OPEN EXECUTIVE SESSION ON THE CHAIRMAN'S MARK OF THE BALANCED BUDGET ADJUSTMENT ACT OF 1999

THURSDAY, OCTOBER 21, 1999

U.S. Senate,

Committee on Finance,

Washington, DC.

Gilmour 19 pp.

The meeting was convened, pursuant to notice, at 11:22 a.m., in room 215, Dirksen Building, Hon. William V. Roth, Jr., (chairman of the committee) presiding.

Also present: Senators Chafee, Grassley, Hatch, Murkowski, Nickles, Lott, Jeffords, Mack, Thompson, Moynihan, Baucus, Rockefeller, Breaux, Conrad, Graham, Byran, Kerrey, and Robb.

Also present: Franklin G. Polk, Staff Director and Chief Counsel; David Podoff, Minority Staff Director and Chief Economist.

Also present: Kathy Means, Chief Health Analyst.

OPENING STATEMENT OF HON. WILLIAM V. ROTH, JR., A U.S. SENATOR FROM DELAWARE, CHAIRMAN, COMMITTEE ON FINANCE

The Chairman. The meeting will please be in order.

We are here to discuss the mark-up of the Balanced Budget Adjustment Act of 1999. I would call upon Kathy to very quickly go through the proposal.

Senator Moynihan. Two minutes.

Ms. Means. Thank you, Senator. Thank you, Mr. Chairman.

You have before you the Balanced Budget Adjustment Act of 1999. It is a package of $15.4 billion in adjustments to provider payment policies through a variety of areas in the Medicare program.

I will just touch briefly on the major program areas. In the Medicare+Choice program, the package makes adjustments of slightly over $2 billion. We have approximately $1.5 million of adjustments in rural health care initiatives, nearly $4 billion in adjustments for hospital payments.

In post-acute care, we have approximately $3.8 billion in adjustments, $2 billion for skilled nursing facility payments and $1.7 billion in adjustments for beneficiary therapy cap limits.

On home health agencies, we have $1.5 billion in

adjustments. We have put changes in the end-stage renal disease program, hospice benefits, and a variety of changes for the Medicaid program, the Children's Health insurance program, and a series of minor technical adjustments in both Medicare and Medicaid.

The Chairman. Thank you, Kathy.

Senator Moynihan. Well done.

Senator Graham. Mr. Chairman, could I ask a question?

The Chairman. Yes, Senator Graham.

Senator Graham. There is an analysis of the House version of this bill done by the Office of the Actuary of the Health Care Financing Administration, which states that, under current law, the HI trust fund is projected to be exhausted in 2015. We estimate that the subject legislation would advance the exhaustion date of the HI trust fund assets by approximately one year, to 2014.

Do you have an analysis of what the effect of the changes made in this legislation would be on the HI trust fund?

Ms. Means. No, Senator Graham, we do not. Our policies differ in some significant respects from the House bill, and it would take an entirely different calculation as to the effects of this legislation.

Senator Graham. Is the total amount of expenditure

under this bill that derives from the HI trust fund more or less than it is in the House equivalent bill?

Ms. Means. We do not know that, Senator Graham. We do not know the distribution of spending in the House bill.

Senator Graham. What is the amount of spending in the Senate bill from the HI trust fund?

Ms. Means. The amount of spending on Part A is approximately 60 percent of the bill. So out of the $15.4 billion, about 60 percent comes from Part A.

Senator Graham. Thank you.

The Chairman. Are there any amendments?

Senator Graham. Yes, Mr. Chairman.

The Chairman. The Senator from Florida.

Senator Graham. I offer my amendment number one, as filed.

The Chairman. Number one. Would you briefly state the purpose of that amendment?

Senator Graham. The purpose of the amendment, Mr. Chairman, is to pay for this legislation. There are, clearly, some very important items in this bill which relate to increasing the reimbursement level to a variety of Medicare providers.

If these items are important, then they are important enough for us to pay for. The consequences of us not

paying for them is to do what we have all committed not to do, which is to spend the Social Security trust fund.

We have already this year spent the full amount of the non-Social Security surplus, which was originally estimated at $21 billion, and have spent some $16 billion, either through scorekeeping adjustments or emergency spending items, of the Social Security trust fund. We are now proposing to spend yet another billion dollars of the Social Security trust fund.

Our colleagues in the House have been very straightforward on this. They passed a resolution in September which stated that they would not spend even "a single penny" of the Social Security surplus.

Our resolve to end the 80-year raid on Social Security is total. We have drawn a line in the sand. That is the position that our colleagues in the House have taken on spending the Social Security surplus. I think we should be equally as adamant.

We also have this very disturbing fact that we are spending 60 percent of this money out of the HI trust fund, which is a higher percentage than the House is proposing to spend out of the HI trust fund.

Therefore, if the analysis that has been done for the House bill by the HCFA actuaries, which is that the effect of this bill is to reduce the solvency of the

Medicare trust fund by one year, it would be at least that or more true of the bill that we are about to pass.

It would be ironic if, in a Congressional session that started with one of our commitments to strengthen the Medicare program, if we were to end the session by passing a bill which reduces the solvency of the Part A Medicare trust fund by one year.

So in order to avoid those negative results, I have proposed that we pay for this. I have suggested three measures. One, to reinstate the three super fund excise taxes beginning November 1 of this year, to reinstate the corporate environmental income tax for taxable years beginning December 31 of this year, and to repeal the lower of cost or market method of accounting for inventories.

This proposal, incidentally, was approved by the Finance Committee in 1994 as part of the General Agreement on Tariffs and Trade legislation. Those three items would raise, over the 10 years, $15.216 billion, and would raise in the first year $1.116 billion, making the bill paid for over the 10-year period and making the bill paid for in this first year.

I would modify my amendment to provide that the proceeds derived from these three tax measures, two reinstatements and one repeal of an existing law, would

be directed to the Part A trust fund so that we would not have this effect of reducing by one year or more the solvency of the Part A trust fund.

The Chairman. I would point out that the bill before us has as its basic purpose providing health care providers with relief from budget cuts made in the Balanced Budget Act of 1997.

It is entirely a Medicare--Medicare--bill. It is not a revenue act. Neither is the companion bill in the House a revenue bill. If the revenue offsets offered in this amendment were adopted and passed by the Senate, the entire bill would be blue-slipped by the House. That the adoption of one amendment could lose a whole bill should warn us that something is wrong here.

Nothing in the bill deals with taxes, hence, the amendment is not germane to the mark under consideration, and under Rule 2A of the committee rules, the Chairman rules the pending amendment non-germane.

Senator Graham. Mr. Chairman, I would like to note that just yesterday this committee passed a bill relative to tax extenders, which was paid for by a series of tax increases and adjustments. I do not understand why it is appropriate to pay for a tax extender bill, and yet not to pay for this BBA pay-back bill.

So, based on that, I would ask for a challenge to the

ruling of the Chair relative to the germanity of this amendment.

The Chairman. Under the committee rules, a waiver requires a two-thirds vote. The clerk will call the roll.

Senator Conrad. Mr. Chairman, before we have a vote, might I take a moment?

The Chairman. Yes. I would ask you to be brief, because we do have a vote.

Senator Conrad. I will be brief, Mr. Chairman.

The Chairman. I am advised that the waiver has never been debated before, so I would ask that we proceed.

Senator Baucus. Mr. Chairman, I would urge us to maybe modify that slightly so that some members could speak. I think those who do speak are going to speak very briefly, recognizing the time constraints.

The Chairman. Well, we are going to have a vote, as I understand, at 11:30. So I would ask everyone to resist from speaking. I will recognize the distinguished Senator from North Dakota, and ask him to keep it to a minute, please.

Senator Conrad. Thank you, Mr. Chairman. Thank you, members of the committee.

I believe this is a critically important vote. I

believe this is a defining vote. On both sides here, we have said publicly we are against raiding Social Security, this year. Yet, that is just about what is in front of us. We are about to do exactly what we say we will not do.

On July 1, CBO reported there was a $14 billion non-Social Security surplus. That surplus has already been spent. We passed an agriculture disaster bill that has $8.3 billion in outlays for 2000. Another $4.8 billion in defense spending has been designated as emergency----

Senator Mack. I would like to ask Senator Conrad, did he insist that the agriculture bill be offset?

Senator Conrad. I did not interrupt you and I would like a chance to finish my statement. I would be happy to answer that question, because at the point we passed the agriculture disaster bill, we were not over the $14 billion.

That has happened with the conferees on commerce day justice, designating over $4 billion in emergency spending for the Census, even though we have had a Census for over 200 years.

The fact is, the $14.3 billion non-Social Security surplus has been spent. So the question squarely before this committee on this vote is whether or not we are going to raid Social Security funds to provide for this

bill. Everyone has said that they do not intend to do that this year, yet that is what we are about to do.

I would just ask my colleagues, I would say to you, this is a defining vote. The question squarely before this committee is, are we going to raid Social Security or are we not? If we are not, we have got to pay for this bill.

Senator Lott. Mr. Chairman, I ask for regular order, and I ask restraint on both sides of the aisle. We have a bipartisan bill here we need to vote on. It is not debatable. I urge members, please, let us restrain ourselves and vote.

The Chairman. The Leader is correct, time is limited. I would ask the clerk to call the roll.

Senator Nickles. Mr. Chairman?

The Chairman. I know that you would like equal time, but----

Senator Nickles. Just for half a second. Thirty seconds.

The bill before us puts super fund taxes into Medicare, or into Part A hospitals. That is not what super fund taxes are for. Super fund taxes have a purpose. We need to reauthorize the super fund program, and I feel very strongly we should not pass a super fund extension on the taxes until we do reauthorize the

program. Certainly, they should not be earmarked for Medicare. Medicare is paid for by payroll taxes.

The Chairman. The clerk will call the roll.

Senator Baucus. Mr. Chairman?

The Chairman. No further time is----

Senator Baucus. Mr. Chairman, if I might, just 15 seconds.

The Chairman. No.

Senator Baucus. Fifteen seconds, Mr. Chairman.

The Chairman. I am going to ask the clerk to call the roll.

The Clerk. Mr. Chafee?

Senator Chafee. No.

The Clerk. Mr. Grassley?

Senator Grassley. No.

The Clerk. Mr. Hatch?

Senator Hatch. No.

The Clerk. Mr. Murkowski?

Senator Murkowski. No.

The Clerk. Mr. Nickles?

Senator Nickles. No.

The Clerk. Mr. Gramm, of Texas?

Senator Gramm. [No response].

The Clerk. Mr. Lott?

Senator Lott. No.

The Clerk. Mr. Moynihan?
Senator Moynihan. No.
The Clerk. Mr. Baucus?
Senator Baucus. No.
The Clerk. Mr. Rockefeller?
Senator Rockefeller. Aye.
The Clerk. Mr. Breaux?
Senator Breaux. No.
The Clerk. Mr. Conrad?
Senator Conrad. Aye.
The Clerk. Mr. Graham, of Florida?
Senator Graham. Aye.
The Clerk. Mr. Bryan?
Senator Bryan. Aye.
The Clerk. Mr. Kerrey?
Senator Kerrey. No.
The Clerk. Mr. Robb?
Senator Robb. Aye.
The Clerk. Mr. Chairman?
The Chairman. No.
The Clerk. 14 nays, 5 yeas.
The Chairman. There is not agreement to a waiver. The amendment is non-germane.
Are there any further amendments?
Senator Graham. Yes, Mr. Chairman. I offer a

second amendment which relates to fee-for-service modification.

Mr. Chairman, in the 1997 Balanced Budget Act, we did several things that were intended to enhance the fee-for-service component of Medicare, which is the portion of Medicare that provides for 85 percent of the Medicare beneficiaries' services.

The most significant of those was a provision that directed that there be a demonstration of competitive bidding for Part B medical services and products.

There was a demonstration project held. It happened to have been held in Lakeland, Florida. It has demonstrated that there have been cost savings in the range of 15 to 30 percent on the various medical products which are secured for Medicare beneficiaries.

I would like to underscore that every one of those savings, 20 percent of the savings goes to the beneficiary by the reduction in the amount of their co-payments, and 80 percent goes to the American taxpayers by reducing their cost of purchasing those items.

So, Mr. Chairman, I would offer as the second amendment the amendment which I had previously filed, which would have the effect of directing HCFA to initiate competitive bidding for Part B products and services, except for physician services, on a nationwide basis.

The savings would be $1.1 billion.

The Chairman. Senator Breaux?

Senator Breaux. Mr. Chairman, I will try to be very brief because we have got a vote going on. But many of the ideas that Senator Graham has proposed ought to be considered by this committee, and some of them ought to be adopted, but it cannot be adopted in a vacuum. It cannot be adopted if you are only going to look at reforming part of the program.

I mean, the whole thing this committee has to do, and I think the Chairman is committed to doing a full-scale effort to try and reform Medicare in toto at the beginning of next year, that is when these types of items should be considered.

What are trying to do, briefly, here, is put more money back to the providers. This amendment gives HCFA more bureaucratic authority to make more cuts, and they are going to come from the same providers that we are trying to help. If we put a little bit of money in and take a whole lot of money out, we are not helping anybody. I mean, these ideas should be discussed in the context of overall reform.

Senator Moynihan. Good job.

The Chairman. Senator Chafee.

Senator Chafee. Mr. Chairman, I am very sympathetic

to the proposals by the Senator from Florida and, indeed, have worked with him on them in the past.

Two things have occurred, I would briefly mention. One, it is apparent that if we attempt to adopt this, if this were adopted, I think the whole bill would bog down. There is considerable opposition to proceeding with it, and that presents us with problems. I am very anxious to get on with this bill.

Second, we have the commitment from the Chairman of the committee that we are going to consider Medicare reforms when we come back next year. When we come back, it is only three and a half months from now, there I believe we will take up the Graham proposals, which are good ones, and I am quite confident they will be adopted.

Senator Kerrey. Mr. Chairman?

The Chairman. Yes, Senator Kerrey?

Senator Kerrey. Mr. Chairman, so that we can vote and leave relatively quickly afterwards, I feel similarly to Senator Chafee, that Senator Graham has got some excellent ideas.

You made a good statement before we came out here, indicating that you hoped to take up next year restructuring of Medicare, and I want to thank you as well for your commitment to hold hearings on the pediatric GME issue and try to get that considered next

year as well. Your sympathy and concern there is very much appreciated.

Senator Murkowski. Mr. Chairman?

The Chairman. Yes, Senator Murkowski?

Senator Murkowski. Just very briefly. I would like the record to note the general understanding that we have had to try and mandate the CBO, find a way to score telemedicine for this committee so we can address it next year.

Senator Moynihan. Mr. Chairman, may I indicate our understanding that that all three things have been exactly right. We are going to have major hearings on Medicare, we are going to address the pediatric hospitals, and the very important issue of telemedicine.

Senator Rockefeller. Mr. Chairman?

The Chairman. Yes, Senator Rockefeller?

Senator Rockefeller. Could I just ask that the colloquy, which has been agreed to most graciously by the Chairman, Ranking Member, and staffs, be entered in the record?

The Chairman. Let me point out, there are two colloquys, one with Senator Rockefeller and one with Senator Graham, that will be included in the record.

[The colloquys appear in the appendix.]

The Chairman. Now, let me say again that it is my

intent to move right ahead in major hearings on Medicare reform. I intend to do everything I can to develop a broad consensus on such reforms.

Senator Baucus. Mr. Chairman?

The Chairman. Yes?

Senator Baucus. Mr. Chairman, I just want to tell you you have done a good job. This is extremely difficult. We had, I think, a very constructive meeting beforehand just about an hour ago in which, in good faith, everybody brought together some ideas. I wanted to commend you very much for the good work that you have done.

Senator Grassley. I want you to know that Republicans think you do a good job, too. [Laughter].

Senator Moynihan. But do not forget to vote.

The Chairman. We are now ready to vote. The Clerk will call the roll on the Graham amendment. It is an up and down vote.

The Clerk. Mr. Chafee?

Senator Chafee. No.

The Clerk. Mr. Grassley?

Senator Grassley. No.

The Clerk. Mr. Hatch?

Senator Hatch. No.

The Clerk. Mr. Murkowski?

Senator Murkowski. No.

The Clerk. Mr. Nickles?

Senator Nickles. No.

The Clerk. Mr. Gramm, of Texas?

The Chairman. No, by proxy.

The Clerk. Mr. Lott?

Senator Lott. No.

The Clerk. Mr. Jeffords?

Senator Jeffords. No.

The Clerk. Mr. Mack?

Senator Mack. No.

The Clerk. Mr. Thompson?

Senator Thompson. No.

The Clerk. Mr. Moynihan?

Senator Moynihan. No.

The Clerk. Mr. Baucus?

Senator Baucus. No.

The Clerk. Mr. Rockefeller?

Senator Rockefeller. No.

The Clerk. Mr. Breaux?

Senator Breaux. No.

The Clerk. Mr. Conrad?

Senator Conrad. No.

The Clerk. Mr. Graham, of Florida?

Senator Graham. Aye.

The Clerk. Mr. Bryan?

Senator Bryan. No.

The Clerk. Mr. Kerrey?

Senator Kerrey. No.

The Clerk. Mr. Robb?

Senator Robb. Aye.

The Clerk. Mr. Chairman?

The Chairman. No.

The Clerk. The votes are 18 nay, 2 yeas.

The Chairman. The amendment is not agreed to.

I move to report the bill, and those in favor please say aye.

[Chorus of ayes]

The Chairman. Those opposed, say no.

[Chorus of nays]

The Chairman. The ayes have it. The bill is reported.

Thank you, gentlemen, very much, for your cooperation.

Senator Moynihan. Thank you, Mr. Chairman.

The Chairman. Particularly you, Pat Moynihan.

[Whereupon, at 11:44 a.m., the meeting was concluded.]

UNITED STATES SENATE
COMMITTEE ON FINANCE

Thursday, October 21, 1999 -- 10:00 a.m.
SD-215 Dirksen Senate Office Building

OPEN EXECUTIVE SESSION
AGENDA

I. Chairman's Mark of The Balanced Budget Adjustment Act of 1999

The Chairman will rule out of order nongermane items (offered as a single amendment or as part of a larger amendment). Additionally, all amendments must be revenue neutral

Statement of Sen. Orrin G. Hatch
before the
Committee on Finance
United States Senate
October 21, 1999

Mark-up of the Balanced Budget Adjustments Act of 1999

Mr. Chairman, I want to commend you on your hard work in putting together a very reasonable and thoughtful legislative package. Your willingness to address important issues such as skilled nursing facilities, community health centers, and Medicare reimbursement for medical devices, pharmaceuticals and biologicals is greatly appreciated by me.

With respect to the skilled nursing facility provisions, I want to make it perfectly clear, based on our discussions yesterday, that the dollars must be available and flowing on the April 1, 2000 effective date of the SNF provisions. It is vitally important that these revenues become available at the soonest possible date.

As this measure moves forward, I hope that an adjustment in the effective date can be made so that the SNF provisions take effect on January 1, 2000, rather than on April 1, 2000. Nursing homes are facing financial difficulty today; an additional three months is significant for this industry so I hope this issue will be properly resolved in conference.

Regarding community health centers, I recognize the time and energy you and your staff put into finding appropriate language that addresses their concerns. I believe that we have made significant progress on this issue. However, the community health centers are not satisfied with the temporary approach contained in our product. I hope to work with the

Chairman in developing a long-term solution to this very serious problem for the community health centers.

I am also grateful to you for agreeing to include language which addresses Medicare reimbursement issues for the medical device industry, the pharmaceutical industry and the biological industry. I am hopeful that this legislative language will send a message to HCFA that Congress is concerned about Medicare's reimbursement policies for new technology, pharmaceuticals and biologicals. This is a serious concern and I believe that my legislation is the right solution to this problem.

Your willingness to include strong report language clarifying BBA 97's intent that chiropractic services are covered in the Medicare+Choice program is also appreciated by me. It was the clear intent of Congress, and especially this committee, that beneficiaries enrolled in the Medicare +Choice plans have access to the same services available under Part B.

This is not what is occurring today; we now know that some plans are, in fact, not providing chiropractic services to enrollees. Moreover, we need to clarify that these services should be performed by doctors of chiropractic who are uniquely trained and educated in the treatment of manual manipulation of the spine to correct a subluxation.

And finally, I want to raise one more concern that I hope the Finance Committee can review at a later date and that is the issue of Medicare beneficiary copayments for outpatient services. I recently sent you a letter on this important issue and want you to know that issue is a concern of mine. I am hopeful that we can have a fruitful discussion on this matter in the near future.

Mr. Chairman, you and your staff are to be commended for a good job

in putting together this package under very difficult budget constraints. I also want to acknowledge the ranking minority member, Senator Moynihan, for his assistance in crafting this bipartisan package of adjustments to the BBA.

I strongly support your efforts and will continue to work with you in order to ensure that these important provisions are in the final legislative package signed into law by the President.

THE BALANCED BUDGET ADJUSTMENT ACT OF 1999

TITLE I-PROVISIONS RELATING TO PART A ONLY

Subtitle A-Skilled Nursing Facility Services

Section 101. Increase in payment for certain high cost patients.

Current Law

The BBA 97 required that a prospective payment system be implemented for skilled nursing facility care starting in July 1998. The prospective payment system outlined in the BBA reflects the Resource Utilization Group (RUG) design HCFA developed over several years and tested on a demonstration project basis. The RUG system requires skilled nursing facilities (SNFs) to categorize their Medicare patients according to 44 hierarchical groups based on the kinds and intensities of care and services they need. For example, patients needing mostly physical therapy or speech therapy of different intensities use different kinds and amounts of resources from patients needing such services as skilled nursing care, intravenous feeding or medications, extensive laboratory testing, or use of a respirator, and such patients would be assigned to different groups. The SNF prospective payment system provides facilities a fixed amount per day per patient (a "per diem" payment), with the amount of the payment determined by the RUG into which the patient is classified. This RUG classification system serves as the case-mix adjustment that is used to relate program payment to individual patient characteristics and resource use.

The BBA 97 instructs the Secretary how to (a) compute average per diem payment rates using Medicare-approved SNF costs in 1995 as the base year; (b) adjust the average rates for facility case-mix and geographic differences; and © update the per diem rates for years after 1995. This methodology aims at setting the prospective payment system per diem amounts to reflect overall Medicare payments for SNF care under the retrospective reimbursement payment system used prior to the prospective payment system in order to achieve budget neutrality for the new payment system when it is first implemented. The law specifies limited updates to payments under the RUG system in future years.

Explanation of Provision

The bill would add 25% to the federal per diem payments for beneficiaries in the Extensive Services and Special Care RUGs (categories SE3, SE2, SE1, SSC, SSB, SSA as listed in HCFA's May 12, 1998 final rule) for the period April 1, 2000 to October 1, 2001. It would also add specified dollar amounts to RUG payments for five rehabilitation therapy RUGS (RMC, RUC, RMB, RHC, and RVC). These additional amounts would be paid from April 1, 2000 to October 1, 2001.

Reason for Change

In a report prepared for the Health Care Financing Administration (HCFA), an independent review of the RUGs classifications demonstrated that the payment rates for the Extensive Services and Special Care RUGs did not meet the anticipated costs

for the medically complex patients that fall within these categories. Data also has demonstrated the appropriateness of specific add-ons to the five rehab categories. The additional payments provide targeted relief in the interim, as the Secretary refines allocations among the RUGs in preparation for publication of the final rule.

Effective Date

April 1, 2000.

Section 102. Provision for Part B add-ons for facilities participating in the NCHMQ demonstration project.

Current Law

A demonstration project, the Nursing Home Case Mix and Quality (NHCMQ) demonstration, preceded implementation of the SNF prospective payment system. Nursing facilities participating in that project are not currently receiving the cost of Medicare Part B services to SNF patients accounted for under the facility-specific component of the prospective payment system as are other SNFs, although their federal per diem amounts are higher than those for other SNFs because they are based on allowable costs in 1997 rather than 1995.

Explanation of Provision

The bill would include the cost of Part B services, and specified updates, in the facility-specific component of Medicare payments to SNFs that participated in the Nursing Home Case Mix and Quality demonstration project.

Reason for Change

HCFA has interpreted inadvertent placement of the Part B provisions in the BBA to mean that Congressional intent was to prohibit these facilities from adding appropriate reimbursement for Part B services to facility-specific rates for participants in the RUG III Demonstration Project. The provision would allow these facilities to receive payments for Part B services provided since enactment of the BBA.

Effective Date

As if included in the BBA.

Section 103. Exemption of facilities from 3-year transition period under the prospective payment system for skilled nursing facility services.

Current Law

The BBA 97 requires that the SNF prospective payment system be phased in over 3 years starting July 1, 1998 (or the first date thereafter on which a SNF started a new annual cost reporting period). During this phase-in period, part of the per diem payment to each SNF is based on the facility's historical costs (the "facility specific"

component of the prospective payment system), and part is based on the new federal per diem prospective payment. During the 3-year phase-in period, a SNF receives per diem rates that are a "blend" of 75% the facility-specific rate and 25% of the federal per diem rate. The proportion of the facility-specific rate to the federal per diem rate shifts annually by 25 percentage points until the federal rate equals the full payment.

Explanation of Provision

Effective upon enactment, the bill would allow SNFs to elect to be paid according to the transition formula or exclusively under the federal per diem rate if the full federal per diem amount would be more advantageous.

Reason for Change

By allowing facilities to choose the federal rate instead of the blended rate, the provision seeks to more adequately reimburse facilities whose Medicare population may have increased in volume or case mix since the 1995 base year.

Effective Date

Upon Enactment.

Section 104. Study on respiratory competency requirements.

Current Law

No provision.

Explanation of Provision

The Secretary would be required to report on variations in state licensure and certification standards for health providers, including nurses and allied health professionals, providing respiratory therapy in skilled nursing facilities. The report would focus on whether the Medicare program should require competency examinations or certification for respiratory care. The Secretary should submit this report to Congress within one year of enactment of the act.

Reason for Change

There is some evidence suggesting that the quality of respiratory care provided to Medicare beneficiaries in skilled nursing facilities is varied and, in some cases, inadequate. The purpose of this study is to examine whether the Medicare program should require competency exams or certification for those providing respiratory care.

Effective Date

Upon enactment.

Section 105. Report on SNFs specializing in care of extremely high cost, chronically ill populations.

Current Law

No provision.

Explanation of Provision

This provision would require the Secretary to study and issue a report to Congress on alternative payment methods for skilled nursing facilities that specialize in providing care to extremely high cost, chronically ill populations.

Reason for Change

A broad-based prospective payment system might be inappropriate for a facility that exclusively specializes in caring for AIDS patients, for example. This study is intended to address payment issues for such facilities.

Effective Date

Upon enactment.

Subtitle B-Hospice Services

Section 121. Payment for Hospice Care

Current Law

Medicare covers hospice care, in lieu of most other Medicare benefits, for terminally ill beneficiaries. Payment for hospice care is based on one of four prospectively determined rates which correspond to four different levels of care; hospices receive one of these rates for each day a beneficiary is under the care of the hospice. The four rate categories are routine home care, continuous home care, inpatient respite care, and general inpatient care. The prospective payments are updated annually by the hospital market basket.

The BBA 97 reduced the hospice payment update to market basket minus 1 percentage point for each of FY 1998 through FY 2002. It required the Secretary of HHS to collect data from hospices on the costs of care they provide for each fiscal year beginning with FY 1999.

Explanation of Provision

The bill would change the hospice payment rate to market basket minus .5 percentage point through FY 2002.

Reason for Change

Due to the rising costs of pharmaceuticals and technological advances in pain management, there was evidence of a need to provide relief to the payment reduction included in the market basket update.

Effective Date

Retroactive to October 1, 1999

Section 122. Study and report to Congress regarding modification of the payment rates for hospice care.

Current Law

No provision.

Explanation of Provision

The bill requires the Comptroller General of the United States to conduct a study on the feasibility and advisability of updating the hospice rates, including an evaluation of whether the cost factors used to determine the rates should be modified, eliminated, or supplemented with additional cost factors. A report on that study would be required to be submitted to Congress within 1 year of enactment, and would also include any recommendations for legislation the Comptroller General determines appropriate based on the study.

Reason for Change

Because of the unique role of the hospice benefit within the Medicare program, and the changing needs of the Medicare population, a thorough review of the current hospice benefit structure and payment method is warranted.

Effective Date

Upon enactment.

Subtitle C – Other Part A Provisions

Section 141. Study on prospective payment system for psychiatric hospitals.

Current Law

No provision.

Explanation of Provision

The Secretary must report to Congress within two years of enactment

of this act on the development of a prospective payment system for psychiatric hospitals. Special attention should be given to the unique circumstances affecting mental health facilities in rural areas.

Reason for Change

Medicare payment systems have moved from cost-based reimbursement to prospective payment. Psychiatric hospitals are currently exempt from the PPS for inpatient hospital services. This study would examine the feasibility and advisability of adopting a PPS for these hospitals.

Effective Date

Upon enactment.

Section 142. Rehabilitation Hospitals.

Current Law

BBA 97 requires the Secretary to establish a case-mix adjusted prospective payment system (PPS) for rehabilitation hospitals and distinct part units, effective beginning in FY 2001. PPS rates are to be phased-in between October 1, 2000 and October 1, 2002 with an increasing percentage of the hospitals' payment based on the PPS amount. For FY 2001 and FY 2002, the Secretary is required to establish prospective payment amounts that are budget neutral so that total payments for rehabilitation hospitals equal 98% of the amount that would have been paid if the PPS system had not been enacted. PPS will be fully implemented by October 1, 2002.

Explanation of Provision

The mark makes two changes to the rehabilitation prospective payment system (PPS) section of the BBA. First, consistent with HCFA's implementation decision, it prescribes the payment unit for this system to be a discharge. Payment classifications under this system will be based on function, taking into consideration factors such as impairment, age, comorbidities and functional capability of the patient and other such factors the Secretary deems appropriate to improve the functional status of the beneficiary.

The Secretary is required to report on the impacts of the prospective payment system within two years of implementation.

Reason for Change

In its March, 1999 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) endorsed a per discharge approach to the pending prospective payment system for rehabilitation hospitals. MedPAC also recommended that the payment system should be based on the Functional Independence Measure-Functional Related Groups (FIM-FRG) classification system.

Effective Date

Upon enactment.

Section 143. Exception to CMI Qualifier for One Year.

Current Law

No provision.

Explanation of Provision

The provision excepts Northwest Regional Mississippi Regional Medical Center from the case mix index (CMI) for one year.

Reason for Change

Although Northwest Mississippi Regional Medical Center recently completed new capital renovations to the facility, in 1998 two key physician positions were vacant and the facilities were not utilized. Since that time, the hospital's case mix has remained above requirements for rural referral center status designation. However, the hospital is in jeopardy of losing that status due to the reduced case mix level in 1998.

Effective Date

The provisions are effective October 1, 1999.

Section 144. Reclassification of certain counties as large urban areas under Medicare program.

Current Law

No provision.

Explanation of Provision

Specifies that, for the purpose of Medicare PPS payments to inpatient hospitals, the large urban area of Charlotte-Gastonia-Rock Hill, North Carolina-South Carolina may be deemed to include Iredell County, North Carolina.

Reason for Change

Iredell County is still classified as "rural" for the purposes of Medicare reimbursement, even though Iredell County is almost completely surrounded by three "urban" Metropolitan Statistical Areas.

Effective Date

Effective for discharges occurring on or after October 1, 1999.

Section 145. Wage Index Correction

Current Law

No provision.

Explanation of Provision

The provision directs the Secretary to recalculate the Hattiesburg, Mississippi Metropolitan Statistical Area (MSA) wage index for FY2000 using Wesley Medical Center's FY 1996 wage and hour data and to issue a wage index correction.

Reason for Change

Due to the Health Care Financing Administration's error in not including Wesley Medical Center's FY1996 wage and hour data in the FY2000 Hattiesburg, Mississippi MSA wage index, Forrest General Hospital is facing severe and unexpected losses in Medicare payments this year. The hospital was unable to achieve an administrative correction in time to be included in HCFA's PPS final rule, published August 1, 1999. This provision grants the Secretary authority to make this change prior to publication of the PPS rule next year.

Effective Date

The provisions in this section are effective October 1, 1999.

Section 146. Reclassification of certain counties as large urban areas under Medicare program.

Current Law

No provision.

Explanation of Provision

Specifies that, for the purpose of Medicare PPS payments to inpatient hospitals, the large urban area of New York, New York may be deemed to include Orange County, New York.

Reason for Change

Orange County hospitals compete directly for personnel with neighboring counties that are reimbursed on the higher New York City wage index. More specifically, these hospitals receive a reimbursement that is 26% less than neighboring counties solely based on the MSA to which it is classified.

Effective Date

Effective for discharges occurring on or after October 1, 1999.

Section 147. Consideration of an application by a certain entity for Medicare certification as an application by a new provider.

Current Law

No provision.

Explanation of provision

The Secretary would consider an application (or reapplication) for certification of a long-term care facility under the Medicare program that is, or was, submitted after January 1, 1994, by a subsidiary of a not-for-profit, municipally-owned, and Medicare-certified hospital, where such facility has had a change of management from the previous owner prior to acquisition by such subsidiary, as an application by a prospective provider.

Reason for Change

To correct unintended consequences stemming from a change in ownership.

Effective Date

Upon enactment.

TITLE II-PROVISIONS RELATING TO PART B ONLY

Subtitle A-Hospital Outpatient Department Services

Section 201. Multi-year transition to prospective payment system for hospital outpatient department services.

Current Law

The BBA 97 directed the Secretary of HHS to implement a prospective payment system for hospital outpatient departments in 1999. In proposed rules issued on September 8, 1998, HCFA delayed implementation of the new system until after the start of 2000 in order to ensure that "year 2000" data processing problems were fully resolved before the new system was implemented. The agency currently estimates that the hospital outpatient prospective payment system will be implemented in July 2000.

The BBA required that the outpatient prospective payment system be designed so that the estimated sum of Medicare payments to hospital outpatient departments would equal the aggregate amount Medicare would have paid hospitals in 1999 under old law, prior to the prospective payment system. This requirement makes the new prospective payment system budget-neutral with regard to the cost to the government for outpatient hospital care for Medicare beneficiaries. HCFA computer simulation analysis of the new system showed the effects to be uneven among hospitals, with

some hospitals losing more than others compared with their old law Medicare payments.

Explanation of Provision

The bill would authorize Medicare payments to hospitals for outpatient services in amounts such that the ratio of Medicare payments plus beneficiary copayments (computed with the corrected formula-driven overpayment under the new BBA 97) to the hospitals' costs would be no less than 90%, 85%, and 80% of the ratio of the hospital's 1996 payments to costs in the first, second, and third years (transition years) of the new system, respectively. The bill directs the Secretary to make interim payments to hospitals during the transition years, if necessary, and subsequently to make retroactive adjustments. The bill would waive the budget neutrality requirements of the BBA with respect to Medicare payments in the transition years.

The bill also exempts certain rural hospitals and cancer hospitals from the hospital outpatient prospective payment systems.

Reason for Change

Certain classes of hospitals are expected to lose a substantial share of their Medicare outpatient revenues under the proposed PPS. Low-volume rural hospitals and cancer hospitals, for example, are expected to lose 17.4% and 32.4% of their Medicare outpatient revenue, respectively. Teaching hospitals also are expected to lose 11% of their Medicare revenue.

By establishing a transition policy under the hospital outpatient department prospective payment system, the bill provides protection for all hospitals for the first three years of the new system.

Effective Date

Upon enactment.

Section 202. Study and report to Congress regarding the inclusion of rural and cancer hospitals in prospective payment system for hospital outpatient department services.

Current Law

No provision.

Explanation of Provision

The bill would require the Medicare Payment Advisory Commission to prepare a report for Congress within 2 years of enactment regarding the feasibility and advisability of including cancer hospitals and rural hospitals in the outpatient prospective payment system.

Reason for Change

Although the bill protects cancer and rural hospitals from the impact of the hospital outpatient prospective payment system on a permanent basis, this provision requires the Secretary to consider whether this protection is warranted over time and should be maintained.

Effective Date

Upon enactment.

Section 203. Transition Provisions for Drugs, Biologicals and Devices in the Prospective Payment System for Hospital Outpatient Departments

Current Law

The BBA 97 directed the Secretary of HHS to implement a prospective payment system for hospital outpatient departments in 1999. In proposed rules issued on September 8, 1998, HCFA delayed implementation of the new system until after the start of 2000. The agency currently estimates that the hospital outpatient prospective payment system will be implemented in July 2000.

Although the Balanced Budget Act (BBA) gave the Secretary the discretion to make additional payments, in a budget neutral manner, for outlier cases, the Secretary elected not to exercise this authority in developing the proposed payment policy.

As permitted under the statute, HCFA elected to implement a payment system based on groups of services rather than individual services. Although services grouped together were required to be clinically comparable and comparable with respect to resource use, the variability in costs of services grouped together varies widely for many of the payment groups.

Explanation of Provision

The bill would require HCFA to establish an outlier policy for extremely high cost cases. Specifically, the Secretary is permitted to set an outlier pool based on up to 2.5 percent of total payments for the first three years under the new payment system, and up to 3 percent of total payments in subsequent years. Services under the outpatient PPS would be eligible for an outlier payment if the cost of providing the service exceeded a threshold set by the Secretary. The amount of the outlier payment would be set by the Secretary to approximate the marginal cost of the service in excess of the threshold.

The bill also provides for transitional payments to cover the add-on costs of certain services involving the use of medical devices, drugs and biologicals. For three years after implementation of the outpatient PPS, orphan drugs, drugs and biologicals used in cancer therapy, medical devices, drugs and biologicals which were not paid as hospital outpatient services in the 1996 base year are eligible for

these payments. The transitional payments are made for a period of at least two years but not more than three years.

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

The total amount of additional payments in a year should not exceed a prescribed percentage of total projected payments under the outpatient prospective payment system. The percentage is established at 2.5 percent for the first three years after implementation of the new outpatient payment system and up to 2.0 percent in subsequent years.

The bill also seeks to limit variation in costs among services included in a group. The most costly item or service in a group could not have a mean or median cost that was more than twice the mean or median cost of the least costly item or service in the group. The Secretary would be given the flexibility to base the relative payment weights on either mean or median cost of the items and services in a group. The Secretary would be required to review the OPD payment groups and amounts annually and to update them as necessary.

Importantly, these provisions would not alter the rules for determining the beneficiary coinsurance. In addition, all of the changes in this bill would be implemented in a budget neutral manner.

Reason for Change

The provisions ensure that beneficiaries have access to the newest and most effective medical technology, drugs and biologics. This section expands the APCs so that they are clinically and economically more appropriate. Currently, expensive procedures are being inappropriately "grouped" with low-cost procedures, thus causing their Medicare reimbursement levels to be extremely low. As a result, the most innovative services may not be offered to Medicare beneficiaries because it would not be financially feasible for hospitals (or manufacturers) to offer such products and services.

The legislation also creates an outlier payment for hospitals so they can offer the newest technology to patients without taking a financial loss. In addition, there is an exemption from the prospective payment system (PPS) for certain medical devices, drugs and biologics so that both hospitals and suppliers are not losing money when providing the newest technology, orphan drugs, and cancer drugs to patients.

Effective Date

Upon enactment.

Subtitle B. Physicians Services

Section 221. Technical Amendment to Update Adjustment Factor and Physician Sustainable Growth Rate.

Current Law

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

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

Prior to the enactment of BBA 97, the Secretary was required to make a conversion factor update recommendation to the Congress by April 15 of each year. The Physician Payment Review Commission (one of MedPAC's predecessor Commissions) was required to comment on the Secretary's recommendation and make its own recommendation by May 15. BBA 97 eliminated these requirements.

Explanation of Provision

Subsection (a) implements technical changes to limit oscillations in the annual update to the conversion factor used to determine physician payment rates beginning in calendar year 2000. This is accomplished in three ways. First, the provision requires that future update adjustment factors be calculated using data measured on a calendar year basis. This will ensure that the time periods used for variables used in the update adjustment formula conform to the calendar system used for updating payments. In addition, the provision modifies the formula for determining the update adjustment factor by adding a new component to the formula to measure past year variances from allowed spending growth. This measure is to be used in conjunction with the existing formula component that measures cumulative spending variances from the sustainable physician payment baseline established in 1997. Finally, the impact of these measures on the update formula are mitigated by the addition of dampening multipliers. Both formula changes are designed to lessen oscillations in the annual update adjustment factor and thereby make annual adjustments in the conversion factor less severe.

The subsection includes language requiring the Secretary to develop CY 1999 allowed expenditure targets based on current law so that a budget-neutral transition to the revised system can begin with CY 2000. The subsection also clarifies that the Secretary is to publish annual updates to the conversion factor on November 1st, while adding a new requirement that she publish an early estimate of such conversion factor by April 1st each year. In addition, MedPAC is instructed to review this early estimate and comment on it in its annual report to Congress. The subsection also includes conforming technical amendments.

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

The Secretary, acting through the Administrator of the Agency for Health Care Policy and Research, would conduct a study on the utilization of physicians services under the fee-for-service program by Medicare beneficiaries. The study would include an analysis of: (1) the various methods for accurately estimating the economic impact on physician expenditures of improvements in medical capabilities, advancements in scientific technology, demographic changes, and geographic changes in where beneficiaries receive benefits; (2) the rate of usage of physicians services by age group; and (3) other factors that may be reliable predictors of utilization. The Secretary would submit the report to MedPAC within 3 years of enactment. MedPAC would be required to report to Congress on such report within 180 days of receipt.

Reason for Change

The bill corrects what HCFA actuaries have determined to be unstable aspects of the SGR system that will cause payments to fluctuate widely from year to year. A second problem that has been identified is that once the SGR target is set for a year, it cannot be changed, even to correct for estimation errors and even if better data become available. The bill would address these shortcomings of the new system.

Effective Date

Upon enactment.

Section 222. Clarification of the Inherent Reasonableness (IR) Authority.

Current Law

The BBA 97 provided the Secretary of HHS with enhanced authority to adjust Medicare Part B payment levels when those payments are not found to be "inherently reasonable." HCFA has proposed through its durable medical equipment regional carriers (DMERCs), applying the new inherent reasonableness authority to a variety

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of medical equipment items. HCFA promulgated its new IR authority via an interim final rule rather than a proposed rule with traditional notice and comment period.

Explanation of Provision

The bill would also require the Secretary to suspend use of the inherent reasonableness authority. This suspension would be in place until 3 months following the release of a report by the GAO on the impact of the Secretary's use of the inherent reasonableness authority to date.

Reasons for Change

Several concerns have been raised regarding HCFA's use of the IR authority. Specifically, it is possible that use of the IR authority may have a negative impact on patients. Additionally, GAO is conducting an examination of the statute and regulation to determine whether HCFA is appropriately using its enhanced IR authority.

Effective

Upon enactment.

TITLE III-PROVISIONS RELATING TO PARTS A AND B

Subtitle A-Home Health Services

Section 301. Modify the 15% contingency reduction to home health agencies.

Current Law

BBA 97 required the Secretary to implement a prospective payment system for Medicare home health care cost reporting periods beginning on or after October 1, 1999, and required that the new system be designed to reduce the initial aggregate cost of Medicare home health care by 15%. The BBA allows a transition period for implementation of the new system of not longer than 4 years.

The BBA put in place an "interim payment system" for home health care to replace temporarily the prior retrospective system that reimbursed home health agencies for the lesser of their reasonable costs or a limited amount per visit, applied in the aggregate. (The limit was 112% of the national average cost, which was calculated separately for each type of service such as nursing or therapy.) The interim payment system applies a new methodology, based on the least of agency costs, per visit limits, or agency average costs per beneficiary in fiscal year 1994 (with certain updates), to determine aggregate payments to home health agencies. The interim system is to remain in effect until implementation of the prospective payment system. The BBA provides that if the new prospective payment system were not ready for implementation on October 1, 1999, the cost limits and per beneficiary limits then in effect under the interim system would be reduced by 15%.

The Omnibus Consolidated and Emergency Supplemental Appropriations Act for Fiscal Year 1999 (P.L. 105-277) moved implementation of the home health care prospective payment system to October 1, 2000, and moved the 15% reduction in cost limits and per beneficiary limits to coincide with implementation of the prospective payment system on October 1, 2000. Should the prospective payment system not be implemented on October 1, 2000, payment limits to home health agencies will be reduced by 15%, and when the prospective payment system is subsequently implemented it will be budget neutral compared to the interim payment levels with the 15% reduction.

Explanation of Provision

This provision would delay implementation of the scheduled 15% reduction in per beneficiary and per visit limits until the new prospective payment system is implemented.

Reason for Change

Implementing the scheduled reduction in home health payments simultaneously with the new prospective payment system is necessary to ease the administrative burden on agencies. The bill ensures that any reduction in payments would not occur under the interim payment system but would be delayed until PPS is implemented.

Effective Date

Upon enactment.

Section 302. Delay in the 15 percent reduction in payments under the PPS for home health service.

Current Law

BBA 97 required the Secretary of HHS to implement a prospective payment system for Medicare home health care cost reporting periods beginning on or after October 1, 1999, and required that the new system be designed to reduce the initial aggregate cost of Medicare home health care by 15%. The BBA allows a transition period for implementation of the new system of not longer than 4 years. The Consolidated and Emergency Supplemental Appropriations Act for 1999 delayed implementation to October 1, 2000, and retained the requirement for payments to be reduced by 15% in the aggregate.

Explanation of Provision

The bill would require the home health prospective payment system to be structured so that total Medicare payments for home health services would be reduced by 15% compared with the pre-prospective payment system year over a 3 year phase-in period. In fiscal year 2001 the prospective payment system payments would be 5% less than the prior year, which would be the base year; in the second year, costs would be 10% less than the base year; and in the third year costs would be 15% less than the base year.

Reason for Change

The bill would moderate the impact of the scheduled 15% reduction in payments under the prospective payment system for home health services by requiring that the reduction be phased-in over three years. This provision ensures that home health patients, particularly high cost patients, will continue to receive access to quality home health care services.

Effective Date

Upon enactment.

Section 303. Increase in per visit limit.

Current Law

The Omnibus Consolidated and Emergency Supplemental Appropriations Act for fiscal year 1999 (P.L. 105-277) increased the limits on per-visit payments to home health agencies beyond those specified in BBA 97. BBA 97 limited per visit payments to 105% of the national median payment, and P.L. 105-277 increased it to 106% of the national median. HCFA estimates that about one-fifth of agencies are subject to the per visit limit because it is less than the per beneficiary limit that would apply to them.

Explanation of Provision

The bill would increase the per visit limit to 112% of the national median.

Reason for Change

The per visit limits are particularly problematic for home health providers in rural areas because of the travel distances required for providers to see patients. These providers are reportedly more likely to exceed the payment caps than providers in urban areas. This bill would assist rural home health agencies and low-cost agencies that have been disadvantaged under the interim payment system by increasing the per visit limit for patient cost reimbursement.

Effective Date

October 1, 1999.

Section 304. Increase Per Beneficiary Limits for Home Health Agencies.

Current Law

Under the interim payment system that BBA implemented temporarily until the home health prospective payment system is implemented, home health agencies receive payments from Medicare that are the least of three amounts: (1) the agency's reasonable costs; (2) aggregate payments determined under limits per visit set at

105% of the national median cost per visit (the bill would increase it to 112%); or (3) aggregate payments under a formula based on average payments per beneficiary. About one-fifth of agencies receive payments under the per visit limit and the remainder receive payments under the per beneficiary formula. The per beneficiary aggregate limit does not restrict the amount a home health agency can spend on any individual, it is simply a technique for arriving at an aggregate budget amount for an agency's Medicare patients. For long-standing home health agencies, the per beneficiary limit is derived from the average payment the agency received for Medicare beneficiaries in fiscal year 1994 (with certain updates and adjustments); for newer agencies the per beneficiary limit is the median of the limits applied to other agencies. The average annual per beneficiary limit is approximately $3,800 but ranges up and down by about $1,200.

The prospective payment system is scheduled to replace the interim system in October 2000.

Explanation of Provision

The bill would add 1.0% to the amount of an agency's per beneficiary limit.

Reason for Change

Since 1994, many agencies have undergone changes in their caseload and in the characteristics of the Medicare beneficiaries they serve. A small increase in the per beneficiary limit would provide some relief during the remainder of the interim payment system.

Effective Date

Upon enactment.

Section 305. Elimination of 15-minute billing requirement.

Current Law

The BBA 97 requires home health agencies to keep track of and report their activities during a home visit in 15-minute increments.

Explanation of Provision

The bill would repeal the requirement that home health agencies report their activities during a home visit in 15-minute intervals.

Reason for Change

The 15-minute reporting requirement was established to collect data in the event that a coding system based on the amount of time a home health provider spent with a beneficiary was developed. However, with the establishment and pending implementation of the proposed prospective payment system, there is no longer a need for the collection of this data.

Effective Date

Upon enactment.

Section 306. Refinement of home health agency consolidated billing.

Current Law

The BBA 97 requires that Medicare payments for items such as durable medical equipment, oxygen and oxygen supplies used by Medicare beneficiaries who are under a home health plan of care be billed to Medicare by the home health agency and be paid by Medicare to the home health agency rather than to the provider or the supplier of the item or equipment. The home health agency would be responsible for paying the supplier.

Explanation of Provision

The bill would exclude durable medical equipment, including oxygen and oxygen supplies, from the consolidated billing requirement.

Reason for Change

Many home health agencies may not be ready to administer the additional administrative burden of billing the Medicare program on behalf of durable medical equipment suppliers. The provision maintains the billing responsibility for home medical equipment with the suppliers of that equipment.

Effective Date

Upon enactment.

Section 307. Study and report to Congress regarding the exemption of rural agencies and populations from inclusion in the home health prospective payment system.

Current Law

No provision.

Explanation of Provision

The bill would require that the Medicare Payment Advisory Commission report to Congress within 2 years of enactment of the act on the feasibility and advisability of including rural populations and rural home health agencies in the prospective payment system.

Reason for Change

Concern has been cited that BBA changes in home health care services, and that the establishment of a prospective payment system, will create undue hardships on

rural home health providers. This provision seeks to determine the effects of the prospective payment system on those providers and will advise Congress on whether these providers or populations should be exempt from the home health prospective payment system.

Effective Date

Upon enactment.

Section 308. Extend periodic interim payments to home health agencies.

Current Law

BBA 97 required that the periodic interim payment system for home health care agencies sunset on October 1, 1999.

Explanation of Provision

The bill would continue the periodic interim Medicare payments to home health agencies through the first year of the prospective payment system..

Reason for Change

This provision allows for a supporting transfer by home health providers from the interim payment system to the PPS.

Effective Date

Upon enactment.

Subtitle B – Graduate Medical Education

Section 321. Revision of multi-year reduction of indirect graduate medical education payments.

Current Law

Prior to BBA, the IME adjustment increased Medicare's hospital payments by approximately 7.7% for each 10% increase in a hospital's ratio of interns and residents to beds. The BBA provided for a reduction in the IME adjustment from the 7.7% to 7.0% in fiscal year 1998; to 6.5% in fiscal year 1999; to 6.0% in fiscal year 2000; and to 5.5% in fiscal year 2001 and subsequent years.

Explanation of Provision

The bill freezes the reduction in the IME adjustment factor to 6.5% in fiscal year 2000 through fiscal year 2003. Beginning in fiscal year 2004, the IME adjustment factor becomes 5.5%.

Reason for Change

The cumulative impact of several BBA provisions has produced an unintended financial burden on teaching hospitals. Payments to these hospitals have been reduced by cuts in payments for the indirect costs associated with medical education (IME payments), cuts in payments to "disproportionate share hospitals" that serve a larger share of low-income patients, and the reduction in payment updates to hospitals as a whole. This provision would restore a portion of the funding reductions that teaching hospitals have experienced.

Effective Date

Retroactive to October 1, 1999.

Section 322. Graduate Medical Education Resident Limitation Exception.

Current Law

The Balanced Budget Act of 1997 (BBA) established a cap on the total number of residents reimbursed under Medicare at the level for the cost reporting ending on or before December 31, 1996.

Explanation of Provision

The Committee's provision would make an exception to limitation on the number of residents who participated in graduate medical education at a facility of the Department of Veteran Affairs, was subsequently transferred on or after January 1, 1997, and before July 31 1998, to a hospital, and was transferred because the approved medical residency program in which the resident or intern participated would lose accreditation by the Accreditation Council on Graduate Medical Education if such program continued to train residents at the Department of Veterans Affairs facility.

If the Secretary of HHS determines that a hospital operating an approved medical residency program is owed payments because of this provision, the Secretary shall make such payments within 60 days of enactment.

Reason for Change

The provision is intended to provide relief to a certain hospital in North Dakota, which took on a limited number of residents from a Veteran's Affairs facility that was to lose accreditation by the Accreditation Council on Graduate Medical Education, after the resident limitations were applied in the BBA.

Effective Date

This section shall take place as if included in the Balanced Budget Act of 1997.

TITLE IV— RURAL INITIATIVES

Section 401. Sole Community Hospitals and Medicare Dependent Hospitals.

Current Law

Medicare pays most acute care hospitals under a prospective payment system (PPS) where a fixed predetermined amount is paid according to the patient's diagnosis. Payments to PPS hospitals are updated annually using an update factor which is determined in part by the projected increase in the hospital market basket index (MBI). BBA 97 included a 0% update for fiscal year 1998; the MBI minus 1.9 percentage points for fiscal year 1999; the MBI minus 1.8 percentage points for fiscal year 2000; the MBI minus 1.1 percentage points for fiscal year 2001 and fiscal year 2002; and for fiscal year 2003 and each subsequent year, the MBI percentage increase.

Explanation of Provision

This provision would provide selected rural hospitals, that is, sole community hospitals and Medicare dependent hospitals, the MBI in fiscal year 2000 and in each subsequent year.

Reason for Change

Rural hospitals are among the providers most affected by the changes brought forth in the BBA. This provision recognizes the particular needs of rural health care delivery and addresses those needs by providing additional funding for inpatient, acute care services.

Effective Date

Effective October 1, 1999.

Section 402. Revision of Criteria for Designation as a Critical Access Hospital.

Current Law

BBA 1997 established the criteria for a small, rural, limited service hospital to be designated as a critical access hospital (CAH). These hospitals are required to be a rural nonprofit or public hospital either located more than 35 miles away (or given geographic constraints, 15 miles away) from another hospital and certified by the State as a necessary provider. The CAHs provide 24-hour emergency services, have up to 15 acute care inpatient beds (or up to 25 beds if CAH is also a swing bed provider) and have hospitals stays of no more than 96 hours except under certain circumstances. For instance, a longer inpatient stay is permitted if inclement weather or other emergency circumstances prevent the transfer of a patient to another hospital; alternatively, a peer review organization or comparable entity may waive the 96-hour restriction on a case-by-case basis.

Explanation of Provision

This provision would change the 96-hour restriction on individual inpatient hospital stays to a requirement that the *average* inpatient stay of patients not exceed 96 hours.

Reason for Change

This change would provide increased flexibility and choice for rural health care delivery settings. The provision also eliminates increased administrative burdens on these facilities.

Effective Date

Effective October 1, 1999.

Section 403. Medicare Waivers for Providers in Rural Areas.

Current Law

Medicare's payments to acute hospitals vary depending upon the geographic location of the hospital. Specifically, hospitals are paid using an average standardized amount. Two standardized amounts are calculated: one for hospitals located in large urban areas and one for hospitals located in other areas--both smaller urban and rural counties. Large urban areas are statutorily defined to be a metropolitan statistical area (MSAs) as defined by the Office of Management and Budget or within a similar area as defined by the Secretary that has a population of more than 1 million as measured by the most recently available Bureau of Census data. Urban areas are defined to be MSAs and rural areas are areas outside of MSAs.

Explanation of Provision

This provision would permit a hospital that is considered to be in an urban or large urban area, for the purposes of PPS reimbursement using the existing definition, to be treated as a hospital in a rural area if classified as such by either of two alternative definitions. The Secretary is directed to set up a waiver process within 180 days of enactment of this legislation whereby hospitals currently treated as urban or large urban would be treated as rural if located in a rural area within a metropolitan county as defined by the most recent update of the Goldsmith Modification or as determined by the census tract definition adopted by the Office of Rural Health Policy.

Reason for Change

Because MSAs are based on county boundaries, some cover large geographic areas that include rural areas. For purposes of Medicare reimbursements and policies, this provision would allow hospitals and providers to be considered rural even if they are located in MSAs, if they meet certain other definitions of rural. The provision would allow these providers to participate in programs aimed at expanding access in rural areas.

Effective Date

Upon enactment.

Section 404. Extending Medicare Dependent Hospitals.

Current Law

BBA 1997 extended the Medicare Dependent Hospital Program for cost reporting periods beginning on or after October 1, 1997 and before October 1, 2001, applicable with respect to discharges occurring on or after October 1, 1997.

Explanation of Provision

The change would extend the Medicare Dependent Hospital program for discharges occurring after October 1, 1997 and before October 1, 2003.

Reason for Change

These hospitals are vital to ensuring access to care for Medicare beneficiaries in rural areas. Extending Medicare Dependent Hospitals is important to the communities served by these providers.

Effective Date

As if included in the Balanced Budget Act of 1997.

Section 405. Assisting Rural Graduate Medical Education Residency Programs.

Current Law

In general, BBA 1997 limited the number of residents that Medicare will count for reimbursement of graduate medical education to the total recognized by the hospital in their cost reporting period ending on or before December 31, 1996.

Explanation of Provision

This provision would expand the number of residents reimbursed by Medicare to those appointed by the hospitals' approved medical residency training programs for cost reporting periods ending on or before December 31, 1996; would allow hospitals that sponsor only one residency program to increase their resident count by one per year, up to a maximum of three; would allow hospitals to count residents associated with new training programs established on or after January 1, 1995 *and before September 30, 1999;* would instruct the Secretary to give special consideration to facilities that meet the needs of underserved rural areas including those facilities that are not located in the area but have established separately accredited rural training tracks.

Reason for Change

Language in the BBA unintentionally excluded certain residents affiliated with approved residency programs from the count in determining the resident caps. This provision will allow hospitals to adjust their count to include resident's appointed by the hospital in 1996 but not currently counted. In addition, it will boost rural residency programs by allowing them to exceed current resident limits.

Effective Date

As if included in the Balanced Budget Act of 1997.

TITLE V: PROVISIONS RELATING TO PART C

Subtitle A – Provisions to Accommodate and Protect Medicare Beneficiaries.

Section 501. Permitting Enrollment in Alternative Medicare+Choice Plans and Medigap Coverage in Case of Involuntary Termination of Medicare Enrollment.

Current Law

Some HMOs have announced their intention not to renew their Medicare+Choice contracts or to reduce the service area covered by the contracts. These decisions become effective for the next contract period which begins on January 1, 2000. Most beneficiaries enrolled in these Medicare+Choice plans will be able to enroll in another Medicare+Choice plan in their area. Generally this would occur during the November 1999 open enrollment period; coverage under the new plan would begin January 1, 2000. These beneficiaries could also return to "original Medicare." Beneficiaries in counties with no available managed care plans will be automatically moved to "original Medicare."

Effective January 1, 2002, beneficiaries will only be able to discontinue their enrollment with a Medicare+Choice plan during the annual coordinated election period, except under certain specified conditions.

Persons returning to original Medicare have certain rights with regard to purchase of Medigap plans. Medigap refers to individually purchased insurance policies which supplement Medicare's benefits. Beneficiaries select a policy from one of 10 standardized plans; these are known as Plan A through Plan J.

Individuals who are enrolled with an HMO at the time its contract terminates are guaranteed issue of any Medigap Plan A, B, C, or F that is sold to new enrollees by Medigap issuers in the state. This right must be exercised within 63 days of termination of prior HMO coverage. Since prior coverage is terminated at the end of the calendar year, the 63-day period begins January 1, 2000.

Explanation of Provision

The bill would modify the conditions under which an individual would be entitled to a special election period to include situations where the individual is notified of an impending termination of certification of the plan or an impending termination or discontinuation of the plan.

The bill would modify the Medigap 63-day guaranteed issue provision. At the individual's discretion, the 63-day guaranteed issue period could begin on the date the individual is notified by the plan of either impending termination or discontinuance of the plan in the area where the individual resides.

Reason for change

To ease the transition for beneficiaries whose Medicare+Choice plan leaves the program.

Effective date

Upon enactment.

Section 502. Change in Effective Date of Elections.

Current Law

Under Medicare+Choice, changes of election of coverage during continuous open enrollment periods take effect on the first day of the first calendar month following the date on which the election is made.

Explanation of Provision

The bill would require that the election must occur by the tenth of the month in order to be effective the following month.

Reason for Change

This provision would allow plans time to process the beneficiary's enrollment information and ensure a smooth transition in coverage.

Effective date

Upon enactment.

Section 503. Extension of Reasonable Cost Contracts.

Current Law

Prior to enactment of BBA 97, beneficiaries were able to enroll in risk-based health maintenance organizations (HMOs). They could also enroll in organizations with cost contracts. These entities were required to meet essentially the same

conditions of participation as risk contractors. Under a cost contract, Medicare pays the actual cost the entity incurs in furnishing covered services.

BBA 97 replaced the risk program with Medicare+Choice. It also specified that no new cost contracts could be initiated and most cost-based contracts could not be renewed beyond December 31, 2002.

Explanation of Provision

The bill would extend cost contracts through December 31, 2004. However, after December 31, 2003, cost contractors could not enroll any persons who had not been enrolled in the plan on that date.

Reason for change

There are a small number of pre-BBA "cost contracts" that are scheduled to expire in 2002. This provision would allow these plans another two years of operation. This provision would allow both the beneficiaries and the plans additional time to transition to the Medicare+Choice program.

Effective Date

Upon enactment.

Section 504. Revision of Notice by Hospitals Regarding Coverage of Inpatient Hospital Services.

Current Law

Hospitals are required to provide patients, on or about the time of admission, a written statement. This statement must contain information on the individual's rights to benefits; the circumstances under which an individual would, and would not, be liable for charges for continued stays in a hospital; the individual's right to appeal benefit denials; and the individual's liability if the denial is upheld on appeal.

Explanation of Provision

The provision specifies that the notice must be provided within 16 - 24 hours prior to discharge. It would also modify the notice requirements. The notice would be required to include a specific mention that appeals for continued stays are made to the peer review organization. The notice would also be required, in the case of a Medicare+Choice enrollee, to contain additional information, as determined by the Secretary, regarding appeal rights.

Reason for Change

This provision would have the traditional fee-for-service program operate under the same rules as the Medicare+Choice program in informing beneficiaries of their rights to appeal when being discharged from the hospital, creating a "level playing field" between the traditional program and the Medicare+Choice plans. This would

also ensure that all beneficiaries are informed of their appeal rights. HCFA is more than willing to implement this change, but requires statutory authority to proceed.

Effective Date

Upon enactment.

Section 505. Extended Medicare+Choice Disenrollment Window for Certain Involuntarily Terminated Enrollees.

Current Law

The law guarantees issuance of specified Medigap policies (without an exclusion based on a pre-existing condition) for certain persons. Guaranteed issue protections extend to certain persons who elect to try out one of the options available under the Medicare+Choice program. An individual is guaranteed issuance of the Medigap policy in which he or she was previously enrolled if the individual terminated enrollment in a Medigap policy, enrolled in a Medicare+Choice organization, and then terminated such enrollment within 12 months. The guarantee only applies if the individual was never previously enrolled in a Medicare+Choice plan.

One group of persons is guaranteed issuance of any Medigap policy. These are persons who, when they first become entitled to Medicare at age 65, enroll in a Medicare+Choice plan and disenroll from the plan within 12 months.

Explanation of Provision

The bill would extend the period when re-enrollment was allowed for these persons if their enrollment in a Medicare+Choice plan was involuntarily terminated either because the plan's certification is terminated or the organization no longer provides the plan in the individual's service area. The 12-month period would begin when the individual re-enrolled in a Medicare+Choice organization or plan.

Reason for change

The purpose of the provision is to ease the transition for beneficiaries who lose their Medicare+Choice plan. To provide these beneficiaries with the option of returning to the traditional fee-for-service program and securing Medigap coverage.

Effective Date

Upon enactment.

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

Section 521. Moderation of Medicare+Choice Risk Adjustment Implementation.

Present law

Currently HCFA plans to implement the risk adjustment of Medicare+Choice plan payments by 2004. This was done administratively by HCFA, so any changes to the phase-in formula will be necessary only if the Administration is unwilling to make the suggested changes administratively.

Explanation of provision

Under the proposal, risk adjustment would be fully phased in 2006, rather than 2004. The table below details the current phase-in formula, as well as the proposed change.

Proposed Modifications to the Risk Adjustment of Medicare+Choice Payments			
Year	Current HCFA Proposal	Proposed Modification	Type of Risk Adjuster
2000	10%	10%	inpatient only
2001	30%	10%	inpatient only
2002	55%	20%	inpatient only
2003	80%	30%	inpatient only
2004	100%	55%	inpatient and outpatient[1]
2005	100%	80%	inpatient and outpatient[2]
2006	100%	100	inpatient and outpatient[3]

[1] The proposal would also phase-in the introduction of the new risk adjustment method that includes both inpatient and outpatient data. In 2004, the first year outpatient data would be used, the payment would be a mix where 67 percent of the risk-adjusted portion would be based on the old method (inpatient data only) and 33 percent would be based on the new method (both inpatient and outpatient data).

[2] In 2005, 33 percent of the risk-adjusted portion would be based on the old method and 67 percent based on the new method.

[3] By 2006, the new risk adjustment method that uses both inpatient and outpatient data would comprise 100 percent of the payment.

Reason for change

In the last two years, plans have found the Medicare program to be an increasingly volatile business environment. Plans are concerned that the current implementation schedule will result in further volatility and cuts in their payments, which could lead to further plan withdrawals. By slowing the implementation of risk adjustment, plans will see smaller cuts and less volatility. In addition, in 2004 the risk adjuster will be changed to include both inpatient and outpatient data, while this should be an improvement, it will add to the uncertainty and volatility of plan payments. By slowing the phase-in, only 55% of plan payments will be risk adjusted in 2004, rather than 100% as under the HCFA plan.

Effective date

Upon enactment.

Section 522. Delay in Deadline for Submission of Adjusted Community Rates Under Medicare+Choice Program and Related Modifications.

Current Law

BBA 97 required Medicare+Choice plans to submit adjusted community rate (ACR) proposals by May 1 of the year prior to the actual contract year. Medicare+Choice organizations are required to submit ACR proposals to show that the benefit packages they plan to market neither exceed cost sharing for traditional Medicare plans nor unfairly charge enrollees for additional benefits.

Under the law in effect prior to BBA 97, risk plans had a November 15 deadline for submission of their ACRs. The earlier deadline means that Medicare+Choice organizations must now project future payments and costs six months further out. The earlier deadline was selected, in part, to ensure HCFA had the time both to review and approve submissions and to include information on all plan choices in the information sent to beneficiaries before the annual open enrollment season.

Explanation of Provision

The bill would delay the deadline for the ACR submission to July 1. It would also require that any organization that wished to terminate its contract at the end of the contract year must inform the Secretary of such fact by not later than July 1.

The bill would also modify the requirement that the Secretary make available to beneficiaries, during the annual open enrollment period, comparative information on all plan choices. The requirement would apply to the extent such information was available at the time of the preparation of the material for mailing.

Reason for change

Administratively the May 1 deadline has proven to be unreasonable. HCFA has allowed plans until July 1, but needs statutory authority to be able to continue the practice.

The second part of the provision allows the Secretary flexibility to provide beneficiaries with whatever information is available in a timely manner.

Effective Date

Upon enactment.

Section 523. User Fee for Medicare+Choice Organizations Based on the Number of Enrolled Beneficiaries.

Current Law

The law requires the Secretary to collect a user fee from each Medicare+Choice organization for use in carrying out: (1) the enrollment activities and distribution of related information for Medicare+Choice; and (2) the health insurance and counseling and assistance program. The user fee is equal to the organization's pro rata share of the aggregate amount of fees collected from Medicare+Choice organizations. Collection of fees is contingent upon enactment of appropriations. All beneficiary education activities are financed by the Medicare+Choice user fees, although only 15 percent of all beneficiaries are enrolled in Medicare+Choice plans.

Explanation of Provision

The bill specifies that the aggregate amount of fees collected would be based on the number of beneficiaries in Medicare+Choice plans compared to the total number of Medicare beneficiaries. The limit on the total amount available in a fiscal year to the Secretary to carry out the functions would be $100 million. No further appropriation would be required.

Reason for Change

The information campaign is key to ensuring that beneficiaries have proper information to make prudent choices between plan options, including the traditional fee-for-service plan. Currently the Medicare+Choice plans pay the full cost of supplying information to beneficiaries concerning their Medicare benefits, including enrollment and plan options, although the Medicare+Choice plans comprise only about 15 percent of Medicare enrollees. Allowing HCFA the ability to use the Part A trust fund to finance these essential beneficiary information activities ensures the program will be able to meet its obligation in this key area.

Effective Date

Upon enactment.

Section 524. Change in Time Period for Exclusion of Medicare+Choice Organizations That Have Had a Contract Terminated.

Current Law

The law specifies that the Secretary cannot enter into a Medicare+Choice contract with a Medicare+Choice organization, if within the preceding five years, that organization had a Medicare+Choice contract which it did not renew. An exception may be made for special circumstances that warrant special consideration, as determined by the Secretary.

HCFA has indicated that it will apply the prohibition only in cases where the entire contract is nonrenewed. Thus, the ban would not apply if an organization dropped a single county from a service area while retaining the rest of the service area. It would also not apply if a managed care organization nonrenewed one plan under a contract but retained other plans in that contract.

Explanation of Provision

The bill would provide that the exclusion period would be reduced from five years to two years.

Reason for Change

The logic behind the original lengthy exclusion is to keep plans from dropping in and out of the program. In practice this has not been a problem. In addition, other similar programs, such as the Federal Employees Health Benefits Program (FEHBP), have no such exclusion.

Effective Date

Upon enactment.

Section 525. Flexibility to Tailor Benefits Under Medicare+Choice Plans.

Current Law

In general, M+C managed care plans offer benefits in addition to those provided under Medicare's benefit package. In certain cases, the beneficiary has the option of selecting the additional benefits, while in other cases some or all of the supplementary benefits are mandatory.

Some plans may require members to accept additional benefits, and pay extra for them in some cases. The amount a plan may charge for additional benefits is based on a comparison between the plan's adjusted community rate (ACR, essentially the estimated market price) for the Medicare package and the average of the M+C

payment rate. A plan must offer "additional benefits" at no additional charge if the plan achieves a savings from Medicare.

If the difference between the average M+C payment rate and the adjusted ACR is insufficient to cover the cost of additional benefits, the plan may charge a supplemental premium for the benefits. Under current law, the monthly basic and supplemental premiums, benefits covered, and cost sharing may not vary among individuals enrolled in the plan.

Explanation of Provision

The bill would allow plans to vary premiums, benefits, and cost sharing across individuals enrolled in the plan so long as these were uniform within an entire segment in a service area. A segment would comprise one or more counties within the plan's service area.

Reason for Change

Before the BBA, plans could offer different benefits in different counties, paralleling the different payment rates found in different counties. More benefits could be offered in counties with higher payment rates. The BBA would require uniform benefits across all counties a plan serves in a particular market. In the interim, HCFA has allowed plans to "segment" their markets into groups of counties. This provision would allow that interim practice to continue.

Effective Date

The provision would apply to contract years beginning on or after January 1, 2000.

Section 526. Inapplicability of QISMC to Preferred Provider Organizations.

Current Law.

In implementing the statutory requirement that Medicare+Choice plans have ongoing quality assurance programs, the Secretary has required that participating plans meet Quality Improvement System for Managed Care (QISMC) standards and guidelines.

Explanation of Provision

The bill would exempt Medicare+Choice preferred provider organizations from the requirements of QISMC. If the Secretary establishes requirements similar to QISMC's for fee-for-service providers participating under Parts A and B of Medicare, then preferred provider organizations would be required to comply with them.

Reason for Change

Preferred Provider Organizations (PPO) in many ways operate more like a fee-for-service plan than a health maintenance organization. Standards developed for HMOs appear to have discouraged the entry of PPO plans into the Medicare+Choice system, because these standards are incompatible with the financing and delivery model of PPOs. This change would hold PPO plans to the same standards as the fee-for-service program, rather than those used for HMOs.

Effective Date

The provision would apply to contract years beginning on or after January 1, 2000.

Section 527. To provide HCFA with flexibility with regard to the timing of health information fair activities.

Current Law

Current law establishes an annual coordinated election period in November of each year for individuals to elect or change their election of a Medicare+Choice plan. The law also provides for a nationally coordinated information and publicity campaign, to be held in the month of November, to inform beneficiaries concerning their Medicare+Choice options.

Explanation of Provision

The provision would permit HCFA to conduct the information campaign earlier in the fall season. This would give HCFA flexibility with regard to the timing of health information fair activities.

Reason for Change

To allow beneficiaries access to information about plans choices as early as possible.

Effective Date

Upon enactment.

Section 528. Rules Regarding Physician Referrals for Medicare+Choice program.

Current Law

The law establishes a ban on certain financial arrangements between a referring physician and an entity. Specifically, if a physician (or immediate family member) has an ownership or investment interest in or a compensation arrangement with an entity, the physician is prohibited from making a referral to the entity for services for which Medicare would otherwise pay. Current law provides an exception

to both the ownership and compensation arrangement prohibitions for services provided by an organization with a contract under section 1876.

Explanation of Provision

The provision would extend this exception to Medicare+Choice coordinated care plans.

Reason for Change

To ensure that Medicare+Choice plans are excepted from self-referral laws for practices that are considered routine or characteristic of managed care providers.

Effective Date

Upon enactment.

Section 529. To clarify that an eligible fraternal benefit organization can offer a fee-for-service option under Medicare+Choice.

Current Law

Current law permits religious fraternal benefit societies that offer Medicare +Choice plans to restrict enrollment in such plans to their members. Currently, this allowable restriction applies only to coordinated care plans.

Explanation of Provision

The provision would extend the authority to private-fee-for-service plans.

Reason for Change

To correct a drafting error made during BBA97, which put religious fraternal benefit societies, such as the Mennonite Mutual Aid, into the plan category designed for HMOs, rather than into the category for fee-for-service plans.

Effective Date

Upon enactment.

Subtitle C-Provisions regarding special Medicare populations

Section 541. Extension of social health maintenance organizations.

Current Law

The Deficit Reduction Act of 1984 required the Secretary of HHS to grant 3-year waivers for demonstrations of social health maintenance organizations (SHMOs) which provide integrated health and long-term care services on a prepaid

capitation basis. The waivers have been extended on several occasions since then, and a second generation of projects was authorized by the Omnibus Budget Reconciliation Act of 1990.

The 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.

Explanation of Provision

The bill would extend the waivers for first and second generation social health maintenance organizations (SHMO) one year after their respective reports are issued by the Secretary of HHS.

Reason for Change

The Secretary has not issued a report on the effectiveness of these demonstrations. This provision would ensure that the demonstrations not expire before the Secretary's report is issued and that there is ample time to act after the results of the report are known.

Effective Date

Upon enactment.

Section 542. Inapplicability of OASIS to PACE.

Current Law

BBA 97 authorized HCFA to undertake research and data collection to develop a case mix adjustment system for the home health prospective payment system. HCFA has used that authority to require home health agencies to administer and report information from a data collection instrument known as the Outcome and Assessment Information Set (OASIS), which had been under design and pilot testing for several years. OASIS will permit HCFA to obtain information on which to base the design and case mix adjustment of the home health care prospective payment system. It is a questionnaire required to be administered by a home health worker to home health beneficiaries at the start of a spell of care and occasionally thereafter.

PACE is a managed-care approach to integration of acute care and long-term care services for the frail elderly. Enrollment is limited to individuals whose impairments are severe enough that they meet state nursing home admission requirements, but the objective is to maintain the individuals in their homes and in the community. PACE originally operated in a limited number of sites as a demonstration project and the BBA 97 made it a permanent component of Medicare, allowing up to 40 sites to be approved in 1998 and 20 more to be added annually thereafter.

Explanation of Provision

The bill would prohibit the Secretary from applying the data collection and reporting requirements of OASIS to home health services provided by PACE directly, or through a contract with a home health care agency.

Reason for Change

OASIS is designed to collect data from home health agencies. While PACE plans do provide home health services, they receive capitated payments based on the Medicare+Choice plan payment formula. The collection of OASIS data under these circumstances is unwarranted.

Effective Date

Upon enactment.

Section 543. Medigap Protections for PACE program enrollees.

Current Law

The law guarantees issuance of specified Medigap policies (without an exclusion based on a pre-existing condition) for certain persons. Guaranteed issue protections extend to certain persons who elect to try one of the options available under the Medicare+Choice program. An individual is guaranteed issuance of the Medigap policy in which he or she was previously enrolled if the individual terminated enrollment in a Medigap policy, enrolled in a Medicare+Choice organization, and then terminated such enrollment within 12 months. The guarantee only applies if the individual was never previously enrolled in a Medicare+Choice plan.

One group of persons is guaranteed issuance of any Medigap policy. These are persons who, when they first become entitled to Medicare at age 65, enroll in a Medicare+Choice plan and disenroll from the plan within 12 months.

Explanation of Provision

The bill would extend the re-enrollment protections provided beneficiaries whose Medicare+Choice plan withdraws from their county to beneficiaries whose PACE plan withdraws from their county. These protections would include re-enrollment in their previous Medigap plan and the restarting of their 12-month trail period.

Reason for change

The purpose of the provision is to ease the transition for beneficiaries who lose their PACE option. To provide these beneficiaries with the option of returning to the traditional fee-for-service program and secure Medigap coverage.

Effective Date

Upon enactment.

Section 544. Continuation of the Frail Elderly Demonstration Project.

Current Law

The EverCare demonstration project allows frail elderly beneficiaries in Medicare+Choice plans access to additional, specialized benefits and services. These demonstrations are due to expire at the end of 2000.

Explanation of Provision

This provision would extend the EverCare demonstration two additional years until 12/31/02. It would also exempt the EverCare demonstration project from the new risk adjustment methodology for one year. In addition, the demonstration project could employ an open enrollment policy.

Reason for Change

The EverCare program's focus on the frail elderly makes it especially vulnerable to certain aspects of the new risk adjustment methodology. MedPAC has issued a report detailing the need for certain technical adjustments to by made to the proposed risk adjustment methodology. This two-year extension would allow HCFA and MedPAC additional time to develop a more effective risk adjuster for the frail elderly. In addition, the open enrollment feature would allow beneficiaries easier access to needed services.

Effective Date

Upon enactment.

Subtitle D - Studies and Reports to Assist in Making Future Improvements in the Medicare Program.

Section 561. GAO Studies, Audits and Reports.

Current Law

The Secretary is required to provide information to Medicare beneficiaries on the Medicare+Choice program.

Explanation of Provision

The bill would require GAO to conduct a study on Medigap policies. The report would include a study of: (1) the level of coverage provided by each type of Medigap policy; (2) the current enrollment levels in each type of policy; (3) the availability of each type of policy to persons over age 65 ½; (4) the number of states that offer each

type of policy; and (5) the average out-of-pocket costs (including premiums) per beneficiary under each type of policy.

The bill also would require the General Accounting Office (GAO), beginning in 2000, to conduct an annual audit of the Secretary's expenditures for providing information on Medicare+Choice to beneficiaries. By March 31 of 2000, 2003, 2006, and 2009, the GAO would submit the results of the preceding year's audit to Congress. The report would also include an evaluation of the effectiveness of the means used to provide the information.

Reason for Change

Millions of Medicare beneficiaries rely on supplemental Medigap plans to provide additional coverage beyond what they receive from the Medicare fee-for-service plan. Information on the availability, adequacy and expense of such coverage is essential for a complete understanding of the coverage protections available to the Medicare population.

In the past, questions have been raised about the adequacy and effectiveness of the information HHS provides beneficiaries on their coverage options under both Medicare+Choice and the traditional fee-for-service plans. This provision asks GAO to audit this activity and report on the effectiveness of the program every three years. This information is provided to the Congress to help improve the information process.

Effective Date

GAO would report its Medigap findings to Congress by July 1, 2001.

GAO would submit the results of the preceding year's audit by March 31 of 2001, 2004, 2007, and 2010.

Section 562. Medicare Payment Advisory Commission Studies and Reports.

Current Law

The Medicare Payment Advisory Commission (MedPAC) is required to review Medicare payment policies and prepare annual reports to Congress on the results of the reviews.

Explanation of Provision

The bill would require MedPAC to conduct a study that evaluates the methodology used by the Secretary in developing risk adjustment factors for Medicare+Choice capitation rates. Specific issues would include: The ability of risk adjustment to explain variations in plans' average per capita costs. The year-to-year stability of risk adjustment factors, especially for plans with smaller enrollments. Risk adjustment factors for beneficiaries entering and exiting Medicare+Choice plans. A report on the study, together with any recommendations, would be due to the Congress by December 1, 2000.

The bill would also require MedPAC to conduct a study on the development of a payment methodology under the Medicare+Choice program for frail elderly beneficiaries enrolled in a specialized program for the frail elderly. Such payment methodology would account for: (1) the prevalence, mix and severity of chronic conditions among such beneficiaries; (2) include medical diagnostic factors from all provider settings; and (3) include functional indicators of health status and such other factors that may be necessary to achieve appropriate payments for plans serving such beneficiaries.

Reason for Change

The introduction of risk adjustment in the Medicare+Choice program will result in significant changes in the way plans are paid by Medicare. MedPAC is asked to examine and evaluate the relative effects of the new system under a wide variety of circumstances. MedPAC is asked to provide the Congress with analysis necessary to judge the effectiveness of the new payment methodology.

MedPAC is also asked to analyze and report on the appropriate modifications that may be necessary to ensure that risk adjustment methodologies will prove effective when dealing with the frail elderly. The frail elderly present a particularly complex problem for risk adjustment, as earlier MedPAC analysis brought to light. If there are modifications needed to ensure the frail elderly are properly served in the Medicare+Choice program, the Congress needs to be informed as soon as possible.

Effective Dates

A report on the risk adjustment study, together with any recommendations, would be due to the Congress by December 1, 2000.

The report on an appropriate risk adjustment methodology for the frail elderly would be due to Congress within one year of enactment, together with any legislative recommendations determined appropriate by MedPAC.

Section 563. Computation and Report on Medicare Original Fee-for-Service Expenditures on a County-by-County Basis.

Current law

The Secretary is required to announce M+C payment rates for each payment area, and risk and other factors to be used in adjusting payments, not later than March 1 before the calendar year concerned. At least 45 days before making the announcement for a year, the Secretary must provide for notice to M+C organizations of proposed changes to be made in the methodology and assumptions used in the previous announcement. The Secretary must also provide sufficient detail so that M+C organizations can compute monthly adjusted M+C capitation rates for individuals in each M+C payment area.

The Secretary is not required to publish original fee-for-service expenditures on a county-by-county basis. These data comprise adjusted average per-capita cost (AAPCC) data. AAPCCs formed the basis of payments to managed care plans prior

to enactment of BBA 97, and represented the costs of providing Medicare benefits to beneficiaries under the original fee-for-service program under parts A and B in each county nationwide. Because M+C payments are no longer directly tied to a payment area's fee-for-service costs, AAPCCs have not been published.

Explanation of Provision

The Secretary of Health and Human Services would be required to compute expenditures under the original fee-for-service program under parts A and B of the Medicare program on a county-by-county basis, and submit a report to Congress on the computation. This report would include any recommendations for legislation that the Secretary determines to be appropriate as a result of the computation.

Reason for Change

It is essential to the proper legislative oversight of the Medicare program to have accurate data on the variations in Medicare spending across the country. These data are necessary to judge the cost-effectiveness of Medicare+Choice plans and ensure that their payment rates reflect an appropriate amount for the markets they operate within. The data are equally essential to understand variations in fee-for-services spending in different markets across the country.

Effective Date

The Secretary must submit a report to Congress not later than January 1, 2000, and biannually thereafter.

Section 564. Study and Report on the Effects, Costs, and Feasibility of Requiring Medicare Original Fee-For-Service Entities and Medicare+Choice Coordinated Care Plans to Comply With Uniform Quality Standards and Related Reporting Requirements.

Current Law

Medicare+Choice organizations are required to comply with certain quality standards and related reporting requirements.

Explanation of Provision

The bill would require the Secretary to conduct a study on the effects, costs, and feasibility of requiring fee-for-service providers and entities to comply with quality standards and related reporting requirements which are comparable to those required for Medicare+Choice plans. The study would also include an examination the effects, costs, and feasibility of developing specific quality standards for different types of Medicare+Choice coordinated care plans.

Reasons for Change

As quality has become more of an issue in the Medicare program, the primary emphasis has been on the HMOs. This study would provide analysis to help look

beyond HMOs, to both the traditional fee-for-service program, as well as other types of plans that became possible as a result of the BBA, (e.g., preferred provider organizations, or point-of-service plans).

Effective Date

A report on the study, together with any legislative recommendations, would be due to Congress by January 1, 2000.

Section 565. Study and Report to Congress Regarding Data Submission Used to Establish Risk Adjustment Methodology Under the Medicare+Choice Program.

Current Law

No provision.

Explanation of provision

The Secretary of Health and Human Services would conduct a study on reducing the amount of data that are required to be submitted by M+C organizations in order for the Secretary to establish a risk adjustment methodology. The Secretary would submit a report to Congress on the study, together with any recommendations for legislation that the Secretary determines to be appropriate as a result of the study.

Reason for Change

As risk adjustment becomes a more powerful influence in plan payments, it is necessary to ensure that the data needed to build the risk adjusters is collected in the most efficient, least burdensome manner. It is also important that these adjusters be as accurate as possible to avoid over payment or under payment of plans. Given the amount of controversy surrounding the use of risk adjusters, it is important that the process be open and understood.

Effective Date

The Secretary would submit the report by July 1, 2000.

TITLE VI. OTHER MEDICARE PROVISIONS

Section 601. Moratorium on Therapy Services Payment Limits.

Current Law

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

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

The Secretary is required to report to Congress by January 1, 2000, on recommendations for establishing a revised payment policy based on classification of individuals by diagnostic coverage groups.

Explanation of Provision

The bill would place a 2-year moratorium on implementing the caps. It would also require the Secretary to report to the Congress on utilization of therapy services and an alternative payment methodology.

Reason for Change

The current $1500 cap is an arbitrary amount. Moreover, the cap does not allow flexibility for the needs of a particular beneficiary. This proposal is intended to provide targeted relief until the Secretary reports on a more appropriate long-term policy with regard to outpatient therapy services.

Effective Date

January 1, 2000.

Section 602. Increase in Payment Amount for Renal Dialysis Services Furnished Under the Medicare Program

Current Law

Dialysis facilities providing care to beneficiaries with end-stage renal disease (ESRD) receive a fixed prospective payment amount for each dialysis treatment. This composite rate also includes payment for tests, services, drugs and supplies routinely required for dialysis treatment. The base composite rate for hospital-based providers is $126 and for free-standing facilities, it is $122. P.L. 101-508 required that the composite payment rate to dialysis facilities be increased by $1 above the rate that was in effect as of September 30, 1990. The composite rate has not been changed since then.

Explanation of Provision

The bill would set the composite rate for services furnished after October 1, 2000, at 102.0% of the rate for services furnished on December 31, 1999.

Reason for Change

The prospective payment, or composite rate, paid to dialysis facilities for each dialysis treatment they provide to Medicare beneficiaries has remained essentially

unchanged since 1983. MedPAC reports that costs have risen in relation to the composite rate in recent years and has recommended that the rate be increased.

Effective Date

Services furnished on or after October 1, 2000.

Section 603. Pap Smears

Current Law

Medicare pays for Pap smears under the clinical laboratory fee schedule. Prior to January 1, 1999, a separate payment could be made under the physician fee schedule for the interpretation of an abnormal pap smear furnished to a hospital inpatient by a physician. Beginning after January 1, 1999, a separate payment may be made for a physician's interpretation of a pap smear to any patient (i.e., hospital or non-hospital) as long as (1) the laboratory's screening personnel suspect an abnormality; and (2) the physician reviews and interprets the pap smear.

Explanation of Provision

The provision would provide for an update in payments for pap smears. The Secretary would be required to report to Congress on the best ways to update the current payment methodology under the clinical lab fee schedule to address changes in technology.

Reason for Change

Through the BBA, Congress emphasized the importance of preventive benefits, including pap smears, for Medicare beneficiaries. Yet, the current $7.15 reimbursement rate for pap smears is far below the national median cost of $14.60. The provision would address current payment issues, while seeking to develop a better long-term policy.

Effective Date

January 1, 2000.

Section 604. Disproportionate Share Hospitals.

Current Law

Medicare makes additional payments to hospitals that serve a disproportionate share of low income Medicare and Medicaid patients. BBA 97 reduced the disproportionate share hospital (DSH) payment formula by 1% in FY 1998; 2% in FY 1999; 3% in FY 2000; 4% in FY 2001; 5% in FY 2002 and 0% in FY 2003 and in each subsequent year.

Explanation of Provision

The bill freezes the reduction in the DSH payment formula at 3% in FY 2001.

Reason for Change

The Committee believes that the cumulative impact of several BBA provisions has produced an unintended financial burden on DSH hospitals. Payments to these hospitals have been reduced by cuts in payments to DSH, cuts in payments for the indirect costs associated with medical education (IME payments), and the reduction in payment updates to hospitals as a whole. This provision would restore a portion of the funding reductions that DSH hospitals have experienced.

Effective Date

Effective for payments made in FY2000

Section 604. Technical amendments relating to BBA Provisions.

(a) Medicare Rural Hospital Flexibility Program

Current Law

BBA 1997 established the criteria for a small, rural, limited service hospital to be designated as a critical access hospital (CAH). The facility is designated as a critical access hospital if the facility is a nonprofit or public hospital and is located in a county that is either located more than 35 miles away (or given geographic constraints, 15 miles away) from another hospital or is certified by the State as a necessary provider.

Explanation of Provision

This change would clarify a drafting ambiguity and ensure an interpretation where the hospital, and not the rural area itself, must be a certain distance from other hospitals or certified as a necessary provider of health services.

Reason for Change

The provision has been identified as a drafting ambiguity that requires legislative clarification.

Effective Date

Effective as if included in the Balanced Budget Act of 1997.

(b) Rural Health Clinic Services

Current Law

BBA 1997 applied a per-visit payment limit for rural health clinic services (other than those provided in clinics in rural hospitals with less than 50 beds) furnished on or after January 1, 1998.

Explanation of Provision

This provision would change the effective date of the per-visit payment limit to cost reporting periods beginning on or after January 1, 1998.

Reason for Change

The provision has been identified as a drafting ambiguity that requires legislative clarification.

Effective Date

As if in included in the Balanced Budget Act of 1997.

© PPS Hospital Payment Update for Temporary Relief Hospitals

Current Law

BBA 1997 provided a temporary special payment in FY 1998 and FY 1999 for certain hospitals. Qualifying hospitals received a .5% additional increase to the FY1998 hospital market basket index and were supposed to have a .3% additional increase to the FY 1999 market basket index. However the existing language establishing the way these qualifying hospitals should be treated in FY 1999 refers to the FY 1998 hospital market basket update.

Explanation of Provision

This legislation would correct the reference.

Reason for Change

The description of how hospitals should be treated in FY99 currently refers to the hospital market basket (MB) update in 1998. The proposal corrects the reference.

Effective Date

As if included in the Balanced Budget Act of 1997.

(d) Maintaining Savings From Temporary Reduction in Capital Payments for PPS Hospitals

Current Law

BBA 97 required the Secretary to rebase the acute hospital's capital payment rates by the actual rates in effect in FY 1995, so that aggregate capital payments will equal 90% of what payments would have been under reasonable cost payments, with an additional reduction of 2.1%. This capital payment method applies to discharges occurring on or after October 1, 1997 and before September 30, 2002

Explanation of Provision

The provision would extend the effective date of the existing capital payment method to discharges occurring before October 1, 2002.

Reason for Change

As written, the provision expires the second to last day of FY02, as opposed to the last day of FY02, which creates an unintended gap in expected payment savings.

Effective Date

As if in included in the Balanced Budget Act of 1997.

(e) To allow sufficient time for facility-specific rates to be established for Skilled Nursing Facilities (SNFs) for which the PPS does not begin until after January 1, 1999.

Current Law

The BBA 97 requires that the SNF prospective payment system be phased in over 3 years starting July 1, 1998, or the first date thereafter on which a SNF started a new annual cost reporting period. During this phase-in period, part of the per diem payment to each SNF is based on the facility's historical costs (the "facility specific" component of the prospective payment system), and part is based on the new federal per diem prospective payment. In the first year of the 3-year phase-in period starting on or after July 1, 1998, a SNF receives per diem rates that are a "blend" of 75% of the facility-specific rate and 25% of the federal per diem rate; in the second year the blend is 50% facility specific and 50% federal; in the third year the blend is 25% facility specific and 25% federal; in the fourth year the federal per diem rate is the full rate.

The current law requires that administrative and judicial review of facility specific rates not be permitted for SNFs with cost reporting periods starting before January 1, 9999.

Explanation of Provision

Some SNFs began the first cost reporting period to which the transition period and facility specific rates were applicable on or after January 1, 1999. Under current law, these facilities would be able to appeal their facility specific rate under the transition period. The provision would clarify that administrative and judicial review of facility specific rates under the prospective payment system transition period plan would not be permitted for all SNFs, including those starting their first transition cost reporting period on or after January 1, 1999.

Reason for Change

The amendment applies to facility-specific SNF rates established as of January 1, 1999. However, the effective date for the SNF PPS is set for cost reports beginning on or after July 1, 1998. Thus, the facility-specific rates may not have been established for facilities for which PPS does not begin until after January 1, 1999. This amendment would allow sufficient time so that the provision would apply to all facility-specific rates.

Effective Date

Effective as if in included in the Balanced Budget Act of 1997.

(f) Transfer of Criminal Fines Recovered in a Federal Health Care Offense

Current Law

HIPPA established that criminal fines recovered in cases involving a federal health care offense (as defined by 18 USC 982(a)(6)(B)) shall be transferred to the Hospital Insurance Trust Fund. There is no 18 USC 982(a)(6)(B). 18 USC 982(a)(6) states: the court in imposing sentence on a person convicted of a Federal health care offense, shall order the person to forfeit property, real or personal, that constitutes or is derived directly or indirectly, from gross proceeds traceable to the commission of the offense.

Explanation of Provision

The provision would change the reference to criminal fines recovered in cases involving a federal health care offense as defined by 18 USC 24(a).

Reason for Change

A technical error has been identified in HIPAA that wrongly cites a definition for Federal health care offense. The amendment would fix the technical error and ensure that criminal fines recovered in cases involving a Federal health care offense are properly transferred to the Federal Hospital Insurance (HI) Trust Fund.

Effective Date

Effective as if in included in the HIPPA.

(g) Medicare Payments to Newly Established PPS Exempt Providers.

Current Law

BBA 1997 authorized the Secretary to establish payment limits to new PPS exempt providers that are based on the target amounts of established providers. PPS exempt providers established after October 1, 1997 are subject to a limit equal to 110 percent of the wage and inflation adjusted, median target amount of established facilities in each provider class in FY 1996.

Explanation of Provision

This provision would make the Secretary's authority to estimate these limits explicit.

Reason for Change

The amendment would conform the TEFRA target cap provision in section 4414 and the provision for new providers at section 4416. The amendment is a technical adjustment that clarifies that the Secretary has authority to calculate the median of the target amounts for hospitals within certain classes based upon an estimate.

Effective Date

Effective as if in included in the Balanced Budget Act of 1997.

Section 605. Budgetary Compliance

Current Law

The Budget Enforcement Act requires the Office of Management & Budget to implement automatic across-the-board cuts (known as "sequestration") in non-exempt direct spending programs to offset any "net deficit increase caused by all direct spending and receipts legislation enacted before October 1, 2002."

Explanation of Provision

This provision clarifies that for purposes of section 252 of the Budget Enforcement Act, this bill shall not be considered to cause any "net deficit increase."

Reason for Change

This provision will prevent the bill from triggering a budget sequester.

Effective Date

Upon enactment.

TITLE VII – PROVISIONS RELATING TO MEDICAID AND CHIP

Section 701. Medicaid-related BBA Technicals.

(a). Cross Reference Corrections.

Current Law

No provision.

Explanation of Provision

The Committee's provision makes technical corrections to cross-references in Title XIX.

Reason for Change

The Health Care Financing Administration has identified errors in cross references drafted in the Balanced Budget Act of 1997.

Effective Date

Upon enactment.

(b) Elimination of Duplicative Requirements for External Quality Review of Medicaid Managed Care Organizations.

Current Law

Medicaid managed care organizations are required to obtain annual independent, external reviews using either a utilization and quality control peer review organization, a PRO defined under section 1152, or a private accreditation body. The results must be made available to the State and upon request to the Secretary, the Inspector General of HHS and the Comptroller General. This requirement is contained in two different sections of Medicaid law.

Explanation of Provision

The committee's provision deletes the external review requirements of Section 1902 (a)(C) and would require the Secretary of HHS to certify to Congress that the external review requirement in Section 1932(c)(2) is fully implemented.

Reason for Change

The Health Care Financing Administration has identified redundancies in current law.

Effective Date

Upon enactment.

© Making Enhanced Match Under CHIP Program Inapplicable to Medicaid DSH Payments.

Current Law

Medicaid authorizes states to make special disproportionate share (DSH) payments to certain hospitals treating large numbers of low-income and Medicaid patients. States have a great deal of flexibility in determining the formula used to calculate the payments paid to individual hospitals within minimum and maximum federal criteria. Those payments are matched by the federal government at the federal medical assistance percentage (FMAP), the same percentage that the federal government matches most other Medicaid payments for benefits. On the other hand, Medicaid payments for children who are eligible for benefits on the basis of being a targeted low-income child under Title XXI are matched at an enhanced federal matching percentage which is considerably higher than the basic Medicaid FMAP.

Explanation of Provision

The Committee's provision clarifies that Medicaid DSH payments are matched at the FMAP and not at the enhanced federal matching percentage authorized under Title XXI.

Reason for Change

The Health Care Financing Administration requested clarification to ensure that draw down of state DSH allotments is not altered unintentionally as a result of the creation of the CHIP program.

Effective Date

Effective on October 1, 1999 and applies to expenditures made on or after such date.

(d) Making Deferment of the Effective Date for Outpatient Drug Agreements Optional for States.

Current Law

Medicaid law requires that rebate agreements between the Secretary (or, if authorized by the Secretary, with the States) and drug manufacturers that were not in effect before March 1, 1991 become effective the first day of the calendar quarter that begins more than 60 days after the date the agreement is entered into.

Explanation of Provision

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

Reason for Change

The Health Care Financing Administration and the states believe that flexibility related to effective dates will increase the efficiency of program administration.

Effective Date

Upon enactment.

(e) Authority to Transfer Funds from CHIP Appropriation to HCFA Medicaid Account.

Current Law

No provision.

Explanation of Provision

The Committee's provision would allow the Secretary of HHS to transfer funds appropriated for Title XXI to the appropriations account for Title XIX in amounts necessary to pay for Medicaid spending on children eligible on the basis of Title XXI.

Reason for Change

The Health Care Financing Administration requested this provision to streamline their program accounting practices. The provision does not impact policy.

Effective Date

Effective for funds appropriated for fiscal year 1998 and thereafter.

Section 702. Increase in disproportionate share hospital allotment for certain states and the District of Columbia.

Current Law

The federal share of Medicaid disproportionate share hospital (DSH) payments is capped at amounts specified for each state.

Explanation of Provision

The Committee's provision increases the ceiling on the federal share of Medicaid disproportionate share payments for the District of Columbia, from $23 million to $ 32 million for each of fiscal years 2000 through 2002; for Minnesota, from $16 million to $33 million for each of fiscal years 1999 through 2002; for New Mexico, from $5 million to $9 million for each of fiscal years 1998 through 2002; for Wyoming, from 0 to $.1 million for each of fiscal years 1999 through 2002.

Reason for Change

The Balanced Budget Act (BBA) of 1997 increased the Medicaid matching rate for the District of Columbia, but the DSH table written into Title XIX elsewhere in BBA reflected the previous, lower match rate. This change recalculates DC's allotment based on the new rate. Minnesota, New Mexico, and Wyoming all misreported their DSH spending during the time periods used as the base in calculating the DSH allotments set forth in BBA. These errors, verified by HCFA, have been corrected through the appropriations process in previous years; this provision would make the correction permanent.

Effective Date

Retroactive to October 1, 1999.

Section 703. Making medicaid DSH transition rule permanent.

Current Law

For the period July 1, 1997 through July 1, 1999, hospital-specific disproportionate share hospital (DSH) payments for the State of California may be as high as 175% of the cost of care provided to Medicaid recipients and individuals who have no health insurance or other third-party coverage for services during the year (net of non-disproportionate share Medicaid payments and other payments by uninsured individuals).

Explanation of Provision

The Committee's provision would remove the July 1, 1999 end date for increased hospital-specific disproportionate share payments for the State of California, extending the transition period indefinitely.

Reason for Change

The State has petitioned for continuation of the transition rule to ensure the stability and viability of California's negotiated consensus on the allocation of its DSH allotment. The provision in no way impacts the state's overall DSH spending - it only relates to internal distribution of funds among hospitals. The California hospitals strongly support this provision.

Effective Date

Effective as if included in the Balanced Budget Act of 1997.

Section 704. Increased allotments for territories under the state children's health insurance program.

Current Law

Of the total amount available for allotment for the CHIP program, commonwealths and territories are allotted .25%, to be divided among them based on specified percentages. In addition, for fiscal year 1999, commonwealths and territories were allotted $32 million. This "additional allotment" amount was also divided among them based on the same specified percentages as the basic allotment.

Explanation of Provision

The provision requires an additional allotment to be available for the commonwealths and territories of $34.2 million for each of fiscal years 2000 and 2001, $25.2 million for each of fiscal years 2002 through 2004, $32.4 million for each of fiscal years 2005 and 2006, and $40 million for fiscal year 2007.

Reason for Change

The provision permanently corrects an under-representation of the population of the territories reflected in the original formula set forth in the Balanced Budget Act of 1997, rather than relying on the appropriations process to make the correction as was done in fiscal year 1999.

Effective Date

Upon enactment.

Section 705. Removal of fiscal year limitation on certain transitional administrative costs assistance.

Current Law

The Personal Welfare and Responsibility Act of 1996 replaced the Aid to Families with Dependent Children (AFDC) program and established the Temporary Assistance for Needy Families (TANF) program. Under the old program, people who qualified for AFDC were automatically eligible for Medicaid. Welfare reform de-linked Medicaid and TANF eligibility. Further, it provided states with a great deal more flexibility in designing welfare benefits and eligibility rules. Concerned that state Medicaid programs would face large new administrative costs for conducting Medicaid eligibility determinations that would otherwise not have occurred, Congress established a fund of $500 million to assist with the transitional costs of the new dual eligibility activities. The funds are available at an increased federal matching rates for states that can demonstrate to the satisfaction of the Secretary that such additional administrative costs were attributable to welfare reform. The increased matching funds are available for the period beginning with fiscal year 1997 and ending with fiscal year 2000 and must relate to costs incurred during the first 12 quarters following the welfare reform effective date.

Explanation of Provision

The Committee's provision would extend the availability of the transitional increased federal matching funds beyond fiscal year 2000 and allow costs for which the increased matching funds are claimed to relate to costs incurred for the calender quarters beyond the first 12 following the effective date of welfare reform.

Reason for Change

The Health Care Financing Administration is conducting state-by-state reviews to ensure that Medicaid and welfare eligibility systems are properly aligned. Extension of the period of access to the transition fund would make assistance available to correct any problems that are identified by the HCFA site visits.

Effective Date

The provision is effective as if included in the enactment of Section 114 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

Section 706. Stabilization of CHIP allotment formula.

Current Law

States and the District of Columbia are allotted funds for the CHIP program using a distribution formula based on the product of the number of low-income uncovered children and a "state cost factor". For fiscal years 1998 through 2000, low income uncovered children are equal to the 3-year average of uninsured children in families with income below 200% of the federal poverty level estimated for the fiscal year using the three most recent supplements to the March Current Population Survey. For fiscal year 2001, low-income uncovered children become 75% of the 3-year average of uninsured children in families with income below 200% of poverty plus 25% of the number of low-income children in the state. For years thereafter, low-income uncovered children would be equal to 50% of the 3-year average of uninsured, low-income children plus 50% of the low-income children in the state. The state cost factor for a fiscal year would be equal to the sum of .85 multiplied by the ratio of the annual average wages per employee in the state for such year to the national average wages per employee for such year and .15. The annual average wage per employee for each year would be calculated using the wages of employees in the health services industry as reported by the Bureau of Labor Statistics of the Department of Labor for each of the most recent 3 years before the beginning of the fiscal year involved.

CHIP further provides that allotments for states and the District of Columbia are subject to a floor of $2 million and should the calculation of the distribution formula result in an amount for any state (or the District) that is below $2 million, the allotment amount for that state (or the District) would be raised to $2 million and allotments for all other states be lowered accordingly.

Explanation of Provision

Acceleration of blended rate. The Committee's provision would accelerate the transition to the blended rate formula by one year. For 2000, low-income uncovered children would be calculated as the sum of 75% of the number of low-income uninsured children plus 25% of the number of low-income children. For years thereafter, low-income uncovered children would be calculated as 50% of low-income uninsured plus 50% of the number of low-income.

Floors and Ceilings in State Allotments. For any single state, the committee's provision would provide that the percentage of total federal allotment for any fiscal year cannot decrease by more than 10 percent from the previous year's allotment, nor may any state experience more than a 30 percent cumulative decline. In addition, no state may experience a cumulative increase of more than 45 percent over its fiscal year 1999 allotment. In order to keep within the overall SCHIP allotment amount, a reconciliation process will limit the annual growth of those states experiencing the highest annual increases.

Modification of Data Set Used to Determine Number of Children. The Committee's provision would change the data set to be used to estimate the number of low income uncovered children for a fiscal year from the three most recent March supplements of the CPS to the three most recent March supplements that were available before the calendar year in which the relevant fiscal year begins.

Reason for Change

The formula established by the Balanced Budget Act of 1997 results in allotment fluctuations of as much as 40 percent from one year to the next because of data instability. To avoid those fluctuations, last year Congress froze allotments at the fiscal year 1998 level. The provisions in this package build greater stability into the formula set forth in BBA, without making fundamental changes to the formula itself. These technical stability adjustments were developed with the input of HCFA, GAO, and CBO.

Effective Date

The amendments made by this section apply to allotments for fiscal year 2000 and each fiscal year thereafter.

Section 707. CHIP Data and Evaluation Improvement Act of 1999.

(a) Funding for reliable annual state-by-state estimates on the number of children who do not have health insurance coverage

Current Law

No provision.

Explanation of Provision

The Committee provision requires that the Secretary of Commerce make appropriate adjustments to the annual Current Population Survey (CPS) conducted by the Bureau of the Census to produce statistically reliable annual State-level data on the number of low-income children without health insurance. Data should be stratified by family income, age, and race or ethnicity. Appropriate adjustments to the CPS may include expanding sample size and/or sampling units within States, and appropriate verification methods. For these purposes, the Committee's provision requires that $10 million be appropriated for FY-2000 and for each year thereafter.

These changes to the CPS will improve critical data for evaluation purposes. They will also affect State-specific counts of number of low-income children and the number of such children who have no health insurance coverage that feed into the formula in existing law that determines annual State-specific allotments from Federal CHIP appropriations.

Reason for Change

Current state-by-state estimates of uninsured, low-income children rely on data sets too small to produce reliable results. Increasing the sample size will yield more accurate data.

Effective Date

Upon enactment.

(b) Funding for children's health care access and utilization state-by-state data

Current Law

No provision.

Explanation of Provision

The Committee provision requires the Secretary of Health and Human Services, acting through the National Center for Health Statistics (NCHS), to collect data on children's health insurance through the State and Local Area Integrated Telephone Survey (SLAITS) for the 50 States and the District of Columbia. The data collected must provide reliable, annual State-by-State information on health care access and utilization by low-income children. Data must also allow for stratification by family income, age, and race or ethnicity. The Secretary must obtain input from appropriate sources, including States, in designing the survey and its content. For these purposes, the Committee's provision requires that $9 million be appropriated for FY-2000 and for each year thereafter.

Finally, at State request, the Secretary may also collect additional SLAITS data to assist with individual State CHIP evaluations, for which the States must reimburse NCHS for such services.

Reason for Change

This provision will improve state-by-state data collection on health care access and utilization, which will be useful in evaluations of the state children's health insurance program.

Effective Date

Upon enactment.

(c) Federal evaluation of state children's health insurance programs

Current Law

The Secretary is required to submit to Congress by December 31, 2001, a report based on the annual evaluations submitted by States, with conclusions and recommendations, as appropriate.

Explanation of Provision

The Committee provision adds a new Federal evaluation to current law. The Secretary of Health and Human Services, directly or through contracts or interagency agreements, would be required to conduct an independent evaluation of 10 States with approved CHIP plans. The selected States must represent diverse approaches to providing child health assistance, a mix of geographic areas (including rural and urban areas), and a significant portion of uninsured children. The Federal evaluation will include, but not be limited to: (1) a survey of the target population, (2) an assessment of effective and ineffective outreach and enrollment practices for both CHIP and Medicaid, (3) an analysis of Medicaid eligibility rules and procedures that are a barrier to enrollment in Medicaid, and how coordination between Medicaid and CHIP has affected enrollment under both programs, (4) an assessment of the effects of cost-sharing policies on enrollment, utilization and retention, and (5) an analysis of disenrollment patterns and factors influencing this process. The Secretary must submit the results of the Federal evaluation to Congress no later than December 31, 2001. For these purposes, the Committee's provision requires that $10 million be appropriated for FY-2000. This appropriation shall remain available without fiscal year limitation.

Reason for Change

Under current law, there is no federal evaluation of the CHIP program as a whole, only a compilation of state-by-state reports. This provision would establish a broader evaluation to study trends and patterns and elicit information about areas of possible improvement.

Effective Date

Upon enactment.

(d) Inspector general audit and GAO report on enrollees eligible for medicaid

Current Law

No provision.

Explanation of Provision

The Committee provision requires that the Inspector General of the Department of Health and Human Services conduct an audit to determine how many Medicaid-eligible children are incorrectly enrolled in CHIP among a sample of States that provide child health assistance through separate programs only (not via a Medicaid expansion). This audit will also assess progress in reducing the number of uninsured children relative to the goals stated in approved CHIP plans. The first such audit will be conducted in FY-2000, and will be repeated every third fiscal year thereafter. In addition, this provision requires GAO to monitor these audits and report their results to Congress within six months of audit completion (i.e., by March 1 of the fiscal year following each audit).

Reason for Change

There have been anecdotal reports of Medicaid eligible children enrolling in CHIP inappropriately. This research will determine whether there is in fact a problem with inappropriate program assignment. In addition, the provision also will require ongoing assessment of whether the CHIP program is on track to meet its coverage goals.

Effective Date

Upon enactment.

(e) Coordination of data collection with data requirements under the maternal and child health services block grant

Current Law

Under current law, States are required to submit annual reports detailing their activities under the Maternal and Child Health (MCH) Services Block Grant. These reports must include, among other items, information (by racial and ethnic group) on: (1) the number of deliveries to pregnant women who were provided prenatal, delivery or postpartum care under the block grant or who were entitled to benefits with respect to such deliveries under Medicaid, and (2) the number of infants under one year of age who were provided services under the block grant or were entitled to benefits under Medicaid.

Explanation of Provision

The Committee provision would add to the existing reporting requirement under the MCH Block Grant authority inclusion of information (by racial and ethnic group)

on the number of deliveries to pregnant women entitled to benefits under CHIP, and the number of infants under age one year entitled to CHIP benefits.

Reason for Change

The provision will improve coordination between the MCH and CHIP programs.

Effective Date

Upon enactment.

(f) Coordination of data surveys and reports

Current Law

No provision.

Explanation of Provision

The Committee provision requires that the Secretary of Health and Human Services, through the Assistant Secretary of Planning and Evaluation, establish a clearinghouse for the consolidation and coordination of all Federal data bases and reports regarding children's health.

Reason for Change

The provision will facilitate greater ease of access to data regarding children's health.

Effective Date

Upon enactment.

Section 708. Grants for Federally-Qualified Health Center Services and Rural Health Clinic Services under the Medicaid Program.

Current Law

Under current law, states are required to pay full costs to federally qualified health centers and rural health clinics for services provided to Medicaid beneficiaries through fiscal year 1999. The Balanced Budget Act of 1997 sets forth a phase-out of payment based on reasonable costs for federally qualified health centers and rural health clinics. Beginning October 1, 1999, states have the option to phase down this cost-based reimbursement standard, beginning with 95 percent of reasonable costs in fiscal year 2000, 90 percent for services furnished during fiscal year 2001, 85 percent for services provided in fiscal year 2002, and 70 percent for services furnished during fiscal year 2003. Cost-based reimbursement is repealed beginning in fiscal year 2004.

Explanation of Provision

The bill would create a new transitional grant program outside title XIX to provide an incentive for states not to phase-down the cost-based reimbursement standard as permitted by the Balanced Budget Act. The grants would be available only to those states that do not adopt the phase-down. The grants, funded at $25 million a year for each of fiscal years 2001, 2002, and 2003, will be allotted among the eligible states based on a formula tied to uninsured individuals with a small state minimum. States would be permitted to retain 15 percent of their grant funds for administrative costs associated with state interactions with health clinics. The rest of an eligible state's grant funds would be distributed by the states to their federally qualified health centers and rural health clinics, to be used for the same types of services that would be reimbursed by Medicaid if the patient receiving the services were Medicaid eligible. The General Accounting Office will evaluate the impact on clinics of the phase-down of the cost-based reimbursement system.

Reason for Change

The provision is intended to encourage the maintenance of pre-Balanced Budget Act of 1997 reimbursement levels and make additional funds available to clinics for use in providing services to uninsured individuals.

Effective Date

Upon enactment.

Section 709. Additional technical corrections.

Current Law

No provision

Explanation of Provision

The provision would make technical corrections to Title XIX.

Reason for Change

Legislative counsel recommends that typographical errors in the statute be corrected.

Effective Date

Upon enactment.

Medicare Package
by fiscal year, in billions of dollars

10/21/89
09:40 AM

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2000-2004	2000-2009
Dialysis: 2% increase in composite rate, effective FY01	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.6
SNF: Incr. SSA-C, SE1-3 by 25%, RMC, RUC, RMB, RHC, RVC by S.1500. 4/1/0	0.2	1.0	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.4	1.4
SNF: Part B add on in case mix demo states	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
SNF: better of fed rate or transition rate	0.1	0.3	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.6	0.6
Hospice: Update = Mkt-Bskt - 0.5%, FY2000-2002	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.2	0.4
HOPD stop loss: 90%, 85%, 80%; exempt cancer & certain rural hospitals	0.1	0.3	0.3	0.3	0.2	0.1	0.1	0.1	0.1	0.1	1.2	1.8
HH: Delay 15% reduction until PPS, then phase-in over 3 years	0.0	0.7	0.5	0.1	0.0	0.0	0.0	0.0	0.0	0.0	1.3	1.3
HH: Per-visit limit at 112% of median, FY 2000	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
HH: Continue PIP through 1st year of PPS	0.0	1.0	-1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.0	-0.0
HH: increase per-beneficiary limit 1.0 percent	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
HH: eliminate 15 minute rule	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
HH: exclude DME from consolidated billing	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Physicians: SGR & practice expense fixes	costs/saves less than $50 million/yr, budget neutral over 5&10 yrs.										0.0	0.0
Therapy: 2-year moratorium on caps	0.2	0.3	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.6	0.6
Hospitals: Per Discharge PPS for Rehab	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Hosps: Update MCare-dependent & Sole Community Hosps @ Mkt-Bskt	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.7
Hosps: 96 hour average length of stay for Crit. Access Hosps	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.4
Hosps: Reclassify Urban hospitals as Rural	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
Medicare-dependent hospitals: extend through FY03	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
GME: S 541	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.3
GME: N. Dakota provision	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
IME: 6.5% in 2000-03; 5.5% in 2004 & subsequent	0.2	0.5	0.5	0.5	0.1	0.0	0.0	0.0	0.0	0.0	1.8	1.8
Hospitals: DSH cut: 3% instead of 4% in FY01	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Pap Smears (2 years)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Clarify that Fraternal Benefit Plans can offer FFS +Choice option	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
M+C: Extend S/HMO demonstration 1 year	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
HMO cost contracts: 2 year extension	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Evercare	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
M+C: Risk Adjustment phase-in: 10/10/20/30/55/80/100	0.0	0.2	0.3	0.5	0.6	0.3	0.1	0.0	0.0	0.0	1.6	2.0

Medicare Package
by fiscal year, in billions of dollars

10/21/99
09 40 AM

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2000-2004	2000-2009
M+C: Interaction with FFS policies	0.0	0.6	0.5	0.3	0.1	0.1	0.1	0.2	0.2	0.2	1.6	2.4
Subtotal, Gross Outlays	1.0	5.1	2.1	2.0	1.3	0.9	0.6	0.6	0.7	0.7	11.5	15.0
Part B Premium Interaction	0.0	-0.2	-0.2	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.6	-0.9
Subtotal, Net Medicare Outlays	1.0	4.9	1.8	1.9	1.2	0.8	0.6	0.6	0.6	0.6	10.9	14.1
HHS Mandatory Grants to States for FQHCs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
Medicaid Interaction with Part B Premium	-0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
Medicaid DSH: modify allotments for MN, WY, NM, DC	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.3
Medicaid: lift sunset & limits on welfare reform transition funds	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2
Medicaid: Technical amendments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Subtotal, Medicaid	0.1	0.2	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.4	0.6
S-CHIP: allotments for Puerto Rico & territories	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.3
S-CHIP: modify allocation formula	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
S-CHIP: Improved data collection and evaluations of S-CHIP	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.2
Subtotal, S-CHIP (Outlays, BA may differ)	0.0	0.1	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.2	0.5
Total, Direct Spending	1.1	5.2	2.0	2.0	1.3	0.9	0.7	0.7	0.7	0.7	11.6	15.4

(1)

TITLE ____—COAL MINERS' HEALTH BENEFITS

Subtitle A—Amendments to Surface Mining Act

SEC. ___01. TRANSFER OF INTEREST FROM ABANDONED MINE RECLAMATION FUND TO COMBINED FUND.

(a) IN GENERAL.—Section 402(h)(2) of the Surface Mining Control and Reclamation Act of 1977 (30 U.S.C. 1232(h)(2)) is amended to read as follows:

"(2)(A) Except as provided in subparagraph (B), the Secretary shall transfer from the fund to the United Mine Workers of America Combined Benefit Fund established under section 9702 of the Internal Revenue Code of 1986 for any fiscal year the amount of interest which the Secretary estimates will be earned and paid to the fund during the fiscal year.

"(B) The Secretary shall increase the amount transferred under subparagraph (A) for fiscal year 2000 by the excess of—

"(i) the total amount of interest earned and paid to the fund after September 30, 1992, and before October 1, 1999, over

"(ii) the total amount transferred to the Combined Fund under this subsection for fiscal years beginning before October 1, 1999."

(b) CONFORMING AMENDMENTS.—Section 204(h) of such Act (30 U.S.C. 1232(h)) is amended by striking paragraph (3) and by redesignating paragraph (4) as paragraph (3).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to fiscal years beginning after September 30, 1999.

SEC. ___02. MODIFICATIONS OF ABANDONED MINE RECLAMATION FEE PROGRAM.

(a) REDUCTIONS IN RECLAMATION FEES.—Section 402(a) of the Surface Mining Control and Reclamation Act of 1977 (30 U.S.C. 1232(a)) is amended—

(1) by striking "35 cents" and inserting "20 cents",

(2) by striking "15 cents" and inserting "5 cents", and

(3) by striking "10 cents" and inserting "5 cents".

(b) EXTENSION OF FEE PROGRAM.—Section 402(b) of such Act (30 U.S.C. 1232(b)) is amended by striking "2004" and inserting "2010".

(c) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to fiscal years beginning after September 30, 2000.

Subtitle B—Amendments to Internal Revenue Code of 1986

SEC. ___11. REDUCTION IN ANNUAL PREMIUMS TO COAL MINERS COMBINED FUND IF SURPLUS EXISTS.

(a) IN GENERAL.—Part II of subchapter B of chapter 99 of the Internal Revenue Code of 1986 (relating to financing of Combined Benefit Fund) is amended by inserting after section 9704 the following new section:

"SEC. 9704A. REDUCTIONS IN HEALTH BENEFIT PREMIUM IF SURPLUS EXISTS.

"(a) GENERAL RULE.—If this section applies to any plan year, the per beneficiary premium used for purposes of computing the health benefit premium under section 9704(b) for the plan year shall be the reduced per beneficiary premium determined under subsection (c).

"(b) YEARS TO WHICH SECTION APPLIES.—

"(1) IN GENERAL.—This section applies to any plan year beginning after September 30, 2000, if the trustees determine that the Combined Fund has an excess reserve for the plan year.

"(2) EXCESS RESERVE.—For purposes of this section—

"(A) IN GENERAL.—The term 'excess reserve' means, with respect to any plan year, the excess (if any) of—

"(i) the projected net assets as of the close of the test period for the plan year, over

"(ii) the projected 3-month asset reserve as of such time.

"(B) PROJECTED NET ASSETS.—For purposes of subparagraph (A)(i), the projected net assets shall be the amount of the net assets which the trustees determine will be available at the end of the test period for projected fund benefits. Such determination shall be made in the same manner used by the Combined Fund to calculate net assets available for projected fund benefits in the Statement of Net Assets (Deficits) Available for Fund Benefits for purposes of the monthly financial statements of the Combined Fund for the plan year beginning October 1, 1998.

"(C) PROJECTED 3-MONTH ASSET RESERVE.—For purposes of subparagraph (A)(ii),

the projected 3-month asset reserve is an amount equal to 25 percent of the projected expenses (including administrative expenses) from the health benefit premium account and unassigned beneficiaries premium account for the plan year immediately following the test period. The determination of such amount shall be based on the 10-year forecast of the projected net assets and cash balance of the Combined Fund prepared annually by an actuary retained by the Combined Fund.

"(D) TEST PERIOD.—For purposes of this section, the term 'test period' means, with respect to any plan year, the plan year and the following plan year.

"(c) REDUCED PER BENEFICIARY PREMIUM.—For purposes of this section—

"(1) IN GENERAL.—The reduced per beneficiary premium for any plan year to which this section applies is the per beneficiary premium determined under section 9704(b)(2) without regard to this section, reduced (but not below zero) by—

"(A) in the case of an assigned operator which is not a 1988 agreement operator, the

sum of the amounts determined under paragraphs (2) and (3), and

"(B) in the case of a 1988 agreement operator, the amount determined under paragraph (3).

"(2) INITIAL REDUCTION FOR NON-1988 OPERATORS.—The amount determined under this paragraph is the lesser of—

"(A)(i) 50 percent of the excess reserve, divided by

"(ii) the total number of eligible beneficiaries which have been assigned to assigned operators other than 1988 agreement operators under section 9706, or

"(B) 10 percent of the per beneficiary premium determined under section 9704(b)(2) without regard to this section.

"(3) REDUCTION FOR ALL OPERATORS FOR ADDITIONAL EXCESS.—The amount determined under this paragraph is equal to—

"(A) 50 percent of the excess reserve (reduced by the aggregate reduction in health benefit premiums under section 9704(b) after application of paragraph (2)), divided by

"(B) the total number of eligible beneficiaries which have been assigned to all assigned operators under section 9706.

"(d) TERMINATION OF PREMIUM REDUCTION.—If, on any day during a plan year to which this section applies, the Combined Fund has net assets available for projected fund benefits (determined in the same manner as projected net assets under subsection (b)(2)(B)) in an amount less than the projected 3-month asset reserve determined under subsection (b)(2)(C) for the plan year—

"(1) this section shall not apply to months in the plan year beginning after such day, and

"(2) the monthly installment under section 9704(g)(1) for such months shall be equal to the amount which would have been determined if the health benefits premium under section 9704(b) had not been reduced under this section for the plan year."

(b) CONFORMING AMENDMENTS.—

(1) Section 9704(a) (relating to annual premiums) is amended by striking "Each" and inserting "Subject to section 9704A, each".

(2) The table of sections for part II of subchapter B of chapter 99 is amended by inserting

after the item relating to section 9704 the following new item:

"Sec. 9704A. Reductions in health benefit premium if surplus exists."

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to plan years of the Combined Fund beginning after September 30, 2000.

SEC. ___12. USE OF FUNDS TRANSFERRED FROM ABANDONED MINE RECLAMATION FUND.

(a) IN GENERAL.—Section 9705(b)(2) of the Internal Revenue Code of 1986 (relating to use of funds) is amended to read as follows:

"(2) USE OF FUNDS.—The amount transferred under paragraph (1) for any fiscal year shall be used—

"(A) first, to proportionately reduce the unassigned beneficiary premium under section 9704(a)(3) of each assigned operator for the plan year in which transferred,

"(B) second, to pay the amount of any shortfall in any premium account for any plan year beginning on or after February 1, 1993, and

"(C) last, to pay the amount of any other obligation occurring in the Combined Fund.

Amounts transferred under paragraph (1) for any fiscal year beginning on or after October 1, 1999,

shall not be used in the calculation of a premium reduction under section 9704(e)(3)(A) for such fiscal year."

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to fiscal years beginning on or after October 1, 1999.

(2)

AMENDMENT NO. ____ Calendar No. ____

Purpose: To promote primary and secondary health promotion and disease prevention services and activities among the elderly, to amend title XVIII of the Social Security Act to add preventive benefits, and for other purposes.

IN THE SENATE OF THE UNITED STATES—106th Cong., 1st Sess.

(no.) _____

(title) _____

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by Mr. GRAHAM

Viz:

At the appropriate place, insert the following:

TITLE ____—MEDICARE WELLNESS PROVISIONS

SEC. ___001. FINDING; DEFINITIONS.

(a) FINDING.—Congress finds that despite significant advancements in general research for health promotion and disease prevention among the elderly, there

has been a failure in translating that research into practical intervention.

(b) DEFINITIONS.—As used in this title:

(1) COST-EFFECTIVE BENEFIT.—The term "cost-effective benefit" means a benefit or technique that has—

(A) been subject to peer review;

(B) been described in scientific journals; and

(C) demonstrated value as measured by unit costs relative to health outcomes achieved.

(2) COST-SAVING BENEFIT.—The term "cost-saving benefit" means a benefit or technique that has—

(A) been subject to peer review;

(B) been described in scientific journals; and

(C) caused a net reduction in health care costs for medicare beneficiaries.

(3) MEDICALLY EFFECTIVE.—The term "medically effective" means, with respect to a benefit or technique, that the benefit or technique has been—

(A) subject to peer review;

(B) described in scientific journals; and

(C) determined to achieve an intended goal under normal, programmatic conditions.

(4) MEDICAL EFFICACY; MEDICALLY EFFICACIOUS.—The terms "medical efficacy" and "medically efficacious" mean, with respect to a benefit or technique, that the benefit or technique has been—

(A) subject to peer review;

(B) described in scientific journals; and

(C) determined to achieve an intended goal under controlled conditions.

(5) MEDICARE BENEFICIARY.—The term "medicare beneficiary" means any individual who is entitled to benefits under part A or enrolled under part B of the medicare program, including any individual enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization under part C of such program.

(6) MEDICARE PROGRAM.—The term "medicare program" means the health care program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(7) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

Subtitle A—Healthy Seniors Promotion Program

SEC. ___101. HEALTHY SENIORS PROMOTION PROGRAM.

(a) DEFINITIONS.—As used in this section:

(1) ELIGIBLE ENTITY.—The term "eligible entity" means an entity that the Working Group determines has demonstrated expertise in research regarding health promotion and disease prevention among the elderly.

(2) WORKING GROUP.—The term "Working Group" means the Healthy Seniors Working Group established under subsection (d).

(b) PROGRAM AUTHORIZED.—The Secretary, subject to the general policies and criteria established by the Working Group and in accordance with the provisions of this subtitle, is authorized to make grants to eligible entities to pay for the costs of the activities described in subsection (c).

(c) USE OF FUNDS.—An eligible entity may use payments received under this section in any fiscal year to study—

(1) whether using different types of providers of care who are not physicians and alternative settings (including community-based senior centers) for the implementation of a successful health promotion and

disease prevention strategy, including the implications regarding the payment of such providers, is medically efficacious or medically effective;

(2) the most medically effective means of educating medicare beneficiaries and providers of services regarding the importance of health promotion and disease prevention among the elderly and identification of incentives that would increase the use of new and existing preventive services and healthy behaviors by medicare beneficiaries; and

(3) other topics designated by the Secretary.

(d) HEALTHY SENIORS WORKING GROUP.—

(1) ESTABLISHMENT.—There is established within the Department of Health and Human Services a Healthy Seniors Working Group.

(2) COMPOSITION.—Subject to paragraph (3), the Working Group established pursuant to subsection (b) shall be composed of 5 members as follows:

(A) The Administrator of the Health Care Financing Administration.

(B) The Director of the Centers for Disease Control and Prevention.

(C) The Administrator of the Agency for Health Care Policy and Research.

(D) The Assistant Secretary for Aging.

(E) The Director of the National Institute on Aging.

(3) ALTERNATIVE MEMBERSHIP.—

(A) APPOINTMENT.—Any member of the Working Group described in a subparagraph of paragraph (2) may appoint an individual who is an officer or employee of the Federal Government to serve as a member of the Working Group instead of the member described in such subparagraph.

(B) DEADLINE.—If a member described in subparagraph (A) elects to appoint an individual under such subparagraph, such individual shall be appointed not later than December 31, 2000.

(4) GENERAL POLICIES AND CRITERIA.—The Working Group shall establish general policies and criteria with respect to the functions of the Secretary under this section including—

(A) priorities for the approval of applications;

(B) procedures for developing, monitoring, and evaluating research efforts conducted under this section; and

(C) such other matters as are recommended by the Working Group and approved by the Secretary.

(5) CHAIRPERSON.—The Chairperson of the Working Group shall be the Administrator of the Agency for Health Care Policy and Research.

(6) QUORUM.—A majority of the members of the Working Group shall constitute a quorum, but a lesser number of members may hold hearings.

(7) MEETINGS.—The Working Group shall meet at the call of the Chairperson, except that—

(A) it shall meet not less than 4 times each year; and

(B) it shall meet whenever a majority of the appointed members request a meeting in writing.

(8) COMPENSATION OF MEMBERS.—Each member of the Working Group shall be an officer or employee of the Federal Government and shall serve without compensation in addition to that received for their service as an officer or employee of the Federal Government.

(e) APPLICATION.—

(1) IN GENERAL.—Each eligible entity which desires to receive a grant under this section shall

submit an application to the Secretary, at such time, in such manner, and accompanied by such additional information as the Secretary may reasonably require.

(2) CONTENTS.—Each application submitted pursuant to paragraph (1) shall—

(A) describe the activities for which assistance under this section is sought;

(B) describe how the research effort proposed to be conducted will reflect the medical, behavioral, and social aspects of care for the elderly, lead to the development of cost-effective benefits and cost-saving benefits, and impact the quality of life of medicare beneficiaries;

(C) provide evidence that the eligible entity meets the general policies established by the Working Group pursuant to subsection (d)(4);

(D) provide assurances that the eligible entity will take such steps as may be available to it to continue the activities for which the eligible entity is making application after the period for which assistance is sought; and

(E) provide such additional assurances as the Secretary determines to be essential to en-

sure compliance with the requirements of this title.

(3) JOINT APPLICATION.—A consortium of eligible entities may file a joint application under the provisions of paragraph (1) of this subsection.

(f) APPROVAL OF APPLICATION.—The Secretary shall approve applications in accordance with the general policies established by the Working Group under subsection (d).

(g) PAYMENTS.—The Secretary shall pay to each eligible entity having an application approved under subsection (f) the cost of the activities described in the application.

(h) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall conduct an annual evaluation of grants made under this section to determine—

(A) the results of the overall applied research conducted under this title;

(B) the extent to which research assisted under this section has improved or expanded the general research for health promotion and disease prevention among the elderly and identified practical interventions based upon such research;

(C) a list of specific recommendations based upon research conducted under this section which show promise as practical interventions for health promotion and disease prevention among the elderly;

(D) whether or not as a result of the applied research effort certain health promotion and disease prevention benefits or education efforts should be added to the medicare program, including discussions of quality of life, translating the applied research results into a benefit under the medicare program, and whether each additional benefit would be a cost-effective benefit or cost-saving benefit for each proposed addition;

(E) the utility of, potential for, and issues surrounding health risk appraisals sponsored under the medicare program and targeted followup; and

(F) how best to increase utilization of existing and recommended health promotion and disease prevention services, including an education and public awareness component discussion of financial incentives for providers of services and medicare beneficiaries to improve utili-

zation and other administrative means of increasing utilization.

(2) ANNUAL REPORT.—Not later than December 31, 2002, and each year thereafter through 2005, the Secretary shall submit a report to Congress based on the annual studies made under paragraph (1), which shall contain a detailed statement of the findings and conclusions of the Working Group together with its recommendations for such legislation and administrative actions as it considers appropriate.

(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $40,000,000 for each of the fiscal years 2000, 2001, 2002, and 2003 to carry out the provisions of this section.

SEC. ___102. SENSE OF CONGRESS REGARDING THE RESPONSE OF HCFA TO PREVENTIVE HEALTH ISSUES.

It is the sense of Congress that in administering the medicare program the Secretary should ensure that the Administrator of the Health Care Financing Administration encourages the inclusion of preventive measures as part of all treatments described in such program.

SEC. ___103. SENSE OF CONGRESS REGARDING THE EFFORTS OF HCFA TO STUDY HEALTH PROMOTION AND DISEASE PREVENTION FOR MEDICARE BENEFICIARIES.

It is the sense of Congress that the Secretary should ensure that the Administrator of the Health Care Financing Administration expands the study of the most promising behavioral modification of risk factors associated with health promotion and disease prevention for all medicare beneficiaries.

SEC. ___104. SENSE OF CONGRESS REGARDING THE ESTABLISHMENT OF A MEDICARE HEALTH PROMOTION AND DISEASE PREVENTION CLEARINGHOUSE.

It is the sense of Congress that the National Library of Medicine should collect information regarding innovative and successful health promotion and disease prevention interventions from both published and unpublished sources, establish a clearinghouse targeting all medicare beneficiaries in a variety of settings for the consolidation and coordination of all such information, and make the clearinghouse available to the public and accessible through the Internet.

Subtitle B—Medicare Coverage of Preventive Services

SEC. ___201. COUNSELING FOR CESSATION OF TOBACCO USE.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(1) in subparagraph (S), by striking "and" at the end;

(2) in subparagraph (T), by striking the period at the end and inserting "; and"; and

(3) by adding at the end the following:

"(U) counseling for cessation of tobacco use (as defined in subsection (uu)) for individuals who have a history of tobacco use.".

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following:

"Counseling for Cessation of Tobacco Use

"(uu)(1) Except as provided in paragraph (2), the term 'counseling for cessation of tobacco use' means diagnostic, therapy, and counseling services for cessation of tobacco use which are furnished by or under the supervision of a physician or other health care professional who is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished, as

would otherwise be covered if furnished by a physician or as an incident to a physician's professional service.

"(2) The term 'counseling for cessation of tobacco use' does not include coverage for drugs or biologicals that are not otherwise covered under this title.".

(c) ELIMINATION OF COST SHARING.—

(1) ELIMINATION OF COINSURANCE.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended—

(A) by striking "and (S)" and inserting "(S)"; and

(B) by striking the semicolon at the end and inserting the following: ", and (T) with respect to counseling for cessation of tobacco use (as defined in section 1861(uu)), the amount paid shall be the applicable preventive percentage (as defined in subsection (u)) of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph;".

(2) ELIMINATION OF DEDUCTIBLE.—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)) is amended—

(A) by striking "and" before "(6)"; and

(B) by inserting before the period the following: ", and (7) such deductible shall not apply with respect to counseling for cessation of tobacco use (as defined in section 1861(uu))".

(d) APPLICABLE PREVENTIVE PERCENTAGE DEFINED.—Section 1833 (42 U.S.C. 1395l) is amended by adding at the end the following:

"(u) APPLICABLE PREVENTIVE PERCENTAGE DEFINED.—For purposes of subsection (a)(1), the term 'applicable preventive percentage' means—

"(1) for the first calendar year in which the preventive benefit to which the percentage applies is covered under this title, 0 percent; and

"(2) for a subsequent year, the percentage determined under this subsection for the previous year increased by 10 percentage points (not to exceed 100 percent).".

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after December 31, 2001.

SEC. ___202. SCREENING FOR HYPERTENSION.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) (as amended by section ____201(a)) is amended—

(1) in subparagraph (T), by striking "and" at the end;

(2) in subparagraph (U), by striking the period at the end and inserting "; and"; and

(3) by adding at the end the following:

"(V) screening for hypertension (as defined in subsection (vv)) not more frequently than once every 2 years for individuals with normotensive blood pressure measurements and annually for individuals with blood pressure measurements that are not normotensive.".

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x) (as amended by section ____01(b)) is amended by adding at the end the following:

"Screening for Hypertension

"(vv) The term 'screening for hypertension' means diagnostic services for hypertension which are furnished by or under the supervision of a physician or other health care professional who is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service.".

(c) ELIMINATION OF COST SHARING.—

(1) ELIMINATION OF COINSURANCE.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) (as amended by section ____201(c)(1)) is amended—

(A) by striking "and (T)" and inserting "(T)"; and

(B) by striking the semicolon at the end and inserting the following: ", and (U) with respect to screening for hypertension (as defined in section 1861(vv)), the amount paid shall be the applicable preventive percentage (as defined in subsection (u)) of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph;".

(2) ELIMINATION OF DEDUCTIBLE.—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)) (as amended by section ____201(c)(2)) is amended—

(A) by striking "and" before "(7)"; and

(B) by inserting before the period the following: ", and (8) such deductible shall not apply with respect to screening for hypertension (as defined in section 1861(vv))".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after December 31, 2002.

SEC. ___203. COUNSELING FOR HORMONE REPLACEMENT THERAPY.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) (as amended by section ____202(a)) is amended—

(1) in subparagraph (U), by striking "and" at the end;

(2) in subparagraph (V), by striking the period at the end and inserting "; and"; and

(3) by adding at the end the following:

"(W) counseling for hormone replacement therapy (as defined in subsection (ww)).".

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x) (as amended by section ____202(b)) is amended by adding at the end the following:

"Counseling for Hormone Replacement Therapy

"(ww)(1) Except as provided in paragraph (2), the term 'counseling for hormone replacement therapy' means diagnostic, therapy, and counseling services for hormone replacement which are furnished by or under the supervision of a physician or other health care professional who is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service.

"(2) The term 'counseling for hormone replacement therapy' does not include coverage for drugs or biologicals that are not otherwise covered under this title.".

(c) ELIMINATION OF COST SHARING.—

(1) ELIMINATION OF COINSURANCE.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) (as amended by section ____202(c)(1)) is amended—

(A) by striking "and (U)" and inserting "(U)"; and

(B) by striking the semicolon at the end and inserting the following: ", and (V) with respect to counseling for hormone replacement therapy (as defined in section 1861(ww)), the amount paid shall be the applicable preventive percentage (as defined in subsection (u)) of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph;".

(2) ELIMINATION OF DEDUCTIBLE.—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)) (as amended by section ____202(c)(2)) is amended—

(A) by striking "and" before "(8)"; and

(B) by inserting before the period the following: ", and (9) such deductible shall not

apply with respect to counseling for hormone replacement therapy (as defined in section 1861(ww))".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after December 31, 2003.

SEC. ___204. SCREENING FOR GLAUCOMA.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) (as amended by section ____203(a)) is amended—

(1) in subparagraph (V), by striking "and" at the end;

(2) in subparagraph (W), by striking the period at the end and inserting "; and"; and

(3) by adding at the end the following:

"(X) screening for glaucoma (as defined in subsection (xx)) for individuals determined to be at high risk for glaucoma, individuals with a family history of glaucoma, and individuals with diabetes or myopia.".

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x) (as amended by section ____03(b)) is amended by adding at the end the following:

"Screening for Glaucoma

"(xx) The term 'screening for glaucoma' means a dilated eye examination with an intraocular pressure measurement, and a direct ophthalmoscopy or a slit-lamp biomicroscopic examination for the early detection of glaucoma which is furnished by or under the supervision of an optometrist or ophthalmologist who is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service.".

(c) ELIMINATION OF COST SHARING.—

(1) ELIMINATION OF COINSURANCE.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) (as amended by section ____203(c)(1)) is amended—

(A) by striking "and (V)" and inserting "(V)"; and

(B) by striking the semicolon at the end and inserting the following: ", and (W) with respect to screening for glaucoma (as defined in section 1861(xx)), the amount paid shall be the applicable preventive percentage (as defined in subsection (u)) of the lesser of the actual charge for the services or amount determined

by a fee schedule established by the Secretary for the purposes of this subparagraph;".

(2) ELIMINATION OF DEDUCTIBLE.—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)) (as amended by section ____203(c)(2)) is amended—

(A) by striking "and" before "(9)"; and

(B) by inserting before the period the following: ", and (10) such deductible shall not apply with respect to screening for glaucoma (as defined in section 1861(xx))".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after December 31, 2004.

SEC. ___205. SCREENING FOR CHOLESTEROL.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) (as amended by section ____204(a)) is amended—

(1) in subparagraph (W), by striking "and" at the end;

(2) in subparagraph (X), by striking the period at the end and inserting "; and"; and

(3) by adding at the end the following:

"(Y) screening for cholesterol (as defined in subsection (yy)) for individuals between the ages of 65 and 75 that exhibit major risk factors for coro-

nary heart disease, including smoking, hypertension, and diabetes.".

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x) (as amended by section ____04(b)) is amended by adding at the end the following:

"Screening for Cholesterol

"(yy) The term 'screening for cholesterol' means diagnostic services for cholesterol that are furnished by or under the supervision of a physician or other health care professional who is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service.".

(c) ELIMINATION OF COST SHARING.—

(1) ELIMINATION OF COINSURANCE.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) (as amended by section ____204(c)(1)) is amended—

(A) by striking "and (W)" and inserting "(W)"; and

(B) by striking the semicolon at the end and inserting the following: ", and (X) with respect to screening for cholesterol (as defined in section 1861(yy)), the amount paid shall be the

applicable preventive percentage (as defined in subsection (u)) of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph;".

(2) ELIMINATION OF DEDUCTIBLE.—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)) (as amended by section ____204(c)(2)) is amended—

(A) by striking "and" before "(10)"; and

(B) by inserting before the period the following: ", and (11) such deductible shall not apply with respect to screening and counseling for osteoporosis (as defined in section 1861(yy))".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after December 31, 2005.

SEC. ___206. SCREENING AND COUNSELING FOR OSTEOPOROSIS.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) (as amended by section ____205(a)) is amended—

(1) in subparagraph (X), by striking "and" at the end;

(2) in subparagraph (Y), by striking the period at the end and inserting "; and"; and

(3) by adding at the end the following:

"(Z) screening and counseling for osteoporosis (as defined in subsection (zz)) for—

"(i) women; and

"(ii) men with fractures.".

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x) (as amended by section ____205(b)) is amended by adding at the end the following:

"Screening and Counseling for Osteoporosis

"(zz) The term 'screening and counseling for osteoporosis' means diagnostic and counseling services for osteoporosis in addition to a bone mass measurement (as defined in subsection (rr)) which are furnished in accordance with methods approved by the Food and Drug Administration by or under the supervision of a physician or other health care professional who is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service.".

(c) ELIMINATION OF COST SHARING.—

(1) ELIMINATION OF COINSURANCE.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) (as amended by section ____205(c)(1)) is amended—

(A) by striking "and (X)" and inserting "(X)"; and

(B) by striking the semicolon at the end and inserting the following: ", and (Y) with respect to screening and counseling for osteoporosis (as defined in section 1861(zz)), the amount paid shall be the applicable preventive percentage (as defined in subsection (u)) of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph;".

(2) ELIMINATION OF DEDUCTIBLE.—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)) (as amended by section ____205(c)(2)) is amended—

(A) by striking "and" before "(11)"; and

(B) by inserting before the period the following: ", and (12) such deductible shall not apply with respect to screening and counseling for osteoporosis (as defined in section 1861(zz))".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after December 31, 2006.

SEC. ___207. SCREENING FOR HEARING IMPAIRMENT.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) (as amended by section ____206(a)) is amended—

(1) in subparagraph (Y), by striking "and" at the end;

(2) in subparagraph (Z), by striking the period at the end and inserting "; and"; and

(3) by adding at the end the following:

"(AA) screening for hearing impairment (as defined in subsection (zz)).".

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x) (as amended by section ____205(b)) is amended by adding at the end the following:

"Screening for Hearing Impairment

"(ãaaã) The term 'screening for hearing impairment' means diagnostic services for hearing impairment by use of periodic questions, otoscopic examination and audio metric testing if such questions indicate potential hearing impairment, and counseling about hearing aid devices which are furnished by or under the supervision of a physician or other health care professional who is legally au-

thorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service.".

(c) ELIMINATION OF COST SHARING.—

(1) ELIMINATION OF COINSURANCE.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) (as amended by section ____206(c)(1)) is amended—

(A) by striking "and (Y)" and inserting "(Y)"; and

(B) by striking the semicolon at the end and inserting the following: ", and (Z) with respect to screening for hearing impairment (as defined in section 1861(aaa)), the amount paid shall be the applicable preventive percentage (as defined in subsection (u)) of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph;".

(2) ELIMINATION OF DEDUCTIBLE.—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)) (as amended by section ____206(c)(2)) is amended—

(A) by striking "and" before "(12)"; and

(B) by inserting before the period the following: ", and (13) such deductible shall not apply with respect to screening for hearing impairment (as defined in section 1861(aaa))".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after December 31, 2007.

SEC. ___208. SCREENING FOR DIMINISHED VISUAL ACUITY.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) (as amended by section ____207(a)) is amended—

(1) in subparagraph (Z), by striking "and" at the end;

(2) in subparagraph (AA), by striking the period at the end and inserting "; and"; and

(3) by adding at the end the following:

"(BB) screening for diminished visual acuity (as defined in subsection (bbb))."

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x) (as amended by section ____207(b)) is amended by adding at the end the following:

"Screening for Diminished Visual Acuity

"(bbb) The term 'screening for diminished visual acuity' means diagnostic services for screening for diminished visual acuity which are furnished by or under the super-

vision of an optometrist or ophthalmologist who is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service.".

(c) ELIMINATION OF COST SHARING.—

(1) ELIMINATION OF COINSURANCE.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) (as amended by section ____207(c)(1)) is amended—

(A) by striking "and (Z)" and inserting "(Z)"; and

(B) by striking the semicolon at the end and inserting the following: ", and (AA) with respect to screening for diminished visual acuity (as defined in section 1861(bbb)), the amount paid shall be the applicable preventive percentage (as defined in subsection (u)) of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph;".

(2) ELIMINATION OF DEDUCTIBLE.—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)) (as amended by section ____207(c)(2)) is amended—

(A) by striking "and" before "(13)"; and

(B) by inserting before the period the following: ", and (14) such deductible shall not apply with respect to screening for diminished visual acuity (as defined in section 1861(bbb))".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after December 31, 2008.

SEC. ___209. ELIMINATION OF COST SHARING FOR CURRENT PREVENTIVE BENEFITS.

(a) WAIVER OF COINSURANCE AND DEDUCTIBLES.—

(1) IN GENERAL.—Section 1834 (42 U.S.C. 1395m) is amended by adding at the end the following:

"(m) ELIMINATION OF COINSURANCE AND DEDUCTIBLE FOR CERTAIN PREVENTIVE SERVICES.—

"(1) COINSURANCE.—

"(A) IN GENERAL.—Notwithstanding any other provision of this part—

"(i) the Secretary shall reduce by the applicable preventive percentage (as defined in subparagraph (C)) the amount of any coinsurance applicable to services described in subparagraph (B); and

"(ii) the payment amount for such services shall be an amount equal to—

"(I) the total amount that would have been paid under this part for the service (including the amount of any coinsurance) but for this paragraph; minus

"(II) the amount of any coinsurance applicable to such services under clause (i).

"(B) SERVICES DESCRIBED.—The services described in this subparagraph are as follows:

"(i) Screening mammography (as defined in section 1861(jj)).

"(ii) Screening pelvic exam (as defined in section 1861(nn)(2)).

"(iii) Hepatitis B vaccine and its administration (under section 1861(s)(10)(B)).

"(iv) Colorectal cancer screening test (as defined in section 1861(pp)).

"(v) Bone mass measurement (as defined in section 1861(rr)).

"(vi) Prostate cancer screening test (as defined in section 1861(oo)).

"(vii) Diabetes outpatient self-management training services (as defined in section 1861(qq)).

"(C) APPLICABLE PREVENTIVE PERCENTAGE DEFINED.—For purposes of subparagraph (A), the term 'applicable preventive percentage' means—

"(i) for the first calendar year beginning on or after the date of enactment of the [_____ Act of 1999], 0 percent; and

"(ii) for a subsequent year, the percentage determined under this subsection for the previous year increased by 10 percentage points (not to exceed 100 percent).".

"(2) DEDUCTIBLE.—

"(A) IN GENERAL.—Notwithstanding any other provision of this part, the deductible described in section 1833(b) shall not apply with respect to services described in subparagraph (B).

"(B) SERVICES DESCRIBED.—The services described in this subparagraph are the following services:

"(i) Hepatitis B vaccine and its administration (under section 1861(s)(10)(B)).

"(ii) Colorectal cancer screening test (as defined in section 1861(pp)).

"(iii) Bone mass measurement (as defined in section 1861(rr)).

"(iv) Prostate cancer screening test (as defined in section 1861(oo)).

"(v) Diabetes outpatient self-management training services (as defined in section 1861(qq)).".

(2) CONFORMING AMENDMENT.—Section 1833(a) (42 U.S.C. 1395l(a)) is amended by striking "section 1876" and inserting "sections 1834 and 1876" in the matter preceding paragraph (1).

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after December 31, 2001.

SEC. ___210. NATIONAL FALLS PREVENTION EDUCATION AND AWARENESS CAMPAIGN.

The Secretary, in consultation with the Director of the Centers for Disease Control and Prevention, shall conduct a national falls prevention and awareness campaign

to reduce fall-related injuries among medicare beneficiaries.

SEC. ___211. PROGRAM INTEGRITY.

The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall integrate the benefits described in sections ____201 through ____208 with existing program integrity measures.

Subtitle C—Medicare Health Education and Risk Appraisal Program

SEC. ___301. MEDICARE HEALTH EDUCATION AND RISK APPRAISAL PROGRAM.

(a) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following:

"MEDICARE HEALTH EDUCATION AND RISK APPRAISAL PROGRAM

"SEC. 1897. (a) ESTABLISHMENT.—The Secretary, in consultation with the Director of the Centers for Disease Control and Prevention, the Administrator of the Agency for Health Care Policy and Research, and the Administrator of the Health Care Financing Administration, shall establish a health education and risk appraisal program to inform the target individuals described in subsection (b) of the major behavioral risk factors described

in subsection (c) through the self-assessment described in subsection (d) and shall conduct the periodic followup described in subsection (e).

"(b) TARGET INDIVIDUALS.—The target individuals described in this subsection are the following:

"(1) MEDICARE BENEFICIARIES.—Individuals that are beneficiaries under this title.

"(2) INDIVIDUALS BETWEEN THE AGES OF 50 AND 64.—Individuals between the ages of 50 and 64.

"(c) MAJOR BEHAVIORAL RISK FACTORS.—The major behavioral risk factors described in this subsection include—

"(1) the lack of proper nutrition;

"(2) the use of alcohol;

"(3) the lack of regular exercise;

"(4) the use of tobacco;

"(5) depression; and

"(6) other risk factors identified by the Secretary.

"(d) SELF-ASSESSMENT.—

"(1) IN GENERAL.—The self-assessment described in this subsection is a form delivered by the Secretary to each target individual that—

"(A) includes questions regarding major behavioral risk factors;

"(B) requests that such individual answer the questions and return the form to the Secretary; and

"(C) is then assessed using—

"(i) knowledge coupling computer software that assesses overall health risks and then provides options for management of identified risk factors;

"(ii) nurse hotlines; and

"(iii) case managers as the Secretary determines appropriate.

"(2) INDIVIDUALS BETWEEN THE AGES OF 50 AND 64.—With respect to the target individuals described in subsection (b)(2), the Secretary shall coordinate the delivery of the self-assessment form with the issuance of the statement described in section 1143(c)(2).

"(e) PERIODIC FOLLOWUP.—

"(1) MEDICARE BENEFICIARIES.—Not less frequently than once every 2 years, the Secretary shall conduct periodic followup appraisals with respect to the target individuals described in subsection (b)(1) to reduce major behavioral risk factors described in subsection (c)—

"(A) by providing such individuals with—

"(i) information regarding the results of the self-administered risk appraisal;

"(ii) recommendations regarding behavior modifications based on such appraisal; and

"(iii) information regarding any need for further assessment or treatment; and

"(B) by providing the information described in subparagraph (A) to the provider designated by such individual to receive such information.

"(2) INDIVIDUALS BETWEEN THE AGES OF 50 AND 64.—The Secretary shall conduct such periodic followup appraisals with respect to the target individuals described in subsection (b)(2) as the Secretary determines appropriate.".

Subtitle D—Disease Self-Management Demonstration Projects

SEC. __401. DISEASE SELF-MANAGEMENT DEMONSTRATION PROJECTS.

(a) DEMONSTRATION PROJECTS.—

(1) IN GENERAL.—The Secretary, acting through the Administrator of the Health Care Financing Administration, shall conduct demonstration projects for the purpose of promoting disease self-

management for conditions identified by the working group established under paragraph (2) for target individuals (as defined in paragraph (3)).

(2) DISEASE SELF-MANAGEMENT WORKING GROUP.—

(A) ESTABLISHMENT.—There is established within the Department of Health and Human Services a Disease Self-Management Working Group.

(B) COMPOSITION.—The Disease Self-Management Working Group established under subparagraph (A) shall be composed of 4 members as follows:

(i) The Administrator of the Health Care Financing Administration.

(ii) The Director of the Centers for Disease Control and Prevention.

(iii) The Administrator of the Agency for Health Care Policy and Research.

(iv) The Director of the Administration on Aging.

(C) GENERAL POLICIES AND CRITERIA.—The Disease Self-Management Working Group established under paragraph (1) shall establish general policies and criteria with respect to the

functions of the Secretary under this section including—

(i) the identification of conditions for which a demonstration project may be implemented;

(ii) the prioritization of the conditions identified under clause (i) based on potential of self-management of such condition to be medically effective and for such self-management to be a cost-effective benefit or cost-saving benefit, as those terms are defined in section ____001 of this title;

(iii) the identification of target individuals;

(iv) the development of procedures for selecting areas in which a demonstration project may be implemented; and

(v) such other matters as are recommended by the Disease Self-Management Working Group and approved by the Secretary.

(3) TARGET INDIVIDUAL DEFINED.—In this section, the term "target individual" means an individual that is at risk for or has a condition identified by the working group described under paragraph (2)

and is eligible for benefits under the fee-for-service program under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.; 1395j et seq.) or is enrolled under the Medicare+Choice program under part C of title XVIII of such Act (42 U.S.C. 1395w–21 et seq.).

(b) NUMBER, PROJECT AREAS, AND DURATION.—

(1) NUMBER.—Not later than 2 years after the date of enactment of this Act, the Secretary shall implement a series of demonstration projects.

(2) PROJECT AREAS.—The Secretary, acting through the Administrator of the Health Care Financing Administration, shall implement the demonstration projects described in paragraph (1) in urban, suburban, and rural areas.

(3) DURATION.—The demonstration projects under this section shall be conducted for a period of 3 years, beginning on the date on which the Secretary implements the initial demonstration project.

(c) REPORTS TO CONGRESS.—

(1) ANNUAL REPORTS.—

(A) IN GENERAL.—Not later than 1 year after the Secretary implements the initial demonstration project under this section, and biannually thereafter, the Secretary shall submit to

Congress a report regarding the demonstration projects conducted under this section.

(B) CONTENTS OF REPORT.—The report in subparagraph (A) shall include the following:

(i) A description of the demonstration projects conducted under this section.

(ii) An evaluation of—

(I) whether each benefit provided under the demonstration project is a cost-effective benefit or a cost-saving benefit;

(II) the level of the disease self-management attained by target individuals under the demonstration projects; and

(III) the satisfaction of target individuals under the demonstration project.

(iii) Any other information regarding the demonstration projects conducted under this section that the Secretary determines to be appropriate.

(2) FINAL REPORT.—Not later than 1 year after the conclusion of the demonstration projects under this section, the Secretary shall submit a final

report to Congress on the demonstration projects conducted under this section containing the recommendations of the Secretary regarding whether to conduct the demonstration projects on a permanent basis, together with such recommendations for legislation and administrative action as the Secretary considers appropriate.

(d) FUNDING.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) an amount not to exceed $30,000,000 for the costs of carrying out the demonstration projects under this section, establishing the Disease Self-Management Working Group under subsection (a)(2), and submitting the reports to Congress under subsection (c).

Subtitle E—Studies and Reports Advancing Original Research in the Field of Disease Prevention and the Elderly

SEC. ___501. MEDPAC BIANNUAL REPORT.

(a) IN GENERAL.—Section 1805(b) of the Social Security Act (42 U.S.C. 1395b–6(b)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (C), by striking "and" at the end;

(B) in subparagraph (D), by striking the period and inserting "; and"; and

(C) by adding at the end the following:

"(E) by not later than January 1, 2001, and biannually thereafter, submit the report to Congress described in paragraph (7)."; and

(2) by adding at the end the following:

"(7) EVALUATION OF ACTUARIAL EQUIVALENCE OF MEDICARE AND PRIVATE SECTOR BENEFIT PACKAGES.—

"(A) EVALUATION.—The Commission shall—

"(i) evaluate the benefit package offered under the medicare program under this title; and

"(ii) determine the degree to which such benefit package is actuarially equivalent to that offered by health benefit programs available in the private sector to individuals over age 65.

"(B) REPORT.—The Commission shall submit a report to Congress that shall contain—

"(i) a detailed statement of the findings and conclusions of the Commission re-

garding the evaluation conducted under subparagraph (A);

"(ii) the recommendations of the Commission regarding changes in the benefit package offered under the medicare program under this title that would keep the program modern and competitive in relation to health benefit programs available in the private sector; and

"(iii) the recommendations of the Commission for such legislation and administrative actions as it considers appropriate.".

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of enactment of this Act.

SEC. ___502. NATIONAL INSTITUTE ON AGING STUDY AND REPORT.

(a) STUDIES.—The Director of the National Institute on Aging shall conduct 1 or more studies focusing on ways to—

(1) improve quality of life for the elderly;

(2) develop better ways to prevent or delay the onset of age-related functional decline and disease and disability among the elderly; and

(3) develop means of assessing the long-term development of cost-effective benefits and cost-savings benefits for health promotion and disease prevention among the elderly.

(b) REPORT.—Not later than January 1, 2005, the Director of the National Institute on Aging shall submit a report to the Secretary regarding each study conducted under subsection (a) and containing a detailed statement of research findings and conclusions that are scientifically valid and are demonstrated to prevent or delay the onset of chronic illness or disability among the elderly.

(c) TRANSMISSION TO INSTITUTE OF MEDICINE.—Upon receipt of each report described in subsection (b), the Secretary shall transmit such report to the Institute of Medicine of the National Academy of Sciences for consideration in its effort to conduct the comprehensive study of current literature and best practices in the field of health promotion and disease prevention among the medicare beneficiaries described in section ____503.

(d) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated $100,000,000 for fiscal years 2000 through 2005 to carry out the purposes of this section.

(2) AVAILABILITY.—Any sums appropriated under the authorization contained in this subsection shall remain available, without fiscal year limitation, until September 30, 2004.

SEC. ___503. INSTITUTE OF MEDICINE 5-YEAR MEDICARE PREVENTION BENEFIT STUDY AND REPORT.

(a) STUDY.—

(1) IN GENERAL.—The Secretary shall contract with the Institute of Medicine of the National Academy of Sciences to conduct a comprehensive study of current literature and best practices in the field of health promotion and disease prevention among medicare beneficiaries including the issues described in paragraph (2) and to submit the report described in subsection (b).

(2) ISSUES STUDIED.—The study required under paragraph (1) shall include an assessment of—

(A) whether each covered benefit is—

(i) medically effective; and

(ii) a cost-effective benefit or a cost-saving benefit;

(B) utilization of covered benefits (including any barriers to or incentives to increase utilization); and

(C) quality of life issues associated with both health promotion and disease prevention benefits covered under the medicare program and those that are not covered under such program that would affect all medicare beneficiaries.

(b) REPORT.—

(1) IN GENERAL.—Not later than 5 years after the date of enactment of this section, and every fifth year thereafter, the Institute of Medicine of the National Academy of Sciences shall submit to the President a report that contains a detailed statement of the findings and conclusions of the study conducted under subsection (a) and the recommendations for legislation described in paragraph (2).

(2) RECOMMENDATIONS FOR LEGISLATION.—The Institute of Medicine of the National Academy of Sciences, in consultation with the Partnership for Prevention, shall develop recommendations in legislative form that—

(A) prioritize the preventive benefits under the medicare program; and

(B) modify preventive benefits offered under the medicare program based on the study conducted under subsection (a).

(c) TRANSMISSION TO CONGRESS.—

(1) IN GENERAL.—On the day on which the report described in subsection (b) is submitted to the President, the President shall transmit the report and recommendations in legislative form described in subsection (b)(2) to Congress.

(2) DELIVERY.—Copies of the report and recommendations in legislative form required to be transmitted to Congress under paragraph (1) shall be delivered—

(A) to both Houses of Congress on the same day;

(B) to the Clerk of the House of Representatives if the House is not in session; and

(C) to the Secretary of the Senate if the Senate is not in session.

SEC. ___504. FAST-TRACK CONSIDERATION OF PREVENTION BENEFIT LEGISLATION.

(a) RULES OF HOUSE OF REPRESENTATIVES AND SENATE.—This section is enacted by Congress—

(1) as an exercise of the rulemaking power of the House of Representatives and the Senate, re-

spectively, and is deemed a part of the rules of each House of Congress, but—

(A) is applicable only with respect to the procedure to be followed in that House of Congress in the case of an implementing bill (as defined in subsection (d)); and

(B) supersedes other rules only to the extent that such rules are inconsistent with this section; and

(2) with full recognition of the constitutional right of either House of Congress to change the rules (so far as relating to the procedure of that House of Congress) at any time, in the same manner and to the same extent as in the case of any other rule of that House of Congress.

(b) INTRODUCTION AND REFERRAL.—

(1) INTRODUCTION.—

(A) IN GENERAL.—Subject to paragraph (2), on the day on which the President transmits the report pursuant to section ____503(c) to the House of Representatives and the Senate, the recommendations in legislative form transmitted by the President with respect to such report shall be introduced as a bill (by request) in the following manner:

(i) HOUSE OF REPRESENTATIVES.—In the House of Representatives, by the Majority Leader, for himself and the Minority Leader, or by Members of the House of Representatives designated by the Majority Leader and Minority Leader.

(ii) SENATE.—In the Senate, by the Majority Leader, for himself and the Minority Leader, or by Members of the Senate designated by the Majority Leader and Minority Leader.

(B) SPECIAL RULE.—If either House of Congress is not in session on the day on which such recommendations in legislative form are transmitted, the recommendations in legislative form shall be introduced as a bill in that House of Congress, as provided in subparagraph (A), on the first day thereafter on which that House of Congress is in session.

(2) REFERRAL.—Such bills shall be referred by the presiding officers of the respective Houses to the appropriate committee, or, in the case of a bill containing provisions within the jurisdiction of 2 or more committees, jointly to such committees for con-

sideration of those provisions within their respective jurisdictions.

(c) CONSIDERATION.—After the recommendations in legislative form have been introduced as a bill and referred under subsection (b), such implementing bill shall be considered in the same manner as an implementing bill is considered under subsections (d), (e), (f), and (g) of section 151 of the Trade Act of 1974 (19 U.S.C. 2191).

(d) IMPLEMENTING BILL DEFINED.—In this section, the term "implementing bill" means only the recommendations in legislative form of the Institute of Medicine of the National Academy of Sciences described in section ____503(b)(2), transmitted by the President to the House of Representatives and the Senate under subsection ____503(c), and introduced and referred as provided in subsection (b) as a bill of either House of Congress.

(e) COUNTING OF DAYS.—For purposes of this section, any period of days referred to in section 151 of the Trade Act of 1974 shall be computed by excluding—

(1) the days on which either House of Congress is not in session because of an adjournment of more than 3 days to a day certain or an adjournment of Congress sine die; and

(2) any Saturday and Sunday, not excluded under paragraph (1), when either House is not in session.

(3)

Graham Amendment #1

Chairman's Mark

The proposals included in the Chairman's Mark are not offset.

Graham Amendment

The Graham amendment would add the following provisions to offset the cost of the Chairman's mark:

1. reinstate the three Superfund excise taxes beginning November 1, 1999;

2. reinstate the Corporate Environmental Income Tax for taxable years beginning after December 31, 1999; and,

3. repeal the lower of cost or market method of accounting for inventories. This proposal was approved by the Finance Committee in 1994 as part of the General Agreement on Tariffs and Trade legislation.

The combination of these three proposals provides revenues equal to $1.127 billion in FY 2000, $7.664 billion over the first five years, and $15.227 billion over ten years.

Senator Bob Graham

Amendment to include certain fee for service modernization provisions to the Medicare program

Proposals Include:

- Competitive Pricing for Part B Items and Services
- Centers of Excellence
- Disease Management
- Bundled Payments
- Primary Care Case Management (PCM)

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TABLE 2. ESTIMATED COST OF THE PRESIDENT'S MEDICARE PROPOSAL (By fiscal year, in billions of dollars)

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total, 2000-2004	Total, 2000-2009
Prescription Drug Benefit												
Medicare outlays	0	0	14.1	20.9	26.4	29.9	34.6	38.3	44.3	48.8	61.3	257.3
Medicaid outlays	0	0	0.8	1.6	3.0	4.6	5.1	5.4	5.8	6.2	5.3	32.4
Part D premium receipts	0	0	-7.1	-9.9	-12.5	-14.1	-16.3	-17.9	-20.8	-22.8	-29.5	-121.5
Subtotal	0	0	7.8	12.6	16.8	20.5	23.3	25.8	29.3	32.2	37.2	168.2
Changes to Fee-for-Service Medicare												
Adjustments to providers' payments	0.4	1.7	0.9	-1.1	-2.3	-3.3	-4.3	-5.5	-6.8	-8.1	-0.3	-28.3
Adjustments to beneficiaries' cost sharing	0	0	-0.1	-0.3	-0.4	-0.6	-0.7	-0.9	-1.0	-1.2	-0.9	-5.3
New options for paying providers	0	-0.2	-0.3	-0.3	-0.4	-0.4	-0.4	-0.5	-0.5	-0.5	-1.2	-3.5
HMO and Medicaid interactions	a	0.4	0.1	-0.5	-0.9	-1.6	-1.9	-2.7	-3.6	-4.5	-0.8	-15.1
Part B premium interaction	-0.1	-0.2	-0.1	0.1	0.3	0.5	0.6	0.8	1.0	1.2	-0.1	4.0
Subtotal	0.4	1.7	0.5	-2.1	-3.8	-5.4	-6.7	-8.8	-10.8	-13.1	-3.3	-48.2
Competitive Defined Benefit[b]	0	0	0	0	-0.4	-1.0	-1.5	-1.8	-2.0	-2.2	-0.4	-8.9
Total	0.4	1.7	8.3	10.5	12.6	14.1	15.1	15.2	16.4	16.8	33.5	111.1
Medicare	0.4	1.6	7.5	8.9	9.7	9.5	10.1	9.8	10.7	10.7	28.1	78.9
Medicaid	a	a	0.8	1.6	3.0	4.6	5.0	5.4	5.7	6.1	5.4	32.2

SOURCE: Congressional Budget Office based on the July 1999 baseline.

NOTE: Numbers may not add up to totals because of rounding.

a. Less than $50 million.

b. Administration's estimate.

FFS MODERNIZATION PROPOSALS

1. Competitive Pricing for Part B Items and Services --

Proposal: Authorize HCFA to use competitive bidding and price negotiations to set payment rates for Part B items (such as durable medical equipment), rather than relying on fee-schedules determined by the government.

Bids would only be accepted if providers met certain quality and consumer service standards. There would also be protections for bidders (for example, no "winner takes all").

CBO preliminary estimate: $1.1 billion savings over 10 years

2. Centers of Excellence -

Proposal: Expand the current "Centers of Excellence" demonstration to make it a permanent part of Medicare, by authorizing HCFA to contract with competitively selected facilities. The facilities would receive a global payment for services related to a specific surgical procedure; this all-inclusive payment would represent a discount to Medicare.

CBO preliminary estimate: $1.2 billion savings over 10 years

Background: This payment arrangement was tested in a demonstration project that was in place between 1991 and 1996; several participating hospitals received bundled payments for coronary artery by-pass grafts.

3. Disease Management -

Proposal: Authorize HCFA to contract with and competitively pay entities to provide "disease management" services to beneficiaries with certain high-cost, chronic health conditions (such as congestive heart failure and diabetes). These services could include patient screening and assessment, patient education, telephone consultations, etc.

CBO preliminary estimate: Small savings (not given a specific score)

Background: Private health insurance plans are increasingly providing disease management services to their populations, often through subcontracts. For example, Cardiac Solutions, Inc. contracts with 60 managed care programs and estimates they have achieved significant savings and high patient and physician satisfaction. A study panel convened by the National Academy of Social Insurance found that disease management may hold promise for both the cost and quality of care given to FFS Medicare beneficiaries with special health needs.

4. Bundled Payments -

Proposal: Authorize Medicare to provide a single payment per case to combinations of health care providers and suppliers for all care delivered to an individual at a specific site of care.

For example, all payments for the surgeon, anesthesiologist, attending physician and physician consultant(s) for each case would be combined with the applicable DRG and paid to one entity.

CBO preliminary estimate: $1.2 billion savings over 10 years

Background: There is currently a "bundled payment" demonstration project in New York. Hospitals and doctors bundle services together and the payment is distributed by the entity receiving the final payment. This demonstration project was requested by the participating hospital and physicians.

5. Primary Care Case Management (PCCM) -

Proposal: Give Medicare the flexibility to structure payments and systems of care focused on the specific health needs of beneficiaries, which should improve quality and reduce cost .

Background: PCCM refers to a set of activities performed by primary care physicians to coordinate the full range of health care services used by participating beneficiaries. Medicare would be given the authority to develop PCCMs in areas or for beneficiary groups where there is evidence of lack of coordination of care or a pattern of inappropriate utilization, such as a high rate of hospitalization for conditions that could be treated in outpatient settings.

This approach mirrors the managed care "gate keeper" approach, which has a history of yielding significant savings.

KERREY AMENDMENT #1

Establishes a fund to support residency training expenses for free standing children's hospitals. This amendment would put children's hospitals on equal footing with all other teaching hospitals, which rely on Medicare Graduate Medical Education (GME) to support their resident training programs. This pediatric GME amendment would provide short-term support to children's hospitals through a capped, time-limited fund.

Cost: $451 million over three years, beginning in 2001.