



Medicare Provisions in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554)

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Summary

Since the passage of the Balanced Budget Act of 1997 (BBA, P.L. 105-33) Medicare spending has set records for low or declining rates of program growth. Congress first addressed the issue of slower rates of growth in Medicare spending with the passage of the Balanced Budget Refinement Act of 1999 (BBRA, P.L. 106-113).

However, while part of the slower rates of growth may be attributed to under-estimates of the savings derived from the BBA, it is difficult to pinpoint any one factor as the exact cause for this projected decline in spending. Provider groups argue that the BBA reductions have threatened both their economic viability and their ability to provide services for Medicare beneficiaries. However, government studies have indicated that this lower rate of growth has not resulted in inadequate reimbursement rates.

As the Congress debated further amendments to the BBA, the current CBO projections were those released in July, 2000. CBO projected that Medicare would spend about a total of \$1.339 trillion over the following 5 years (2001-2005). These figures continued to reflect a downward trend in estimates. Five-year (2001-2005) estimates of Medicare spending were down by \$378 billion, or more than 20%, with a concomitant decline in the estimated average annual rate of growth from 9.4% to 7.5% per year.

The FY2001 budget resolution, H.Con.Res. 290, earmarked specific funds for new Medicare spending. The House Commerce Committee (renamed the House Energy and Commerce Committee in the 107th Congress) and Ways and Means Committee, as well as the Senate Finance Committee each developed legislation to increase funding for the Medicare program. Using as a basis the Medicare provisions included in their bills, the three committees developed an agreement, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554). The provisions were designed to increase payments for many of the services covered by the Medicare program, such as hospitals, Medicare+Choice organizations, home health agencies, and skilled nursing facilities. The legislation also included limited expansions of certain preventive benefits and modifies the appeals and coverage processes.

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Table 1. CBO Baseline Estimates for Medicare 2

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Background

Since the passage of the Balanced Budget Act of 1997 (BBA, P.L. 105-33) Medicare spending has set records for low or declining rates of program growth. In fiscal year 1998, the Medicare growth rate slowed to a then record low of just 1.5% for the entire year, an amount less than would be expected allowing for increases in enrollment and for inflation. The following year set a new record, when, for the first time in the program's history Medicare spending dropped from one year to the next. Mandatory program spending declined by about \$2 billion, from \$211 billion in 1998 to \$209.3 billion in 1999, almost a 1% decline. According to the Department of the Treasury, Medicare spending for 2000 increased by about 3%.

Although part of the slower rates of growth may be attributed to under-estimates of the savings derived from the BBA, it is difficult to pinpoint any one factor as the exact cause for this projected decline in spending. Many factors other than the BBA, such as an improved economic forecast and heightened anti-fraud activities, are significant components of the decline in the rates of growth in Medicare spending. (See CRS Report RS20238, *Trends in Medicare Spending After the Balanced Budget Act*, for a detailed discussion of the factors affecting Medicare projections).

Provider groups argue that the BBA reductions have threatened both their economic viability and their ability to provide services for Medicare beneficiaries. However, government studies have indicated that this lower rate of growth has not resulted in inadequate reimbursement rates. For example, reports on the Medicare+Choice (M+C) program by both the Department of Health and Human Services (HHS) and the GAO indicate that payment levels are not too low. The Inspector General of the HHS reported in September, 2000 that M+C organizations "receive more than an adequate amount of funds to deliver the Medicare package of covered services". GAO also reported in August, 2000 on their examination of 1998 payments, the second year that plans were paid using the M+C payment rates. Their examination showed that the M+C program spent about \$3.2 billion or over 13% more on health plan enrollees than if these enrollees had received services through traditional fee-for-service Medicare. Despite these findings, M+C organizations are withdrawing from the program; disrupting coverage to many Medicare beneficiaries.

Studies of the adequacy of payment extend beyond the M+C program. The Inspector General of HHS, in a series of reports on skilled nursing facilities (SNFs), reported that even under the new prospective payment system, most hospital discharge planners were able to place patients that need care in a nursing facility.

Congress first addressed the issue of slower rates of growth in Medicare spending with the passage of the Balanced Budget Refinement Act of 1999 (BBRA, P.L. 106-113). At time of passage, CBO estimated that the BBRA would add approximately \$16 billion in total back into the Medicare program for 2001-2005.

CBO's July 2000 estimates of Medicare spending, released in July, 2000 projected that Medicare spending growth over the course of the 2001 to 2010 decade would average 7.3% annually. Over that period, Medicare's share of the U.S. national income was projected to increase from 2.3% of Gross Domestic Product (GDP) in 2000 to 2.8% by 2010. Most of Medicare's program growth was expected to result from two factors: increased enrollment and automatic updates in reimbursements for services.

The table below compares CBO's July 2000 projections with two earlier estimates: those made in July 1999, just prior to the passage of the BBRA, and the January, 1997, estimates calculated prior to the passage of the BBA. As shown in the table, according to CBO's July 2000 projections, Medicare would spend about a total of \$1.339 trillion over the following 5 years (2001-2005). These figures reflected the downward trend in estimates. For the 5-year period, CBO's estimated spending was lower by \$60 billion, a 4% reduction. Concurrently, the projected rate of growth for Medicare spending for the 5-year period was reduced from 7.8% per year to 7.5% per year. Comparing the July 2000 estimates to pre-BBA estimates, computed 3 years ago, showed a significant decline in the projected rate of growth. Five-year estimates of Medicare spending were down by \$378 billion, or more than 20%, with a concomitant decline in the estimated average annual rate of growth from 9.4% to 7.5% per year.

Table I. CBO Baseline Estimates for Medicare
(fiscal year, dollars in billions)

	5 years
	(2001-2005)
Mandatory Outlays	
CBO Pre-BBA Baseline (1/97)	\$1,717
CBO Pre-BBRA Baseline (7/99)	\$1,399
CBO July 2000 Baseline (7/00)	\$1,339
Change	
Pre-BBA to Pre-BBRA Baseline	-\$318
Pre-BBRA to July 2000 Baseline	-\$60
Total Change	-\$378
Average Annual Rates of Growth	
CBO Pre-BBA Baseline (1/97)	9.4%
CBO Pre-BBRA Baseline (7/99)	7.8%
CBO July 2000 Baseline (7/00)	7.5%

Source: U.S. Congressional Budget Office.

Notes:

- 1) Mandatory Outlays include benefits outlays and only mandatory administration outlays. It does not include discretionary administration outlays.
- 2) BBA is the Balanced Budget Act of 1997.
- 3) BBRA is the Balanced Budget Refinement Act of 1999.

Legislation in 2nd Session of the 106th Congress

Budget Resolution

The 106th Congress debated and then passed legislation that would increase funding to the Medicare program. The FY2001 Budget Resolution (H.Con.Res. 290) earmarked specific funds for the Medicare spending. The conference report (H.Rept. 106-577, approved by both House and Senate on April 13, 2000) contained assumptions of both the House and Senate bills. In the House, there was a \$40 billion reserve fund over 5 years (2001-2005) for legislation to provide for Medicare reform and prescription drug coverage. In the Senate, there was a two-part reserve fund. The first part was a 5-year \$20 billion fund for legislation to provide for prescription drugs. The second part was a \$40 billion reserve fund for legislation improving the solvency of Medicare and improving access to prescription drugs (or continuing access provided under the first part). Funds available under the second part would be reduced by any amounts made available under the first part. The \$40 billion figure was close to the 5-year cost estimate for the drug benefit included in the Administration's original bill. The CBO estimate for the Administration's revised proposal was higher (\$98.5 billion over the FY2001-FY2005 period.)

Medicare Bills

The House Commerce Committee¹ ordered reported H.R. 5291 (*Beneficiary Improvement and Protection Act of 2000*) on September 27, 2000 and the Ways and Means Subcommittee on Health ordered reported its bill to the full committee October 3, 2000. (The House Ways and Means Committee has jurisdiction over Part A of the Medicare program, the Hospital Insurance program, and shares jurisdiction with the House Commerce Committee over Part B, the Supplementary Medical Insurance program.) Each of these bills provided additional funding to the Medicare program. On October 5, 2000, Senator Roth of the Senate Finance Committee introduced S. 3165, a bill that also increased Medicare program funding. (In the Senate, the Senate Finance Committee has sole jurisdiction over Medicare, i.e., over both Part A and Part B of the program.)

¹ The House Commerce Committee has been renamed the House Energy and Commerce Committee in the 107th Congress.

Based on the provisions in the House Ways and Means, House Commerce, and Senate Finance Committee legislation, these three committees, together with House and Senate leadership, proposed an agreement, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000. This agreement was attached to H.R. 2614 and passed by the House of Representatives on October 26, 2000. On December 14, 2000, Representative Thomas introduced H.R. 5661, which included the Medicare (as well as Medicaid, SCHIP and other) provisions of H.R. 2614, with a few modifications. On December 15, 2000, the House and the Senate passed H.R. 4577, the Consolidated Appropriations Act of 2001, which incorporated by reference H.R. 5661. The Medicare legislative proposals included in H.R. 5661 were designed to increase payments for many of the services covered by the Medicare program, such as hospitals, Medicare+Choice organizations, home health agencies, and skilled nursing facilities. The legislation also included limited expansions of certain preventive benefits and modified the appeals and coverage processes, but did not address the issue of prescription drug coverage.

CBO estimates that this legislation will increase Medicare spending by \$32.3 billion over the 5-year period (2001-2005) and \$81.5 billion over the 10-year period (2001-2010)². A substantial portion of these funds would be spent on the Medicare+Choice program; \$11.2 billion over 5 years and \$32.5 billion over 10 years. CBO also estimated a significant increase in federal spending for hospital outpatient services (\$5.7 billion over 5 years and \$14.2 billion over 10 years) and hospital inpatient services (\$5.2 billion over 5 years and \$9.6 billion over 10 years). The remainder of the spending increase would be spread across Medicare to cover beneficiary improvements, rural health care, skilled nursing facilities, hospice care, physicians and other Medicare services. The total federal budgetary impact on the Medicare, Medicaid, and SCHIP programs is projected to be \$17 billion over 5 years and \$15.1 billion over 10 years. These spending estimates reflect the increased Medicare spending which is significantly offset by savings to the Medicaid program. However, this report is limited to describing the Medicare proposals included in the bill. (For a description of the Medicaid and SCHIP proposals, see CRS Report RL30718, *Medicaid, SCHIP, and Other Health Provisions in H.R. 5661: Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.*)

² CBO estimate, "Estimated Budgetary Effects of Medicare, Medicaid, and SCHIP Benefits Improvement and Protection of 2000 (H.R. 5661)."

Medicare Provisions of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000

Title I—Medicare Beneficiary Improvements

Subtitle A—Improved Preventive Benefits

Section 101. Coverage of Biennial Screening Pap Smear and Pelvic Exam

The provision modifies current law to provide Medicare coverage for biennial screening pap smears and pelvic exams, effective July 1, 2001.

Section 102. Coverage of Screening for Glaucoma

The provision adds Medicare coverage for annual glaucoma screenings, beginning January 1, 2002, for persons determined to be at high risk for glaucoma, individuals with a family history of glaucoma, and individuals with diabetes. The service must be furnished by or under the supervision of an optometrist or ophthalmologist who is legally authorized to perform such services in the state where the services are furnished.

Section 103. Coverage of Screening Colonoscopy for Average Risk Individuals

The provision authorizes coverage for screening colonoscopies, beginning July 1, 2001, for all individuals, not just those at high risk. For persons not at high risk, payments cannot be made for such procedures if performed within 10 years of a previous screening colonoscopy or within 4 years of a screening flexible sigmoidoscopy.

Section 104. Modernization of Screening Mammography Benefit

Beginning in 2002, the provision eliminates the statutorily prescribed payment rate for mammography payments and specifies that the services are to be paid under the physician fee schedule. The provision specifies two new payment rates for mammographies that utilize advanced new technology for the period April 1, 2001 to December 31, 2001. Payment for technologies that directly take digital images equal 150% of what would otherwise be paid for a bilateral diagnostic mammography. For technologies that convert standard film images to digital form, an additional payment of fifteen dollars is authorized. The Secretary is required to determine whether a new code is required for tests furnished after 2001.

Section 105. Coverage of Medical Nutrition Therapy Services for Beneficiaries With Diabetes or a Renal Disease

The provision establishes, effective January 1, 2002, Medicare coverage for medical nutrition therapy services for beneficiaries who have diabetes or a renal disease. Medical nutrition therapy services are defined as nutritional diagnostic, therapy and counseling services for the purpose of disease management which are furnished by a registered dietician or nutrition professional, pursuant to a referral by a physician. The provision specifies that the amount paid for medical nutrition therapy services equals the lesser of the actual charge for the service or 85% of the amount that would be paid under the physician fee schedule if such services were provided by a physician. Assignment is required for all claims. The Secretary is required to submit a report to Congress that contains an evaluation of the effectiveness of services furnished under this provision.

Subtitle B—Other Beneficiary Improvements

Section 111. Acceleration of Reduction of Beneficiary Copayment for Hospital Outpatient Department Services

Effective April 1, 2001, the provision modifies current law by limiting the amount of a beneficiary's copayment for a procedure in a hospital outpatient department to the hospital inpatient deductible applicable in that year.

In addition, starting in April 2001, the provision requires the Secretary of HHS to reduce the effective copayment rate for outpatient services to a maximum rate of 57% and then gradually reduce the effective coinsurance rate in 5 percentage point intervals from 2002 through 2006 until the maximum rate is 40% in 2006. As stated in BBA 97, hospitals may waive any increase in coinsurance that may have arisen from the implementation of the outpatient prospective payment system (PPS).

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

Section 112. Preservation of Coverage of Drugs and Biologicals Under Part B of the Medicare Program

The provision clarifies policy with regard to coverage of drugs, provided incident to physicians services, that cannot be self-administered. The provision specifies that such drugs are covered when they are not usually self-administered by the patient.

Section 113. Elimination of Time Limitation on Medicare Benefits for Immunosuppressive Drugs

The provision eliminates the current time limitations on the coverage of immunosuppressive drugs for beneficiaries who have received a covered organ transplant. The provision applies to drugs furnished, on or after the date of enactment.

Section 114. Imposition of Billing Limits on Drugs

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

Section 115. Waiver of 24-Month Waiting Period for Medicare Coverage of Individuals Disabled with Amyotrophic Lateral Sclerosis (ALS)

The provision waives the 24-month waiting period (otherwise required for an individual to establish Medicare eligibility on the basis of a disability) for persons medically determined to have amyotrophic lateral sclerosis (ALS). The provision is effective July 1, 2001.

Subtitle C—Demonstration Projects and Studies

Section 121. Demonstration Project for Disease Management for Severely Chronically Ill Medicare Beneficiaries

The Secretary is required to conduct a demonstration project to illustrate the impact on costs and health outcomes of applying disease management to Medicare beneficiaries with diagnosed, advanced-stage congestive heart failure, diabetes, or coronary heart disease. Up to 30,000 beneficiaries may enroll, on a voluntary basis, for disease management services related to their chronic health condition. In addition, contractors providing disease management services are responsible for providing beneficiaries enrolled in the project with prescription drugs.

Section 122. Cancer Prevention and Treatment Demonstration for Ethnic and Racial Minorities

The provision requires the Secretary to conduct demonstration projects for the purpose of developing models and evaluating methods that improve the quality of cancer prevention services, improve clinical outcomes, eliminate disparities in the rate of preventive screening measures, and promote collaboration with community-based organizations for ethnic and racial minorities.

Section 123. Study on Medicare Coverage of Routine Thyroid Screening

The provision requires the Secretary to request the National Academy of Sciences, and as appropriate in conjunction with the United States Preventive Services Task Force, to analyze the addition of routine thyroid screening under Medicare. The analysis must consider the short term

and long term benefits and cost to Medicare of adding such coverage for some or all beneficiaries.

Section 124. MedPAC Study on Consumer Coalitions

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

Section 125. Study on Limitation on State Payment for Medicare Cost-Sharing Affecting Access to Services for Qualified Medicare Beneficiaries

The provision requires the Secretary of HHS to conduct a study to determine if access to certain services (including mental health services) has been affected by a specific provision in law. That provision specifies that states are not required to pay Medicare cost-sharing charges for QMBs to the extent these payments would result in a total payment in excess of the Medicaid level.

Section 126. Studies on Preventive Interventions in Primary Care for Older Americans

The provision requires the Secretary, acting through the United States Preventive Services Task Force, to conduct a series of studies designed to identify preventive interventions in primary care for older Americans.

Section 127. MedPAC Study and Report on Medicare Coverage of Cardiac and Pulmonary Rehabilitation and Therapy Services

The provision requires MedPAC to conduct a study on coverage of cardiac and pulmonary rehabilitation therapy services under Medicare.

Section 128. Lifestyle Modification Program Demonstration

The provision modifies the current Medicare demonstration project, known as the Lifestyle Modification Program. It extends the project to 4 years and assures that no fewer than 1,800 beneficiaries complete the entire course of treatment under the Program. The provision requires a study of its cost-effectiveness. An initial report is required within 1 year after 900 beneficiaries complete the Program and a final report is required within 1 year after 1,800 beneficiaries complete the Program.

Title II—Rural Health Care Improvements

Subtitle A—Critical Access Hospital Provisions

Section 201. Clarification of No Beneficiary Cost-Sharing for Clinical Diagnostic Laboratory Tests Furnished by Critical Access Hospitals

Effective for services furnished on or after the enactment of BBRA99, Medicare beneficiaries are not liable for any coinsurance, deductible, copayment, or other cost sharing amount with respect to clinical diagnostic laboratory services furnished as an outpatient critical access hospital (CAH) service. Conforming changes that clarify that CAHs are reimbursed on a reasonable cost basis for outpatient clinical diagnostic laboratory services are also included.

Section 202. Assistance with Fee Schedule Payment for Professional Services Under All-Inclusive Rate

Effective for items and services furnished on or after July 1, 2001, Medicare will pay a CAH for outpatient services based on reasonable costs or, at the election of an entity, will pay the CAH a facility fee based on reasonable costs plus an amount based on 115% of Medicare's fee schedule for professional services.

Section 203. Exemption of Critical Access Hospital Swing Beds from SNF PPS

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

Section 204. Payment in Critical Access Hospitals for Emergency Room On-Call Physicians

When determining the allowable, reasonable cost of outpatient CAH services, the Secretary must recognize amounts for the compensation and related costs for on-call emergency room physicians who are not present on the premises, are not otherwise furnishing services, and are not on-call at any other provider or facility. The Secretary must define the reasonable payment amounts and the meaning of the term "on-call." The provision is effective for cost reporting periods beginning on or after October 1, 2001.

Section 205. Treatment of Ambulance Services Furnished by Certain Critical Access Hospitals

Ambulance services provided by a critical access hospital (CAH) or provided by an entity that is owned or operated by a CAH will be paid on a reasonable cost basis if the CAH or entity is the only provider or supplier of ambulance services that is located within a 35-mile drive of the CAH. The provision is effective for cost reporting periods beginning on or after implementation of the fee schedule.

Section 206. GAO Study on Certain Eligibility Requirements for Critical Access Hospitals

Within 1 year of enactment, GAO is required to conduct a study on the eligibility requirements for critical access hospitals (CAHs) with respect to limitations on average length of stay and number of beds, including an analysis of the feasibility of having a distinct part unit as part of a CAH and the effect of seasonal variations in CAH eligibility requirements. GAO also is required to analyze the effect of seasonal variations in patient admissions on critical access hospital eligibility requirements with respect to limits on average annual length of stay and number of beds.

Subtitle B—Other Rural Hospitals Provisions

Section 211. Treatment of Rural Disproportionate Share Hospitals

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

Section 212. Option to Base Eligibility for Medicare Dependent, Small Rural Hospital Program on Discharges During Two of the Three Most Recent Audited Cost Reporting Periods

An otherwise qualifying small rural hospital may be classified as an MDH if at least 60% of its days or discharges were attributable to Medicare Part A beneficiaries in at least two of the three most recent audited cost reporting periods for which the Secretary has a settled cost report.

Section 213. Extension of Option to Use Rebased Target Amounts to All Sole Community Hospitals

Any SCH may elect payment based on hospital specific, updated FY1996 costs if this target amount resulted in higher Medicare payments. A transition period is established with Medicare payment based completely on updated FY1996 hospital specific costs for discharges occurring after FY2003.

Section 214. MedPAC Analysis of Impact of Volume on Per Unit Cost of Rural Hospitals with Psychiatric Units

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

Subtitle C—Other Rural Provisions

Section 221. Assistance for Providers of Ambulance Services in Rural Areas

The provision makes additional payments to providers of ground ambulance services for trips originating in rural areas that are greater than 17 miles and up to 50 miles. The payments are made for services furnished on or after July 1, 2001 and before January 1, 2004. The provision requires the Comptroller General to conduct a study to examine both the costs of efficiently providing ambulance services for trips originating in rural areas and the means by which rural areas with low population densities can be identified for the purpose of designating areas in which the costs of ambulance services would be expected to be higher. The Comptroller General must submit a report to Congress by June 30, 2002 on the results of the study, together with recommendations on steps that should be taken to assure access to ambulance services for trips originating in rural areas. The Secretary is required to take these findings into account when establishing the fee schedule, beginning with 2004.

Section 222. Payment for Certain Physician Assistant Services

This provision gives permanent authority to physician assistants who owned rural health clinics which lost their designation as such to bill Medicare directly.

Section 223. Revision of Medicare Reimbursement for Telehealth Services

The provision establishes revised payment provisions, effective no later than October 1, 2001, for services that are provided via a telecommunications system by a physician or practitioner to an eligible beneficiary in a rural area. The Secretary is required to make payments for telehealth services to the physician or practitioner at the distant site in an amount equal to the amount that would have been paid to such physician or practitioner if the service had been furnished to the beneficiary without the use of a telecommunications system. A facility fee is paid to the originating site. Originating sites include a physician or practitioner office, a critical access hospital, a rural health clinic, a federally qualified health center, or a hospital. The Secretary is required to conduct a study, and submit recommendations to Congress, that identify additional settings, sites, practitioners and geographic areas that are appropriate for telehealth services. Entities participating in federal demonstration projects approved by, or receiving funding from, the Secretary as of December 31, 2000 are qualified sites.

Section 224. Expanding Access to Rural Health Clinics

All hospitals of less than 50 beds that own rural health clinics are exempt from the per-visit limit.

Section 225. MedPAC Study on Low-Volume, Isolated Rural Health Providers

MedPAC is required to study the effect of low patient and procedure volume on the financial status and Medicare payment methods for hospital outpatient services, ambulance services, hospital inpatient services, skilled nursing facility services, and home health services in isolated rural health care providers.

Title III—Provisions Relating to Part A

Subtitle A—Inpatient Hospital Services

Section 301. Revision of Acute Care Hospital Payment Update for 2001

All hospitals will receive the full market basket index (MBI) as an update for FY2001. In order to implement this increase for hospitals other than sole community hospitals (SCH), those hospitals will receive the MBI minus 1.1 percentage points (the current statutory provision) for discharges occurring on or after October 1, 2000 and before April 1, 2001; these non-SCH hospitals will receive the MBI plus 1.1 percentage points for discharges occurring on or after April 1, 2001 and before October 1, 2001. As indicated by Section 547(a), this payment increase does not apply to discharges occurring after FY2001. For FY2002 and FY2003, hospitals will receive the MBI minus .55 percentage points. For FY2004 and subsequently, hospitals will receive the MBI.

The Secretary is directed to consider the prices of blood and blood products purchased by hospitals in the next rebasing and revision of the hospital market basket to determine whether those prices are adequately reflected in the market basket index. MedPAC is directed to conduct a study on increased hospital costs attributable to complying with new blood safety measures and providing such services using new technologies among other issues.

For discharges occurring on or after October 1, 2001, the Secretary may adjust the standardized amount in future fiscal years to correct for changes in the aggregate Medicare payments caused by adjustments to the DRG weighting factors in a previous fiscal year (or estimates that such adjustments for a future fiscal year) that did not take into account coding improvements or changes in discharge classifications and did not accurately represent increases in the resource intensity of patients treated by PPS hospitals.

Section 302. Additional Modification in Transition for Indirect Medical Education (IME) Percentage Adjustment

Teaching hospitals will receive a 6.25% IME payment adjustment (for each 10% increase in teaching intensity) for discharges occurring on or after October 1, 2000 and before April 1, 2001. The IME adjustment will increase to 6.75% for discharges on or after April 1, 2001 and before October 1, 2001. As indicated in Section 547(a), the payment increase does not apply to discharges after FY2001. The IME adjustment is 6.5% in FY2002 and 5.5% in FY2003 and in subsequent years.

Section 303. Decrease in Reductions for Disproportionate Share Hospital (DSH) Payments

Reductions in the DSH payment formula amounts are 2% in FY2001, 3% in FY2002, and 0% in FY2003 and subsequently. To implement the FY2001 provision, DSH amounts for discharges occurring on or after October 1, 2000 and before April 1, 2001, are reduced by 3%, which was the reduction in effect prior to enactment of this provision. DSH amounts for discharges occurring on or after April 1, 2001 and before October 1, 2001 are reduced by only 1 percentage point. As indicated by Section 547(a), this payment adjustment does not apply to discharges after FY2001.

Section 304. Wage Index Improvements

For FY2001 or any fiscal year thereafter, a Medicare Geographic Classification Review Board (MGCRB) decision to reclassify a prospective payment system hospital for use of a different area's wage index is effective for 3 fiscal years. The Secretary must establish procedures whereby a hospital could elect to terminate this reclassification decision before the end of such period. For FY2003 and subsequently, MGCRB must base any comparison of the average hourly wage of the hospital with the average hourly wage for hospitals in the area using data from the each of the two immediately preceding surveys as well as data from the most recently published hospital wage survey.

The Secretary must establish a process which would first be available for discharges occurring on or after October 1, 2001 where a single wage index is computed for all geographic areas in the state. If the Secretary applies a statewide geographic index, an application by an individual hospital is not considered. The Secretary must also collect occupational data every 3 years in order to construct an occupational mix adjustment for the hospital area wage index. The first complete data collection effort must occur no later than September 30, 2003 for application beginning October 1, 2004.

Section 305. Payment for Inpatient Services in Rehabilitation Hospitals

Total payments for rehabilitation hospitals in FY2002 equals the amounts of payments that would have been made if the rehabilitation prospective payment system (PPS) had not been enacted. A rehabilitation facility may make a one-time election before the start of the PPS to be paid based on a fully phased-in PPS rate.

Section 306. Payment for Inpatient Services of Psychiatric Hospitals

The provision increases the incentive payments for psychiatric hospitals and distinct part units to 3% for cost reporting periods beginning on or after October 1, 2000.

Section 307. Payment for Inpatient Services of Long-Term Care Hospitals

For cost reporting periods beginning during FY2001, the national cap for long term hospitals is increased by 2% and the target amount is increased by 25%. Neither these payments nor the increased bonus payments provided by BBRA 99 may be factored into the development of the prospective payment system (PPS) for long term hospitals. When developing the PPS for inpatient long term hospitals, the Secretary is required to examine the feasibility and impact of basing payment on the existing (or refined) acute hospital DRGs and using the most recently available hospital discharge data. If the Secretary is unable to implement a long term hospital PPS by October 1, 2002, the Secretary is required to implement a PPS for these hospitals using the existing acute hospital DRGs that have been modified where feasible.

Subtitle B—Adjustments to PPS Payments for Skilled Nursing Facilities

Section 311. Elimination of Reduction in Skilled Nursing Facility (SNF) Market Basket Update in 2001

The provision modifies the schedule and rates according to which federal per diem payments are updated. In FY2002 and FY2003 the updates are the market basket index increase minus 0.5 percentage point. The update rate for the period October 1, 2000, through March 31, 2001, is the market basket index increase minus 1 percentage point; the update rate for the period April 1, 2001, through September 30, 2001, is the market basket index increase plus one percentage point (this increase must not be included when determining payment rates for the subsequent period). Temporary increases in the federal per diem rates provided by BBRA 99 are in addition to the increases in this provision. By July 1, 2002, the Comptroller General is required to submit a report to Congress on the adequacy of Medicare payments to SNFs, taking into account the role of private payers, Medicaid, and case mix on the financial performance of SNFs and including an analysis, by RUG classification, of the number and characteristics of such facilities. By January 1, 2005, the Secretary is required to submit a report to Congress on alternatives for classification of SNF patients.

Section 312. Increase in Nursing Component of PPS Federal Rate

The provision increases the nursing component of each RUG by 16.66% over current law for SNF care furnished after April 1, 2001, and before October 1, 2002.

The Comptroller General is required to conduct an audit of nurse staffing ratios in a sample of SNFs and to report to Congress by August 1, 2002, on the results of the audit of nurse staffing ratios and recommend whether the additional 16.66% payment should be continued.

Section 313. Application of SNF Consolidated Billing Requirement Limited to Part A Covered Stays

Effective January 1, 2001, the provision limits the current consolidated billing requirement to services and items furnished to SNF residents in a Medicare Part A covered stay and to therapy services furnished in Part A and Part B covered stays.

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

Section 314. Adjustment of Rehabilitation RUGS to Correct Anomaly in Payment Rates

Effective for skilled nursing facility (SNF) services furnished on or after April 1, 2002, the provision increases by 6.7% certain federal per diem payments to ensure that Medicare payments for SNF residents with “ultra high” and “high” rehabilitation therapy needs are appropriate in relation to payments for residents needing “medium” or “low” levels of therapy. The 20%

additional payment that was provided in BBRA 99 for certain RUGS is removed to make this provision budget neutral.

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

Section 315. Establishment of Process for Geographic Reclassification

The provision permits the Secretary to establish a process for geographic reclassification of skilled nursing facilities based upon the method used for inpatient hospitals. The Secretary may implement the process upon completion of the data collection necessary to calculate an area wage index for workers in skilled nursing facilities.

Subtitle C—Hospice Care

Section 321. Five Percent Increase in Payment Base

The provision increases Medicare daily payment rates for hospice care furnished on or after April 1, 2001, and during FY2001 by 5 percentage points over the rates in effect in FY2000. For determining payment rates for FY2002, the 5 percentage point increase shall be considered in the FY2001 rates. The temporary increase in payment rates provided in BBRA 99 for FY2001 and FY2002 (.5% and .75%, respectively) shall be included in the base on which updates are computed.

Section 322. Clarification of Physician Certification

Effective for certifications of terminal illness made on or after the date of enactment, the provision modifies current law to specify that the physician's or hospice medical director's certification of terminal illness is based on his/her clinical judgment regarding the normal course of the individual's illness. The Secretary is required to study and report to Congress within 2 years of enactment on the appropriateness of certification of terminally ill individuals and the effect of this provision on such certification.

Section 323. MedPAC Report on Access to, and Use of, Hospice Benefit

The provision requires MedPAC to examine the factors affecting the use of Medicare hospice benefits, including delay of entry into the hospice program and urban and rural differences in utilization rates. The provision requires a report on the study to be submitted to Congress 18 months after enactment.

Subtitle D—Other Provisions

Section 331. Relief From Medicare Part A Late Enrollment Penalty for Group Buy-In for State and Local Retirees

The provision exempts certain state and local retirees, retiring prior to January 1, 2002, from the Part A delayed enrollment penalties. These would be groups of persons for whom the state or local government elected to pay the delayed Part A enrollment penalty for life. The amount of the delayed enrollment penalty which would otherwise be assessed is reduced by an amount equal to the total amount of Medicare payroll taxes paid by the employee and the employer on behalf of the employee. The provision applies to premiums for months beginning with January 1, 2002.

Title IV—Provisions Relating to Part B

Subtitle A—Hospital Outpatient Services

Section 401. Revision of Hospital Outpatient PPS Payment Update

The provision modifies the current law update rates applicable to the hospital outpatient PPS by providing in FY2001 an update equal to the full rate of increase in the market basket index. As under current law, the increase in FY2002 would be the market basket index increase minus one percentage point.

A special rule applies to the OPD PPS rates in 2001: For the period January 2, 2001, through March 31, 2001, the PPS amounts shall be those in effect on the day before implementation of the new law. For the periods April 1, 2001, through December 31, 2001, the PPS amounts in effect during the prior period shall be increased by 0.32%.

Effective as if enacted with BBA 97, if the Secretary determines that updates to the adjustment factor used to convert the relative utilization weights under the PPS into payment amounts have, or are likely to, result in hospitals' changing their coding or classification of covered services, thereby changing aggregate payments, the Secretary is authorized to adjust the conversion factor in later years to eliminate the effect of coding or classification changes.

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

The provision modifies the procedures and standards by which certain medical devices are categorized and determined eligible for pass-through payments under the PPS. Through public rule-making procedures, the Secretary is required to establish criteria for defining special payment categories under the PPS for new medical devices. The Secretary must promulgate, through the use of a program memorandum, initial categories that would encompass each of the individual devices that the Secretary had designated as qualifying for the pass-through payments to date. In addition, similar devices not so designated because they were payable under Medicare prior to December 31, 1996, also must be included in initial categories. The Secretary is required

to create additional new categories in the future to accommodate new technologies meeting the “not insignificant cost” test established in BBRA 99.

Once the categories are established, pass-through payments currently authorized under Section 1833(t)(b) of the Social Security Act will proceed on a category-specific, rather than device-specific basis. These payments are designated as “category-based pass-through payments.” These payments will continue to be made for the 2 to 3 years payment period originally specified in BBRA 99, and, for each given category, will begin when the first such payment is made for any device included in a specified category. At the conclusion of this transitional payment period, categories will sunset and payment for the device will be included in the underlying PPS payment for the related service.

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

Effective as if enacted with BBRA 99, the provision modifies current law as enacted in BBA 99 to enable all hospitals, not just those hospitals filing 1996 cost reports, to be eligible for transitional payments under the PPS.

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

The provision grandfathers existing arrangements whereby certain entities (such as outpatient clinics, skilled nursing facilities, etc.) are considered “provider-based” entities, meaning they are affiliated financially and clinically with a main hospital. Existing provider-based status designations continue for 2 years beginning October 1, 2000. If a facility or organization requests approval for provider-based status during the period October 1, 2000, through September 30, 2002, it shall be treated as if it had such status during the period of time the determination is pending. In making such a status determination on or after October 1, 2000, HCFA shall treat the applicant as satisfying any requirements or standards for geographic location if it satisfied geographic location requirements in regulations or is located not more than 35 miles from the main campus of the hospital.

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

These provisions are in effect during a 2-year period beginning on October 1, 2000.

Section 405. Treatment of Children’s Hospitals under Prospective Payment System

The BBRA 99 provides special “hold harmless” payments to ensure that cancer hospitals would receive no less under the hospital outpatient PPS than they would have received, in aggregate, under the “pre-BBA” system, that is, the pre-PPS payment system. Effective as if included in the BBRA 99, the provision extends this hold harmless protection to children’s hospitals.

Section 406. Inclusion of Temperature Monitored Cryoablation in Transitional Pass-Through for Certain Medical Devices, Drugs, and Biologicals Under OPD PPS

The provision includes temperature monitored cryoablation as part of the transitional pass-through for certain medical devices, drugs, and biologicals under the hospital outpatient prospective payment system, effective April 1, 2001.

Subtitle B—Provisions Relating to Physicians Services

Section 411. GAO Studies Relating to Physicians Services

The provision requires the GAO to conduct a study on the appropriateness of furnishing in physicians' offices specialist services (such as gastrointestinal endoscopic physicians services) which are ordinarily furnished in hospital outpatient departments. The GAO also must study the refinements to the practice expense relative value units made during the transition to the resource-based system.

Section 412. Physician Group Practice Demonstration

The provision requires the Secretary to conduct demonstration projects to test, and if proven effective, expand the use of incentives to health care groups participating under Medicare. Such incentives must be designed to encourage coordination of care furnished under Medicare Parts A and B by institutional and other providers and practitioners; to encourage investment in administrative structures and processes to encourage efficient service delivery; and to reward physicians for improving health outcomes. The Secretary must establish, for each group participating in a demonstration, a base expenditure amount and an expenditure target (reflecting base expenditures adjusted for risk and expected growth rates). The Secretary will pay each group a bonus for each year equal to a portion of the savings for the year relative to the target. In addition, at such time as the Secretary has developed appropriate criteria, the Secretary will pay an additional bonus related to process and outcome improvements. Total payments under demonstrations must not exceed what the Secretary estimates would be paid in the absence of the demonstration program.

Section 413. Study on Enrollment Procedures for Groups That Retain Independent Contractor Physicians

The provision requires the Comptroller General to conduct a study of the current Medicare enrollment process for groups that retain independent contractor physicians; particular emphasis is placed on hospital-based physicians, such as emergency department staffing groups.

Subtitle C—Other Services

Section 421. One-Year Extension of Moratorium on Therapy Caps; Report on Standards for Supervision of Physical Therapy Assistants

The provision extends the moratorium on the physical therapy and occupational therapy caps for 1 year through 2002; it also extends the requirement for focused reviews of therapy claims for the same period. The Secretary is required to conduct a study on the implications of eliminating the “in the room” supervision requirement for Medicare payment for physical therapy assistants who are supervised by physical therapists and the implications of this requirement on the physical therapy cap.

Section 422. Update in Renal Dialysis Composite Rate

The provision increases the composite rate payment for renal dialysis services by 2.4% for 2001. The provision requires the Secretary to collect data and develop an end-stage renal disease (ESRD) market basket whereby the Secretary can estimate, before the beginning of a year, the percentage increase in costs for the mix of labor and non-labor goods and services included in the composite rate. The Secretary shall report to Congress on the index together with recommendations on the appropriateness of an annual or periodic update mechanism for dialysis services. The Comptroller General must study the access of beneficiaries to dialysis services. There is a hold harmless provision for facilities who received exceptions for their 2000 rates. In addition, facilities that did not apply for an exception in 2000 may apply in the first 6 months of 2001. The exceptions rates would remain in effect so long as the rate is greater than the updated composite rate. The provision would specify that for the period January 1, 2001-March 31, 2001, the applicable composite rate is the rate in effect before enactment of this provision. The rate in effect for the period April 1, 2001-December 31, 2001, is the rate established under this section increased by a transitional percentage allowance equal to 0.39%.

Section 423. Payment for Ambulance Services

The provision provides for the full inflation update in ambulance payments for 2001. It also specifies that any phase-in of the ambulance fee schedule must provide for full payment of national mileage rates in states where separate mileage payments were not made prior to implementation of the fee schedule. The provision specifies that for the period January 1, 2001-June 30, 2001, the inflation update is that determined prior to enactment of this provision. For services furnished from July 1, 2001-December 31, 2001, the update is 4.7%. The provision relating to mileage payments is effective July 1, 2001.

Section 424. Ambulatory Surgical Centers

The provision delays implementation of proposed regulatory changes to the ambulatory payment classification system, which are based on 1994 cost data, until January 1, 2002. At that time, such changes will be phased in over 4 years: in the first year the payment amounts will be 25% of the revised rates and 75% of the prior system rates; in the second year payments will be 50% of the revised rates and 50% of the prior system rates, etc. The provision also requires that the revised system, based on 1999 (or later) cost data, be implemented January 1, 2003. (The phase-in of the revised system and 1994 data ends when the system with 1999 or later data is implemented.)

Section 425. Full Update for Durable Medical Equipment

The provision would modify updates to payments for durable medical equipment. For 2001, the payments for covered DME are increased by the full increase in the consumer price index for urban consumers (CPI-U) during the 12-month period ending June 2000. In general, in 2002 and thereafter, the annual update equals the full increase in the CPI-U for the 12 months ending the previous June. The provision specifies that for the period January 1, 2001, through June 30, 2000, the applicable amounts paid for DME are the amounts in effect before enactment of this provision. The amounts in effect for the period July 1, 2001, through December 31, 2001, are the amounts established under this section increased by a transitional allowance of 3.28%.

Section 426. Full Update for Orthotics and Prosthetics

The provision modifies updates to payments for orthotics and prosthetics. In 2000, the rates are increased by 1%. In 2001, the increase equals the percentage increase in the CPI-U during the 12-month period ending with June, 2000. For 2002, payments are increased by 1% over the prior year's amounts. The provision specifies that for the period January 1, 2001, through June 30, 2001, the applicable amounts paid for these items are the amounts in effect before enactment of this provision. The amounts in effect for the period July 1, 2001, through December 31, 2001, are the amounts established under this section increased by a transitional allowance of 2.6%.

Section 427. Establishment of Special Payment Provisions and Requirements for Prosthetics and Certain Custom Fabricated Orthotic Items

Under the provision, certain prosthetics or custom fabricated orthotics are covered by Medicare if furnished by a qualified practitioner and fabricated by a qualified practitioner or qualified supplier. The Secretary must establish a list of such items in consultation with experts. Within 1 year of enactment, the Secretary must promulgate regulations to provide these items, using negotiated rulemaking procedures.

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

Section 428. Replacement of Prosthetic Devices and Parts

The provision authorizes Medicare coverage for replacement of artificial limbs, or replacement parts for such devices, if ordered by a physician for specified reasons. Effective for items furnished on or after enactment, coverage applies to prosthetic items 3 or more years old, and supersedes any 5-year age rules for such items under current law.

Section 429. Revised Part B Payment for Drugs and Biologicals and Related Services

The provision requires the Comptroller General to study and submit a report to Congress and the Secretary on the reimbursement for drugs and biologicals and for related services under

Medicare; the report must include specific recommendations for revised payment methodologies. The Secretary must revise the current payment methodologies for covered drugs and biologicals and related services based on these recommendations; however, total payments under the revised methodologies may not exceed the aggregate payments the Secretary estimates would have been made under the current law. The provision establishes a moratorium on changes in payment rates, in effect on January 1, 2001, until the Secretary reviews the GAO report.

Section 430. Contrast Enhanced Diagnostic Procedures Under Hospital Prospective Payment System

The provision requires the Secretary to create under the hospital outpatient PPS additional and separate groups of covered services which include procedures that utilize contrast media. The provision applies to items and services furnished on or after January 1, 2002. The provision adds contrast agents to the medical devices, drugs, and biologicals for which additional payments are provided above and beyond the hospital outpatient department PPS amount, effective July 1, 2001.

Section 431. Qualifications for Community Mental Health Centers

The provision clarifies the qualifications for community mental health centers providing partial hospitalization services under Medicare.

Section 432. Payment of Physician and Nonphysician Services in Certain Indian Providers

The provision authorizes hospitals and free-standing ambulatory care clinics of the Indian Health Service or operated by a tribe or tribal organization to bill Medicare Part B for certain services furnished at the direction of the hospital or clinic. Services covered under the provision are those furnished under the physician fee schedule and services furnished by a practitioner or therapist under a fee schedule. The provision is effective July 1, 2001.

Section 433. GAO Study on Coverage of Surgical First Assisting Services of Certified Registered Nurse First Assistants

The provision requires the Comptroller General to conduct a study on the effect on both the program and beneficiaries of covering surgical first assisting services of certified registered nurse first assistants.

Section 434. MedPAC Study and Report on Medicare Reimbursement for Services Provided by Certain Providers

The provision requires MedPAC to conduct a study on the appropriateness of current payment rates for services provided by a certified nurse midwife, physician assistant, nurse practitioner, and clinical nurse specialist.

Section 435. MedPAC Study and Report on Medicare Coverage of Services Provided by Certain Non-Physician Providers

The provision requires MedPAC to conduct a study to determine the appropriateness of Medicare coverage of the services provided by a surgical technologist, marriage counselor, pastoral care counselor, and licensed professional counselor of mental health.

Section 436. GAO Study and Report on the Costs of Emergency and Medical Transportation Services

The provision requires the Comptroller General to conduct a study on the costs of providing emergency and medical transportation services across the range of acuity levels of conditions for which such transportation services are provided.

Section 437. GAO Studies and Reports on Medicare Payments

The provision requires the Comptroller General to conduct a study on the post-payment audit process for physicians services, including the proper level of resources HCFA should devote to educating physicians regarding coding and billing, documentation requirements, and calculation of overpayments. The Comptroller General is also required to conduct a study of the aggregate effects of regulatory, audit, oversight and paperwork burdens on physicians and other health care providers participating in Medicare.

Section 438. MedPAC Study on Access to Outpatient Pain Management Services

The provision requires MedPAC to conduct a study on the barriers to coverage and payment for outpatient interventional pain medicine procedures under Medicare.

Title V—Provision Relating to Parts A and B

Subtitle A—Home Health Services

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

The provision requires that the aggregate amount of Medicare payments to home health agencies in the second year of the PPS (FY2002) shall equal the aggregate payments in the first year of the PPS, updated by the market basket index (MBI) increase minus 1.1 percentage points. The 15% reduction to aggregate PPS amounts, which, under current law, would go into effect October 1, 2001, are delayed until October 1, 2002.

The Comptroller General (rather than the Secretary) must submit, by April 1, 2002, a report analyzing the need for the 15% or other reduction.

If the Secretary determines that updates to the PPS system for a previous fiscal year (or estimates of such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments due to changes in coding or classification of beneficiaries' service needs that do not reflect real changes in case mix, effective for home health episodes concluding on or after October 1, 2001, the Secretary may adjust PPS amounts to eliminate the effect of such coding or classification changes.

Section 502. Restoration of Full Home Health Market Basket Update for Home Health Services for FY2001

The provision modifies the home health PPS updates. During the period October 1, 2000, through March 31, 2001, the rates promulgated in the home health PPS regulations on July 3, 2000, apply for 60-day episodes of care (or visits) ending in that period. For the period April 1, 2001, through September 31, 2001, those rates are increased by 2.2% for 60-day episodes (or visits) ending in that time period. This increase is included in determining subsequent payment amounts.

Section 503. Temporary 2-Month Extension of Periodic Interim Payments

The provision extends, for certain home health agencies, applicability of periodic interim payments provided under current law. Home health agencies that were receiving such payments as of September 30, 2000, will continue to receive them until December 1, 2000. The payment is a one-time payment equal to 4 times the last 2-week payment the agency received before implementation of the home health PPS on October 1, 2000. The amounts are included in the agency's last settled cost report before implementation of the PPS.

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

The provision clarifies that the telecommunications provisions should not be construed as preventing a home health agency from providing a service, for which payment is made under the prospective payment system, via a telecommunications system, provided that the services do not substitute for "in-person" home health services ordered by a physician as part of a plan of care, or are not considered a home health visit for purposes of eligibility or payment.

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

The provision requires that, not later than October 1, 2001, the Comptroller General shall submit to Congress a report regarding the variation in prices home health agencies pay for nonroutine supplies, the volume of supplies used, and what effect the variations have on the provision of services. The Secretary is required to make recommendations on whether Medicare payment for those supplies should be made separately from the home health PPS.

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

The provision clarifies that neither time nor distance between a home health agency parent office and a branch office shall be the sole determinant of a home health agency's branch office status.

The Secretary is authorized to include forms of technology in determining “supervision” for purposes of determining a home health agency’s branch office status.

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

Section 507. Clarification of the Homebound Definition Under the Medicare Home Health Benefit

The provision specifies that beneficiaries may not be disqualified for home health care as a result of their leaving home if they use adult day care in a licensed facility for therapeutic, psychosocial, or medical treatment purposes. The provision also clarifies that homebound beneficiaries may attend religious services without being disqualified from Medicare coverage for home health care.

Section 508. Temporary Increase for Home Health Services Furnished in a Rural Area

For home health services furnished in certain rural areas from April 1, 2001, through September 31, 2002, Medicare payments are increased by 10%, without regard to budget neutrality for the overall home health prospective payment system. This temporary increase is not included in determining subsequent payments.

Subtitle B—Direct Graduate Medical Education

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

A hospital’s approved per resident amount for cost reporting periods beginning during FY2002 are not less than 85% of the locality adjusted national average per resident amount.

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

A hospital will receive nursing and allied health payments for Medicare managed care enrollees based on its per day cost of allied and nursing health programs and number of days attributed to Medicare enrollees in comparison to that in all other hospitals. The provision is effective for portions of cost reporting periods occurring on or after January 1, 2001.

Subtitle C—Changes in Medicare Coverage and Appeals Process

Section 521. Revisions to Medicare Appeals Process

The provision modifies the Medicare appeals process. Generally, initial determinations by the Secretary shall be concluded no later than 45-days from the date the Secretary received a claim for benefits. Any individual dissatisfied with the initial determination is entitled to a

redetermination by the carrier or fiscal intermediary who made the initial determination. Such redetermination must be completed within 30 days of a beneficiary's request. Beneficiaries may appeal the outcome of a redetermination by seeking a reconsideration. Generally, a request for a reconsideration must be initiated no later than 180 days after the date the individual receives the notice of an adverse redetermination. In addition, if contested amounts are greater than \$100, an individual may appeal an adverse reconsideration decision by requesting a hearing by the Secretary (first for a hearing by an administrative law judge, then in certain circumstances, for a hearing before the Department Appeals Board). If the dispute is not satisfactorily resolved through this administrative process, and if contested amounts are greater than \$1,000, the individual may request judicial review of the Secretary's final decision. Aggregation of claims to meet these thresholds are permitted.

An expedited determination is available for a beneficiary who received notice: 1) that a provider plans to terminate services and a physician certifies that failure to continue the provisions of the services is likely to place the beneficiary's health at risk; or 2) that the provider plans to discharge the beneficiary.

The Secretary shall enter into 3-year contracts with at least 12 qualified independent contractors (QICs) to conduct reconsiderations. A QIC must promptly notify beneficiaries and Medicare claims processing contractors of its determinations. A beneficiary may appeal the decision of a QIC to an ALJ. In cases where the ALJ decision is not rendered within the 90-day deadline, the appealing party may request a DAB hearing.

The Secretary shall perform outreach activities to inform beneficiaries, providers, and suppliers of their appeal rights and procedures. The Secretary must submit to Congress an annual report including information on the number of appeals for the previous year, identifying issues that require administrative or legislative actions, and including recommendations for change as necessary. The report must also contain an analysis of the consistency of the QIC determinations as well as the cause for any identified inconsistencies.

Section 522. Revisions to Medicare Coverage Process

The provision clarifies when and under what circumstances Medicare coverage policy may be challenged. An aggrieved party may file a complaint concerning a national coverage decision. Such complaint is reviewed by the Department Appeals Board (DAB) of HHS. The provision also permits an aggrieved party to file a complaint concerning a local coverage determination. In this case, the determination is reviewed by an administrative law judge. If unsatisfied, complainants may subsequently seek review of such a local policy by the DAB. In both cases, a DAB decision constitutes final HHS action, and is subject to judicial review. The Secretary is required to implement DAB decisions and ALJ decisions (in the case of a local coverage policy) within 30 days. The provision also permits an affected party to submit a request to the Secretary to issue a national coverage or noncoverage determination if one has not been issued. The Secretary has 90 days to respond. HHS is required to prepare an annual report on national coverage determinations.

Subtitle D—Improving Access to New Technologies

Section 531. Reimbursement Improvements for New Clinical Laboratory Tests and Durable Medical Equipment

The provision specifies that the national limitation amount for a new clinical laboratory test would equal 100% of the national median for such test. The Secretary is required to establish procedures that permit public consultation for coding and payment determinations for new clinical diagnostic laboratory tests and new durable medical equipment. The Secretary must report to Congress on specific procedures used to adjust payments for advanced technologies; the report must include recommendations for legislative changes needed to assure fair and appropriate payments.

Section 532. Retention of HCPCS Level III Codes

The provision extends the time for the use of local codes (known as HCPCS level III codes) through December 31, 2003; the Secretary is required to make the codes available to the public.

Section 533. Recognition of New Medical Technologies Under Medicare Inpatient Hospital PPS

The Secretary must submit a report to Congress no later than April 1, 2001, on potential methods for more rapidly incorporating new medical services and technologies used in the inpatient setting in the clinical coding system used with respect to payment for inpatient services. The Secretary must identify the preferred methods for expediting these coding modifications in his report, and to implement such method by October 1, 2001. Additional hospital payments could be made by means of a new technology group (DRG), an add-on payment, payment adjustment or other mechanism. However, separate fee schedules for additional new technology payments are not permitted. The Secretary must implement the new mechanism on a budget neutral basis. The total amount of projected additional payments under the mechanism is limited to an amount not greater than the Secretary's annual estimation of the costs attributable to the introduction of new technology in the hospital sector as a whole (as estimated for purposes of the annual hospital update calculation).

Subtitle E—Other Provisions

Section 541. Increase in Reimbursement for Bad Debt

Effective beginning with cost reports starting in FY2001, the provision increases the percentage of the reasonable costs associated with beneficiaries' bad debt in hospitals that Medicare would reimburse to 70%.

Section 542. Treatment of Certain Physician Pathology Services Under Medicare

The provision permits independent laboratories under a grandfather arrangement to continue, for a 2-year period (2001-2002), direct billing for the technical component of pathology services provided to hospital inpatients and hospital outpatients. The Comptroller General is required to conduct a study of the effect of these provisions on hospitals and laboratories and access of fee-for-service beneficiaries to the technical component of physician pathology services. The report is to include recommendations on whether the provisions should continue after the 2-year period for either (or both) inpatient and outpatient hospital services and whether the provision should be extended to other hospitals.

Section 543. Extension of Advisory Opinion Authority

The Office of the Inspector General's authority to issue advisory opinions to outside parties who request guidance on the applicability of the anti-kickback statute, safe harbor provisions, and other OIG health care fraud and abuse sanctions is made permanent.

Section 544. Change in Annual MedPAC Reporting

The provision delays the reporting date for the MedPAC report on issues affecting the Medicare program by 15 days to June 15. The provision also requires record votes on recommendations contained both in this report and the March report on payment policies.

Section 545. Development of Patient Assessment Instruments

The provision requires the Secretary to report to the Congress on the development of standard instruments for the assessment of the health and functional status of patients and make recommendations on the use of such standard instruments for payment purposes.

Section 546. GAO Report on Impact of the Emergency Medical Treatment and Active Labor Act (EMTALA) on Hospital Emergency Departments

GAO must evaluate the impact of the Emergency Medical Treatment and Active Labor Act on hospitals, emergency physicians, and on-call physicians covering emergency departments and to submit a report to Congress by May 1, 2001.

Section 547. Clarification of Application of Temporary Payment Increases for 2001

The special increases and adjustments of the acute hospital payment update, the indirect medical education adjustment, and the disproportionate share hospital adjustment that are in effect between April and October 2001 do not apply to discharges after FY2001 and are not included in determining subsequent payments.

Special update payments under the skilled nursing facility prospective payment system between April and October 2001 do not apply to SNF services furnished after that period and are not included when determining payments for the subsequent period.

Special market basket update payments under the home health prospective payment system between April and October 2001 are not included in determining subsequent payments. Also, temporary payments to certain rural home health agencies from April 1, 2001, through September 30, 2002, are not included in determining subsequent payments.

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

Subtitle A—Medicare+Choice Payment Reforms

Section 601. Increase in Minimum Payment Amount

The provision sets the minimum payment amount for aged enrollees *within* the 50 states and the District of Columbia in a Metropolitan Statistical Area with a population of more than 250,000 at \$525 in 2001. For all other areas *within* the 50 states and the District of Columbia, the minimum is \$475. For any area *outside* the 50 states and the District of Columbia, the \$525 and \$475 minimum amounts are also applied, except that the 2001 minimum payment amount cannot exceed 120% of the 2000 minimum payment amount. This increase is effective March 1, 2001.

Section 602. Increase in Minimum Percentage Increase

This provision applies a 3% minimum update in 2001 and return to the current law minimum update of 2% thereafter. This increase is effective March 1, 2001.

Section 603. Phase-In of Risk Adjustment

This provision extends the current risk adjustment methodology until 2003, under which 10% of payments are based on risk-adjusted inpatient data built on the 15 principal inpatient diagnostic cost groups (PIP-DCGs) and 90% are adjusted solely using the older demographic method. Beginning in 2004, a new risk adjustment methodology will be phased-in based on data from inpatient hospitals and ambulatory settings. This new risk adjustment will be phased in at the rate of 30% in 2004, 50% in 2005, and 75% in 2006. Beginning in 2007, risk adjustment will be based entirely on data from inpatient hospitals and ambulatory settings.

Section 604. Transition to Revised Medicare+Choice Payment Rates

Within 2 weeks after the date of enactment of the Act, the Secretary announced revised M+C capitation rates for 2001 (completed on January 4, 2001), due to changes from this Act. Plans that previously provided notice of their intention to terminate contracts or reduce their service area for 2001 have 2 weeks after announcement of the revised rates (January 18, 2001) to rescind their

notice and submit ACR information. Further, any M+C organization that will receive higher capitation payments as a result of this Act must submit revised ACR information within 2 weeks after announcement of the revised rates. Plans may only reduce premiums, reduce cost sharing, enhance benefits, utilize stabilization funds, or stabilize or enhance beneficiary access to providers (as long as this does not result in increased beneficiary premiums, increased cost-sharing, or reduced benefits). Any regulations that limit stabilization fund amounts will be waived, with respect to ACR submissions under this section of the bill. Notwithstanding the issuance of revised rates, M+C organizations will continue to be paid on a fee-for-service basis for costs associated with new national coverage determinations that are made mid-year.

Section 605. Revision of Payment Rates for ESRD Patients Enrolled in Medicare+Choice Plans

This provision requires that the Secretary increase the M+C payment rates for enrollees with ESRD. The revised rates will reflect the demonstration rate (including the risk-adjustment methodology) of social health maintenance organizations' ESRD capitation demonstrations. The revised rates will include adjustments for factors such as renal treatment modality, age, and underlying cause of the disease. These revised rates will be effective beginning in January 2002, and the Secretary of HHS is required to publish the adjustments in final form by July 1, 2001.

Section 606. Permitting Premium Reductions as Additional Benefits under Medicare+Choice Plans

This provision permits M+C plans to offer reduced Medicare Part B premiums to their enrollees as part of providing any required additional benefits or reduced cost-sharing. An M+C organization may elect a reduction in its M+C payment up to 125% of the annual Part B premium. However, only 80% of this amount can be used to reduce an enrollee's actual Part B premium. This has the effect of returning up to 100% of the beneficiary's Part B premium. The reduction applies uniformly to each enrollee of the M+C plan. Plans must include information about Part B premium reductions as part of the required information that is provided to enrollees for comparing plan options. This provision will be effective beginning in 2003.

Section 607. Full Implementation of Risk Adjustment for Congestive Heart Failure Enrollees for 2001

This provision fully implements risk adjustment based on inpatient hospital diagnoses for an individual who had a qualifying congestive heart failure inpatient diagnosis between July 1, 1999 and June 30, 2000, if that individual was enrolled in a coordinated care plan offered on January 1, 2001. This will apply for only 1 year, beginning on January 1, 2001. This payment amount will be excluded from the determination of the budget neutrality factor.

Section 608. Expansion of Application of Medicare+Choice New Entry Bonus

This provision expands the application of the new entry bonus for M+C plans to include areas for which notification had been provided, as of October 3, 2000, that no plans are available January 1, 2001.

Section 609. Report on Inclusion of Certain Costs of the Department of Veterans Affairs and Military Facility Services in Calculating Medicare+Choice Payment Rates

The Secretary shall report to Congress by January 1, 2003, on a method to phase-in the costs of military facility services furnished by the Department of Veterans Affairs or the Department of Defense to Medicare-eligible beneficiaries in the calculation of an area's M+C capitation payment. This report will include, on a county-by-county basis: the actual or estimated costs of such services to Medicare-eligible beneficiaries; the change in M+C capitation payment rates if such costs were included in the calculation of payment rates; one or more proposals for the implementation of payment adjustments to M+C plans in counties where the payment rate has been affected due to failure to account for the cost of such services; and a system to ensure that when a M+C enrollee receives covered services through a facility of these Departments, there is an appropriate payment recovery to the Medicare program.

Subtitle B—Other Medicare+Choice Reforms

Section 611. Payments of Additional Amounts for New Benefits Covered During a Contract Term

The provision requires payment adjustments to M+C plans if a legislative change results in significant increased costs, similar to the requirements for adjusting payments due to significant increased costs resulting from National Coverage Determination (NCDs). In addition, this provision requires that cost projections and payment adjustments be based on actuarial estimates provided by the Chief Actuary of the Health Care Financing Administration.

Section 612. Restriction on Implementation of Significant New Regulatory Requirements Mid-Year

The provision precludes the Secretary from implementing, other than at the beginning of a calendar year, regulations that impose new, significant regulatory requirements on M+C organizations.

Section 613. Timely Approval of Marketing Material That Follows Model Marketing Language

The provision requires the Secretary to make decisions, within 10 days, approving or modifying marketing material used by M+C organizations, provided that the organization uses model language specified by the Secretary. This provision applies to marketing material submitted on or after January 1, 2001.

Section 614. Avoiding Duplicative Regulation

This provision further stipulates when Medicare law preempts state law or regulation from applying to M+C plans, by specifying that the term *benefit requirements* includes cost-sharing requirements. Second, the provision stipulates that state laws and regulations affecting marketing

materials, and summaries and schedules of benefits regarding an M+C plan, will also be preempted by Medicare law.

Section 615. Election of Uniform Local Coverage Policy For Medicare+Choice Plan Covering Multiple Localities

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

Section 616. Eliminating Health Disparities in Medicare+Choice Program

This provision expands the M+C quality assurance programs for M+C plans to include a separate focus on racial and ethnic minorities. The Secretary is also required to report to Congress how the quality assurance programs focus on racial and ethnic minorities, within 2 years after enactment and biennially thereafter.

Section 617. Medicare+Choice Program Compatibility with Employer or Union Group Health Plans

In order to make the M+C program compatible with employer or union group health plans, this provision allows the Secretary to waive or modify requirements that hinder the design of, offering of, or enrollment in certain M+C plans. Plans included in the category are M+C plans under contract between M+C organizations and employers, labor organizations, or trustees of a fund established by employers and/or labor organizations.

Section 618. Special Medigap Enrollment Anti-Discrimination Provision for Certain Beneficiaries

This provision extends the period for Medigap enrollment for certain M+C enrollees affected by termination of coverage. For individuals enrolled in an M+C plan during a 12-month trial period, their trial period will begin again if they re-enrolled in another M+C plan because of an involuntary termination. During this new trial period, they will retain their rights to enroll in a Medigap policy; however, the total time for a trial period can not exceed 2 years from the time they first enrolled in an M+C plan.

Section 619. Restoring Effective Date of Elections and Changes of Elections of Medicare+Choice Plans

This provision allows individuals who enroll in an M+C plan after the 10th day of the month to receive coverage beginning on the first day of the next calendar month, effective June 1, 2001.

Section 620. Permitting ESRD Beneficiaries to Enroll in Another Medicare+Choice Plan If the Plan in Which They Are Enrolled Is Terminated

This provision permits ESRD beneficiaries to enroll in another M+C plan if they lost coverage when their plan terminated its contract or reduced its service area. This provision is also retroactive, to include individuals whose enrollment in an M+C plan was terminated involuntarily on or after December 31, 1998.

Section 621. Providing Choice for Skilled Nursing Facility Services under the Medicare+Choice Program

Effective for M+C contracts entered into or renewed on or after the date of enactment, the provision requires an M+C plan to cover post-hospitalization skilled nursing care through an enrollee's "home skilled nursing facility" if the plan has a contract with the facility or if the home facility agrees to accept substantially similar payment under the same terms and conditions that apply to similarly situated SNFs that are under contract with the plan. A "home skilled nursing facility" is defined as (a) one in which the enrollee resided at the time of the hospital admission that triggered eligibility for SNF care upon discharge, or (b) is the facility that is providing such services through the continuing care retirement community in which the enrollee resided at the time of hospital admission, or (c) is the facility in which the spouse of the enrollee is residing at the time of the enrollee's hospital discharge. SNF care at the home facility can be no less favorable than care received in another SNF that has a contract with the plan.

Home skilled nursing facilities are permitted to refuse to accept Medicare+Choice enrollees or to impose conditions on their acceptance of such an enrollee.

The provision requires the Medicare Payment Advisory Commission (MedPAC) to analyze and, within 2 years of enactment, report to Congress on the effects of this provision on the scope of benefits, administrative and other costs incurred by M+C organizations, and the contractual relationships between those plans and SNFs.

Section 622. Providing for Accountability of Medicare+Choice Plans

The provision mandates review of ACR submissions by the HCFA Chief Actuary with respect to submissions for ACRs filed on or after May 1, 2001.

Section 623. Increased Civil Money Penalty for Medicare+Choice Organizations that Terminate Contracts Mid-Year

This provision allows for a civil money penalty of up to \$100,000 (or higher as established by the Secretary of Health and Human Services through regulations) for an M+C organization that terminates its contract other than at an appropriate time after providing appropriate notice.

Subtitle C—Other Managed Care Reforms

Section 631. 1-Year Extension of Social Health Maintenance Organization (SHMO) Demonstration Project

The provision extends SHMO waivers until 30 months after the Secretary submits a report with a plan for integration and transition of SHMOs into an option under the M+C program. This 30-month extension supersedes the 18-month extension in BBRA 99.

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

Effective as if enacted with BBRA99, the provision eliminates the requirement that CNO capitated payments be reduced to ensure budget neutrality. Through December 2001, the projects will operate under the same terms and conditions applicable during 1999 but with modification to the capitation rates. From October 1, 2000, through December 31, 2000, the capitation rates will be adjusted for inflation since 1999 and for changes in service packages, but reduced by 10% for projects in Arizona, Minnesota, and Illinois and by 15% in New York. In 2001, the rates will be determined by actuarially adjusting the rates in the prior period for inflation, utilization, and changes to the service package. Adjustments will be made to case management fees for certain frail enrollees, and requirements will be imposed to create greater uniformity in clinical features among participating sites and to improve quality and enrollee satisfaction.

By July 1, 2001, the Secretary is required to submit to the House Committees on Ways and Means and Commerce and the Senate Committee on Finance a report evaluating the projects for the period July 1997 through December 1999 and for the extension period after September 30, 2000. A final report is required by July 1, 2002. The provision requires certain methods to be used to compare spending per beneficiary under the projects.

Section 633. Extension of Medicare Municipal Health Services Demonstration Projects

The provision extends the Medicare municipal health services demonstration projects for 2 additional years, through December 31, 2004.

Section 634. Service Area Expansion for Medicare Cost Contracts During Transition Period

This provision allows service area expansion for Medicare cost contracts, if the request was submitted to the Secretary before September 1, 2003.

Title IX—Other Provisions

Subtitle A—PACE Program

Section 901. Extension of Transition for Current Waivers

The provision permits the Secretary to continue to operate the Program of All-Inclusive Care for the Elderly (PACE) under waivers for a period of 36 months (rather than 24 months), and states may do so for 4 years (rather than 3 years). OBRA 86 required the Secretary to grant waivers of certain Medicare and Medicaid requirements to not more than 10 public or non-profit private community-based organizations to provide health and long-term care services on a capitated basis to frail elderly persons at risk of institutionalization. BBA 97 established PACE as a permanent provider under Medicare and as a special benefit under Medicaid.

Section 902. Continuing of Certain Operating Arrangements Permitted

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

Section 903. Flexibility in Exercising Waiver Authority

The provision enables the Secretary to exercise authority to modify or waive Medicare or Medicaid requirements to respond to the needs of PACE programs related to employment and the use of community care physicians. The Secretary must approve requests for such waivers within 90 days of the date the request for waiver is received.

Subtitle B—Outreach to Eligible Low-Income Medicare Beneficiaries

Section 911. Outreach on Availability of Medicare Cost-Sharing Assistance to Eligible Low-Income Medicare Beneficiaries

The provision requires the Commissioner of the Social Security Administration to conduct outreach efforts to identify individuals who may be eligible for Medicaid payment of Medicare cost sharing and to notify these persons of the availability of such assistance. The Commissioner must also furnish, at least annually, a list of such individuals who reside in each state to that state's agency responsible for administering the Medicaid program as well as to any other appropriate state agency. The list must include the name and address and whether such individuals have experienced reductions in Social Security benefits. The provision also requires the General Accounting Office to conduct a study of the impact of the outreach activities of the Commissioner to submit to Congress no later than 18 months after such outreach begins. The provision is effective one year after date of enactment.

Subtitle E—Information on Nursing Facility Staffing

Section 941. Posting of Information on Nursing Facility Staffing

The provision requires Medicare skilled nursing facilities and Medicaid nursing facilities to post nurse staffing information daily for each shift in the facility, effective January 1, 2003.

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