating the projects for operations in July 1997 through December 1999 and for the extension period after September 30, 2000. A final report shall be submitted by July 1, 2002. Certain methods are to be used to compare spending per beneficiary under the projects.

Effective Date

Effective as if enacted with BBRA 99.

Section 633. Extension of Medicare Municipal Health Services Demonstration Projects.

Current Law

The Medicare Municipal Health Services demonstration project to improve access to primary care services was extended through December 2000 in BBA 97. BBRA extended the project to December 31, 2002.

Explanation of Provision

The provision extends the demonstration to December 31, 2004.

Effective Date

Enactment.

TITLE VII -- PACE PROGRAM

Section 701. Extension of Transition for Current Waivers.

Current Law

OBRA 86 required the Secretary to grant waivers of certain Medicare and Medicaid requirements to not more than 10 public or non-profit private community-based organizations to provide health and long-term care services on a capitated basis to frail elderly persons at risk of institutionalization. These projects, known as the Program of All-Inclusive Care for the Elderly (PACE), were intended to determine whether an earlier demonstration program, On-Lok, could be replicated across the country. OBRA 90 expanded the number of organizations eligible for waivers to 15. BBA 97 established PACE as a permanent provider under Medicare and as a special benefit under Medicaid. State Medicaid programs are permitted to limit the number of persons enrolled in PACE programs. The Secretary shall issue regulations governing conversion of the projects to permanent program status, and the Secretary may continue to operate programs under the waivers for a transition period of 24 months after publication of the regulations, and states may elect to continue to operate a PACE program under special arrangements for 3 years after the Secretary's regulations.

Explanation of Provision

The Secretary may continue to operate PACE programs under waivers for a period of 36 months (rather than 24 months), and states may do so for 4 years (rather than 3 years).

Effective Date

Effective as if enacted with the BBA 97.

Section 702. Continuing of Certain Operating Arrangements Permitted.

Current Law

BBA 97 established PACE as a permanent part of the Medicare and Medicaid programs and provided for a transition of PACE from demonstration project status to permanent program status.

Explanation of Provision

If prior to becoming a permanent component of Medicare, a PACE demonstration project had contractual or other operating arrangements that are not recognized under permanent program regulations, the Secretary, in consultation with the state agency, shall permit it to continue under such arrangements as long as it is consistent with the objectives of the PACE program.

Effective Date

Effective as if enacted with BBA 97.

Section 703. Flexibility in Exercising Waiver Authority.

Current Law

The regulations for the PACE program allowed for insufficient flexibility and innovation in adopting the intended model of the program.

Explanation of Provision

The provision enables the Secretary to exercise authority to modify or waive requirements to respond to the needs of PACE programs related to employment and the use of community care physicians.

Effective Date

Enactment.