

**AMENDMENT-IN-THE-NATURE-OF-A-SUBSTITUTE
TO H.R.
OFFERED BY MR. THOMAS**

**(Substitute for Medicare Refinement and Benefits
Improvement Act of 2000 (11THPO))**

Strike all after the enacting clause and insert the
following:

1 **SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SE-**
2 **CURITY ACT; REFERENCES TO OTHER ACTS;**
3 **TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the “Medi-
5 care Refinement and Benefits Improvement Act of 2000”.

6 (b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as
7 otherwise specifically provided, whenever in this Act an amend-
8 ment is expressed in terms of an amendment to or repeal of
9 a section or other provision, the reference shall be considered
10 to be made to that section or other provision of the Social Se-
11 curity Act.

12 (c) REFERENCES TO OTHER ACTS.—In this Act:

13 (1) BALANCED BUDGET ACT OF 1997.—The term
14 “BBA” means the Balanced Budget Act of 1997 (Public
15 Law 105–33).

16 (2) MEDICARE, MEDICAID, AND SCHIP BALANCED
17 BUDGET REFINEMENT ACT OF 1999.—The term “BBRA”
18 means the Medicare, Medicaid, and SCHIP Balanced
19 Budget Refinement Act of 1999 (Appendix F), as enacted
20 into law by section 1000(a)(6) of Public Law 106–113.

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

Sec. 1. Short title; amendments to Social Security Act; references to other
Acts; table of contents.

TITLE I—BENEFICIARY PROVISIONS

Sec. 101. Acceleration of reduction of beneficiary copayment for hospital
outpatient services.

Sec. 102. Coverage of medical nutrition therapy services for beneficiaries
with diabetes or a renal disease.



- Sec. 103. Coverage of screening colonoscopy for average risk individuals.
- Sec. 104. Coverage of annual screening pap smear and pelvic exams.
- Sec. 105. Coverage of screening for glaucoma.
- Sec. 106. Modernization of screening mammography benefit.
- Sec. 107. Preservation of coverage of drugs and biologicals under part B of the medicare program.
- Sec. 108. Elimination of time limitation on medicare benefits for immunosuppressive drugs.
- Sec. 109. Imposition of balanced billing limits on prescription drugs.
- Sec. 110. Study on medicare coverage of routine thyroid screening.
- Sec. 111. Demonstration project for disease management for severely chronically ill medicare beneficiaries.
- Sec. 112. MedPAC study on consumer coalitions.

TITLE II—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services

- Sec. 201. Revision of acute care hospital payment update for 2001.
- Sec. 202. Increase in reimbursement for bad debt for qualified medicare beneficiaries.
- Sec. 203. Additional modification in transition for indirect medical education (IME) percentage adjustment.
- Sec. 204. Decrease in reductions for disproportionate share hospital (DSH) payments.
- Sec. 205. Increase in base payment to Puerto Rico acute care hospitals.
- Sec. 206. Wage index improvements.
- Sec. 207. Limitation to residents in allopathic and osteopathic medicine in application of resident limits.
- Sec. 208. Payment for inpatient services of rehabilitation hospitals.
- Sec. 209. Payment for inpatient services of psychiatric hospitals.
- Sec. 210. Payment for inpatient services of long-term care hospitals.

Subtitle B—Adjustments to PPS Payments for Skilled Nursing Facilities

- Sec. 221. Elimination of reduction in skilled nursing facility (SNF) market basket update in 2001.
- Sec. 222. Increase in nursing component of PPS Federal rate.
- Sec. 223. Application of SNF consolidated billing requirement limited to part A covered stays.
- Sec. 224. Adjustment of rehabilitation RUGs to correct anomaly in payment rates.
- Sec. 225. Establishment of process for geographic reclassification.

Subtitle C—Hospice Care

- Sec. 231. Full market basket increase for 2001.
- Sec. 232. Clarification of physician certification.
- Sec. 233. MedPAC report on access to, and use of, hospice benefit.

Subtitle D—Other Provisions

- Sec. 241. Relief from medicare part A late enrollment penalty for group buy-in for State and local retirees.

TITLE III—RURAL PROVIDER PROVISIONS

Subtitle A—Rural Hospitals

- Sec. 301. Equitable treatment for rural disproportionate share hospitals.
- Sec. 302. Extension of option to use rebased target amounts to all sole community hospitals.
- Sec. 303. Updating criteria for medicare dependent hospitals.
- Sec. 304. Other rural hospital provisions.



Subtitle B—Critical Access Hospitals

- Sec. 311. Clarification of no beneficiary cost-sharing for clinical diagnostic laboratory tests furnished by critical access hospitals.
- Sec. 312. Assistance with fee schedule payment for professional services under all-inclusive rate.
- Sec. 313. Exemption of critical access hospital swing beds from SNF PPS.
- Sec. 314. Payment in critical access hospitals for emergency room on-call physicians.
- Sec. 315. Treatment of ambulance services furnished by certain critical access hospitals.
- Sec. 316. Clarification of critical access hospital criteria.

Subtitle C—Other Rural Provisions

- Sec. 321. Assistance for providers of ambulance services in rural areas.
- Sec. 322. Treatment of certain physician pathology services under medicare.
- Sec. 323. Funding for grant program for rural hospital transition to prospective payment.
- Sec. 324. Expansion of medicare payment for telehealth services.
- Sec. 325. Expanding access to rural health clinics.

TITLE IV—PROVISIONS RELATING TO PART B

Subtitle A—Hospital Outpatient Services

- Sec. 401. Revision of hospital outpatient PPS payment update.
- Sec. 402. Clarifying process and standards for determining eligibility of devices for pass-through payments under hospital outpatient PPS.
- Sec. 403. Application of OPD PPS transitional corridor payments to certain hospitals that did not submit a 1996 cost report.
- Sec. 404. Application of rules for determining provider-based status for certain entities.
- Sec. 405. Treatment of children's hospitals under prospective payment system.

Subtitle B—Other Services

- Sec. 411. 1-year extension of moratorium on therapy caps; report on standards for supervision of physical therapy assistants.
- Sec. 412. Update in renal dialysis composite rate.
- Sec. 413. Payment for ambulance services.
- Sec. 414. Ambulatory surgical centers.
- Sec. 415. Full update for durable medical equipment.
- Sec. 416. Full update for orthotics and prosthetics.
- Sec. 417. Establishment of special payment provisions and requirements for prosthetics and certain custom fabricated orthotic items.
- Sec. 418. Revised part B payment for drugs and biologicals and related services.
- Sec. 419. GAO study on coverage of surgical first assisting services of certified registered nurse first assistants.

TITLE V—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

- Sec. 501. 1-year additional delay in application of 15 percent reduction on payment limits for home health services.
- Sec. 502. Restoration of full home health market basket update for home health services for fiscal year 2001.
- Sec. 503. Temporary two-month extension of periodic interim payments.
- Sec. 504. Use of telehealth in delivery of home health services.



- Sec. 505. Study on costs to home health agencies of purchasing nonroutine medical supplies.
- Sec. 506. Treatment of branch offices; GAO study on supervision of home health care provided in isolated rural areas.

Subtitle B—Direct Graduate Medical Education

- Sec. 511. Increase in floor for direct graduate medical education payments.
- Sec. 512. Change in distribution formula for Medicare+Choice-related nursing and allied health education costs.

Subtitle C—Changes in Medicare Coverage and Appeals Process

- Sec. 521. Revisions to medicare appeals process.
- Sec. 522. Revisions to medicare coverage process.

Subtitle D—Veterans Subvention Demonstration Project

- Sec. 531. Veterans access to services under the medicare program.

Subtitle E—Improving Access to New Technologies

- Sec. 541. Process for making and implementing HCPCS coding modifications.
- Sec. 542. Establishment of procedures for medicare coding and payment determinations for new clinical diagnostic laboratory tests and other items on a fee schedule.
- Sec. 543. Retention of HCPCS level III codes.
- Sec. 544. Recognition of new medical technologies under inpatient hospital PPS.

Subtitle F—Other Provisions

- Sec. 551. Extension of advisory opinion authority.
- Sec. 552. Change in annual MedPAC reporting.
- Sec. 553. Development of patient assessment instruments.

**TITLE VI—MEDICARE+CHOICE REFORMS AND OTHER
MANAGED CARE REFORMS**

Subtitle A—Medicare+Choice Payment Reforms

- Sec. 601. Increase in national per capita Medicare+Choice growth percentage in 2001 and 2002.
- Sec. 602. Modification of budget neutrality adjustments.
- Sec. 603. Increase in minimum payment amount.
- Sec. 604. Increase in minimum percentage increase.
- Sec. 605. Allowing movement to 50:50 percent blend.
- Sec. 606. Increased payment for areas with two or fewer Medicare+Choice contracts.
- Sec. 607. Permitting higher negotiated rates in certain Medicare+Choice payment areas below national average.
- Sec. 608. 10-year phase-in of risk adjustment.
- Sec. 609. Transition to revised Medicare+Choice payment rates.
- Sec. 610. Adjustment in payment for Medicare+Choice enrollees with end-stage renal disease.
- Sec. 611. Report on inclusion of certain costs of Department of Veterans Affairs and military facility services in calculating Medicare+Choice payment rates.

Subtitle B—Other Medicare+Choice Reforms

- Sec. 621. Payment of additional amounts for new benefits covered during a contract term.
- Sec. 622. Restriction on implementation of significant new regulatory requirements mid-year.



- Sec. 623. Timely approval of marketing material that follows model marketing language.
- Sec. 624. Avoiding duplicative regulation.
- Sec. 625. Election of uniform local coverage policy for medicare+choice plan covering multiple localities.
- Sec. 626. Providing choice for skilled nursing facility services under the Medicare+Choice program.

Subtitle C—Other Managed Care Reforms

- Sec. 631. 1-year extension of Social Health Maintenance Organization (SHMO) demonstration project.
- Sec. 632. Revised terms and conditions for extension of medicare Community Nursing Organization (CNO) demonstration project.
- Sec. 633. Extension of medicare municipal health services demonstration projects.

TITLE VII—PACE PROGRAM

- Sec. 701. Extension of transition for current waivers.
- Sec. 702. Continuing of certain operating arrangements permitted.
- Sec. 703. Flexibility in exercising waiver authority.

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TITLE I—BENEFICIARY PROVISIONS

SEC. 101. ACCELERATION OF REDUCTION OF BENEFICIARY COPAYMENT FOR HOSPITAL OUTPATIENT SERVICES.

(a) REDUCING THE UPPER LIMIT ON BENEFICIARY COPAYMENT.—

(1) IN GENERAL.—Section 1833(t)(8)(C) (42 U.S.C. 1395l(t)(8)(C)) is amended to read as follows:

“(C) LIMITATION ON COPAYMENT AMOUNT.—

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

“(ii) TO SPECIFIED PERCENTAGE.—The Secretary shall reduce the national unadjusted copayment amount for a covered OPD service (or group of such services) furnished in a year in a manner so that the effective copayment rate (determined on a national unadjusted basis) for that service in the year does not exceed the following percentage:

“(I) For procedures performed in 2001, 60 percent.



1 “(II) For procedures performed in 2002,
2 55 percent.

3 “(III) For procedures performed in 2003,
4 50 percent.

5 “(IV) For procedures performed in 2004
6 and thereafter, 45 percent.”.

7 (2) EFFECTIVE DATE.—The amendment made by
8 paragraph (1) applies with respect to services furnished on
9 or after January 1, 2001.

10 (b) AUTHORIZATION TO LIMIT INCREASES IN COST-SHAR-
11 ING.—Nothing in this Act of the Social Security Act shall be
12 construed as preventing a hospital from waiving the amount of
13 any coinsurance for outpatient hospital services under the
14 medicare program that may have been increased as a result of
15 the implementation of the prospective payment system under
16 section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)).

17 (c) DISCLOSURE OF INFORMATION ABOUT REDUCTION IN
18 MEDIGAP PREMIUM LEVELS RESULTING FROM REDUCTIONS
19 IN COINSURANCE.—Any medicare supplemental policy which
20 the Secretary certifies under section 1882(c) of the Social Se-
21 curity Act (42 U.S.C. 1395ss(c)) shall provide for an annual
22 disclosure to each enrollee of the amount by which the premium
23 for such supplemental policy is lower than the premium that
24 would otherwise apply as a result of the amendment made by
25 subsection (a). Such information shall also be furnished to the
26 Secretary of Health and Human Services and the Comptroller
27 General of the United States, and shall include a description
28 of the methodology by which such reduction was determined.
29 Upon receipt of the information required under this subsection,
30 the Secretary shall make that information available to the pub-
31 lic as soon as practicable.

32 (d) GAO STUDY OF REDUCTION IN MEDIGAP PREMIUM
33 LEVELS RESULTING FROM REDUCTIONS IN COINSURANCE.—
34 The Comptroller General of the United States shall work, in
35 concert with the National Association of Insurance Commis-
36 sioners, to evaluate the extent to which the premium levels for
37 medicare supplemental policies reflect the reductions in coinsur-



1 ance resulting from the amendment made by subsection (a).
 2 The Comptroller General shall submit a report to Congress by
 3 not later than April 1, 2004, on such evaluation and the extent
 4 to which the reductions in beneficiary coinsurance effected by
 5 such amendment have resulted in actual savings to medicare
 6 beneficiaries.

7 **SEC. 102. COVERAGE OF MEDICAL NUTRITION THERAPY**
 8 **SERVICES FOR BENEFICIARIES WITH DIABE-**
 9 **TES OR A RENAL DISEASE.**

10 (a) COVERAGE.—Section 1861(s)(2) (42 U.S.C.
 11 1395x(s)(2)) is amended—

12 (1) by striking “and” at the end of subparagraph (S);
 13 (2) by inserting “and” at the end of subparagraph
 14 (T); and
 15 (3) by adding at the end the following:

16 “(U) medical nutrition therapy services (as defined in
 17 subsection (uu)(1)) in the case of a beneficiary with diabe-
 18 tes or a renal disease;”.

19 (b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C.
 20 1395x) is amended by adding at the end the following:

21 “Medical Nutrition Therapy Services; Registered Dietitian or
 22 Nutrition Professional

23 “(uu)(1) The term ‘medical nutrition therapy services’
 24 means nutritional diagnostic, therapy, and counseling services
 25 for the purpose of disease management which are furnished by
 26 a registered dietitian or nutrition professional (as defined in
 27 paragraph (2)) pursuant to a referral by a physician (as de-
 28 fined in subsection (r)(1)).

29 “(2) Subject to paragraph (3), the term ‘registered dieti-
 30 tian or nutrition professional’ means an individual who—

31 “(A) holds a baccalaureate or higher degree granted
 32 by a regionally accredited college or university in the
 33 United States (or an equivalent foreign degree) with com-
 34 pletion of the academic requirements of a program in nutri-
 35 tion or dietetics, as accredited by an appropriate national
 36 accreditation organization recognized by the Secretary for
 37 this purpose;



1 “(B) has completed at least 900 hours of supervised
2 dietetics practice under the supervision of a registered die-
3 tician or nutrition professional; and

4 “(C)(i) is licensed or certified as a dietitian or nutri-
5 tion professional by the State in which the services are per-
6 formed; or

7 “(ii) in the case of an individual in a State that does
8 not provide for such licensure or certification, meets such
9 other criteria as the Secretary establishes.

10 “(3) Subparagraphs (A) and (B) of paragraph (2) shall
11 not apply in the case of an individual who, as of the date of
12 enactment of this subsection, is licensed or certified as a dieti-
13 tian or nutrition professional by the State in which medical nu-
14 trition therapy services are performed.”.

15 (c) PAYMENT.—Section 1833(a)(1) (42 U.S.C.
16 1395l(a)(1)) is amended—

17 (1) by striking “and” before “(S)”, and

18 (2) by inserting before the semicolon at the end the
19 following: “, and (T) with respect to medical nutrition ther-
20 apy services (as defined in section 1861(uu)), the amount
21 paid shall be the 80 percent of the lesser of the actual
22 charge for the services or 80 percent of the amount deter-
23 mined under the fee schedule established under section
24 1848(b) for the same services if furnished by a physician”.

25 (d) APPLICATION OF LIMITS ON BILLING.—Section
26 1842(b)(18)(C) (42 U.S.C. 1395u(b)(18)(C)) is amended by
27 adding at the end the following new clause:

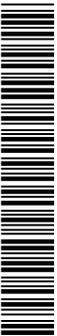
28 “(vi) A registered dietician or nutrition professional.”.

29 (e) EFFECTIVE DATE.—The amendments made by this
30 section apply to services furnished on or after January 1, 2001.

31 **SEC. 103. COVERAGE OF SCREENING COLONOSCOPY**
32 **FOR AVERAGE RISK INDIVIDUALS.**

33 (a) IN GENERAL.—Section 1861(pp) (42 U.S.C.
34 1395x(pp)) is amended—

35 (1) in paragraph (1)(C), by striking “In the case of
36 an individual at high risk for colorectal cancer, screening
37 colonoscopy” and inserting “Screening colonoscopy”; and



1 (2) in paragraph (2), by striking “In paragraph
2 (1)(C), an” and inserting “An”.

3 (b) FREQUENCY LIMITS FOR SCREENING
4 COLONOSCOPY.—Section 1834(d) (42 U.S.C. 1395m(d)) is
5 amended—

6 (1) in paragraph (2)(E)(ii), by inserting before the pe-
7 riod at the end the following: “or, in the case of an indi-
8 vidual who is not at high risk for colorectal cancer, if the
9 procedure is performed within the 119 months after a pre-
10 vious screening colonoscopy”;

11 (2) in paragraph (3)—

12 (A) in the heading by striking “FOR INDIVIDUALS
13 AT HIGH RISK FOR COLORECTAL CANCER”;

14 (B) in subparagraph (A), by striking “ for individ-
15 uals at high risk for colorectal cancer”;

16 (C) in subparagraph (E), by inserting before the
17 period at the end the following: “or for other individ-
18 uals if the procedure is performed within the 119
19 months after a previous screening colonoscopy or within
20 47 months of a previous screening flexible
21 sigmoidoscopy”.

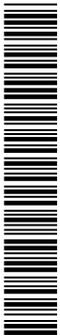
22 (c) EFFECTIVE DATE.—The amendments made by this
23 section apply to colorectal cancer screening services provided on
24 or after January 1, 2001.

25 **SEC. 104. COVERAGE OF ANNUAL SCREENING PAP**
26 **SMEAR AND PELVIC EXAMS.**

27 (a) IN GENERAL.—

28 (1) ANNUAL SCREENING PAP SMEAR.—Section
29 1861(nm)(1) (42 U.S.C. 1395x(nm)(1)) is amended by
30 striking “if the individual involved has not had such a test
31 during the preceding 3 years, or during the preceding year
32 in the case of a woman described in paragraph (3).” and
33 inserting “if the woman involved has not had such a test
34 during the preceding year.”.

35 (2) ANNUAL SCREENING PELVIC EXAM.—Section
36 1861(nm)(2) (42 U.S.C. 1395x(nm)(2)) is amended by
37 striking “during the preceding 3 years, or during the pre-



1 ceding year in the case of a woman described in paragraph
2 (3),” and inserting “during the preceding year,”.

3 (3) CONFORMING AMENDMENT.—Section 1861(nm)
4 (42 U.S.C. 1395x(nm)) is amended by striking paragraph
5 (3).

6 (b) EFFECTIVE DATE.—The amendments made by sub-
7 section (a) apply to items and services furnished on or after
8 January 1, 2001.

9 **SEC. 105. COVERAGE OF SCREENING FOR GLAUCOMA.**

10 (a) COVERAGE.—Section 1861(s)(2) (42 U.S.C.
11 1395x(s)(2)), as amended by section 102(a), is amended—

12 (1) in subparagraph (T), by striking “and” at the end;

13 (2) in subparagraph (U), by inserting “and” at the
14 end; and

15 (3) by adding at the end the following new subpara-
16 graph:

17 “(V) screening for glaucoma (as defined in subsection
18 (vv)) for individuals determined to be at high risk for glau-
19 coma, individuals with a family history of glaucoma and in-
20 dividuals with diabetes or myopia;”.

21 (b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C.
22 1395x), as amended by section 102(b), is amended by adding
23 at the end the following new subsection:

24 “Screening for Glaucoma

25 “(vv) The term ‘screening for glaucoma’ means a dilated
26 eye examination with an intraocular pressure measurement,
27 and a direct ophthalmoscopy or a slit-lamp biomicroscopic ex-
28 amination for the early detection of glaucoma which is fur-
29 nished by or under the direct supervision of an optometrist or
30 ophthalmologist who is legally authorized to furnish such serv-
31 ices under State law (or the State regulatory mechanism pro-
32 vided by State law) of the State in which the services are fur-
33 nished, as would otherwise be covered if furnished by a physi-
34 cian or as an incident to a physician’s professional service, if
35 the individual involved has not had such an examination in the
36 preceding year.”.

37 (c) ELIMINATION OF COST-SHARING.—



1 (1) ELIMINATION OF COINSURANCE.—Section
2 1833(a)(1) (42 U.S.C. 1395l(a)(1)), as amended by section
3 102(c), is amended—

4 (A) by striking “and” before “(T)”;

5 (B) by inserting before the semicolon at the end
6 the following: “, and (U) with respect to screening for
7 glaucoma (as defined in section 1861(vv)), the amount
8 paid shall be 100 percent of the lesser of the actual
9 charge for the services or amount determined by a fee
10 schedule established by the Secretary for the purposes
11 of this subparagraph;”.

12 (2) ELIMINATION OF DEDUCTIBLE.—The first sen-
13 tence of section 1833(b) (42 U.S.C. 1395l(b)) is
14 amended—

15 (A) by striking “and” before “(6)”;

16 (B) by inserting before the period the following: “,
17 and (7) such deductible shall not apply with respect to
18 screening for glaucoma (as defined in section
19 1861(vv))”.

20 (d) CONFORMING AMENDMENT.—Section 1862(a)(1)(F)
21 (42 U.S.C. 1395y(a)(1)(F)) is amended—

22 (1) by striking “and,”;

23 (2) by adding at the end the following: “and, in the
24 case of screening for glaucoma, which is performed more
25 frequently than is provided under section 1861(vv),”.

26 (e) EFFECTIVE DATE.—The amendments made by this
27 section shall apply to services furnished on or after January 1,
28 2001.

29 **SEC. 106. MODERNIZATION OF SCREENING MAMMOG-**
30 **RAPHY BENEFIT.**

31 (a) INCLUSION IN PHYSICIAN FEE SCHEDULE.—Section
32 1848(j)(3) (42 U.S.C. 1395w-4(j)(3)) is amended by inserting
33 “(13),” after “(4),”.

34 (b) CONFORMING AMENDMENT.—Section 1834(c) (42
35 U.S.C. 1395m(c)) is amended to read as follows:

36 “(c) PAYMENT AND STANDARDS FOR SCREENING MAM-
37 MOGRAPHY.—



1 “(1) IN GENERAL.—With respect to expenses incurred
2 for screening mammography (as defined in section
3 1861(jj)), payment may be made only—

4 “(A) for screening mammography conducted con-
5 sistent with the frequency permitted under paragraph
6 (2); and

7 “(B) if the screening mammography is conducted
8 by a facility that has a certificate (or provisional certifi-
9 cate) issued under section 354 of the Public Health
10 Service Act.

11 “(2) FREQUENCY COVERED.—

12 “(A) IN GENERAL.—Subject to revision by the
13 Secretary under subparagraph (B)—

14 “(i) no payment may be made under this part
15 for screening mammography performed on a
16 woman under 35 years of age;

17 “(ii) payment may be made under this part for
18 only one screening mammography performed on a
19 woman over 34 years of age, but under 40 years
20 of age; and

21 “(iii) in the case of a woman over 39 years of
22 age, payment may not be made under this part for
23 screening mammography performed within 11
24 months following the month in which a previous
25 screening mammography was performed.

26 “(B) REVISION OF FREQUENCY.—

27 “(i) REVIEW.—The Secretary, in consultation
28 with the Director of the National Cancer Institute,
29 shall review periodically the appropriate frequency
30 for performing screening mammography, based on
31 age and such other factors as the Secretary believes
32 to be pertinent.

33 “(ii) REVISION OF FREQUENCY.—The Sec-
34 retary, taking into consideration the review made
35 under clause (i), may revise from time to time the
36 frequency with which screening mammography may
37 be paid for under this subsection.”.



1 (c) EFFECTIVE DATE.—The amendments made by sub-
2 section (a) and (b) apply with respect to screening
3 mammographies furnished on or after January 1, 2002.

4 (d) PAYMENT FOR NEW TECHNOLOGIES.—

5 (1) TESTS FURNISHED IN 2001.—In the case of a
6 screening mammography (as defined in section 1861(jj) of
7 the Social Security Act (42 U.S.C. 1395x(jj)) performed
8 during 2001 that uses a new technology (as defined in
9 paragraph (3)), payment for such screening mammography
10 shall be made in an amount equal to 150 percent of the
11 amount of payment under section 1848 of such Act (42
12 U.S.C. 1395w-4) for a bilateral diagnostic screening mam-
13 mography (under HCPCS Code 76091) for such year. The
14 Secretary of Health and Human Services may implement
15 the provisions of this paragraph by program memorandum
16 or otherwise.

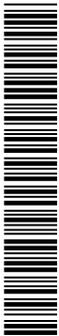
17 (2) CONSIDERATION OF NEW HCPCS CODE FOR NEW
18 TECHNOLOGIES AFTER 2001.—The Secretary shall deter-
19 mine, for such screening mammographies performed after
20 2001, whether the assignment of a new HCPCS code is ap-
21 propriate for screening mammography that uses a new
22 technology. If the Secretary determines that a new code is
23 appropriate for such screening mammography, the Sec-
24 retary shall provide for such new code for such tests fur-
25 nished after 2001.

26 (3) NEW TECHNOLOGY DESCRIBED.—For purposes of
27 this subsection, a new technology with respect to a screen-
28 ing mammography is an advance in technology with respect
29 to the test or equipment that results in the following:

30 (A) A significant increase or decrease in the re-
31 sources used in the test or in the manufacture of the
32 equipment.

33 (B) A significant improvement in the performance
34 of the test or equipment.

35 (C) A significant advance in medical technology
36 that is expected to significantly improve the treatment
37 of medicare beneficiaries.



1 (4) HCPCS CODE DEFINED.—The term “HCPCS
2 code” means an alphanumeric code under the Health Care
3 Financing Administration Common Procedure Coding Sys-
4 tem (HCPCS).

5 **SEC. 107. PRESERVATION OF COVERAGE OF DRUGS AND**
6 **BIOLOGICALS UNDER PART B OF THE MEDI-**
7 **CARE PROGRAM.**

8 (a) IN GENERAL.—Section 1861(s)(2) (42 U.S.C.
9 1395x(s)(2)) is amended, in each of subparagraphs (A) and
10 (B), by striking “(including drugs and biologicals which cannot,
11 as determined in accordance with regulations, be self-adminis-
12 tered)” and inserting “(including drugs and biologicals which
13 are not usually self-administered by the patient)”.

14 (b) EFFECTIVE DATE.—The amendment made by sub-
15 section (a) applies to drugs and biologicals administered on or
16 after October 1, 2000.

17 **SEC. 108. ELIMINATION OF TIME LIMITATION ON MEDI-**
18 **CARE BENEFITS FOR IMMUNOSUPPRESSIVE**
19 **DRUGS.**

20 (a) IN GENERAL.—Section 1861(s)(2)(J) (42 U.S.C.
21 1395x(s)(2)(J)) is amended by striking “, but only” and all
22 that follows up to the semicolon at the end.

23 (b) CONFORMING AMENDMENTS.—

24 (1) EXTENDED COVERAGE.—Section 1832 (42 U.S.C.
25 1395k) is amended—

26 (A) by striking subsection (b); and

27 (B) by redesignating subsection (c) as subsection

28 (b).

29 (2) PASS-THROUGH; REPORT.—Section 227 of BBRA
30 is amended by striking subsection (d).

31 (c) EFFECTIVE DATE.—The amendment made by sub-
32 section (a) shall apply to drugs furnished on or after the date
33 of the enactment of this Act.

34 **SEC. 109. IMPOSITION OF BALANCED BILLING LIMITS**
35 **ON PRESCRIPTION DRUGS.**

36 (a) IN GENERAL.—Section 1842(o) (42 U.S.C. 1395u(o))
37 is amended by adding at the end the following new paragraph:



1 “(3)(A) Subject to subparagraph (C), payment for a
2 charge for any drug or biological for which payment may be
3 made under this part may be made under this part only on an
4 assignment-related basis.

5 “(B) The provisions of subsection (b)(18)(B) shall apply
6 to charges for such drugs or biologicals in the same manner as
7 they apply to services provided by a practitioner described in
8 subsection (b)(18)(C).

9 “(C) This paragraph shall not apply to a such drug or bio-
10 logical for which payment is made under section 1833(t),
11 1853(e), or 1888(e).”.

12 (b) EFFECTIVE DATE.—The amendment made by sub-
13 section (a) shall apply to items furnished on or after January
14 1, 2001.

15 **SEC. 110. STUDY ON MEDICARE COVERAGE OF ROUTINE**
16 **THYROID SCREENING.**

17 (a) STUDY.—The Secretary of Health and Human Serv-
18 ices shall request the National Academy of Sciences, and as ap-
19 propriate in conjunction with the United States Preventive
20 Services Task Force, to analyze the addition of coverage of rou-
21 tine thyroid screening using a thyroid stimulating hormone test
22 as a preventive benefit provided to medicare beneficiaries under
23 title XVIII of the Social Security Act for some or all medicare
24 beneficiaries. The analysis shall consider the short term and
25 long term benefits, and costs to the medicare program, of such
26 addition.

27 (b) REPORT.—Not later than 2 years after the date of the
28 enactment of this Act, the Secretary shall submit a report on
29 the findings of the analysis conducted under subsection (a) to
30 the Committee on Ways and Means and the Committee on
31 Commerce of the House of Representatives and the Committee
32 on Finance of the Senate.

33 (c) FUNDING.—From funds appropriated to the Depart-
34 ment of Health and Human Services for fiscal years 2001 and
35 2002, the Secretary shall provide for such funding as the Sec-
36 retary determines necessary for the conduct of the study by the
37 National Academy of Sciences under this section.



1 **SEC. 111. DEMONSTRATION PROJECT FOR DISEASE**
2 **MANAGEMENT FOR SEVERELY CHRON-**
3 **ICALLY ILL MEDICARE BENEFICIARIES.**

4 (a) IN GENERAL.—The Secretary of Health and Human
5 Services shall conduct a demonstration project under this sec-
6 tion (in this section referred to as the “project”) to dem-
7 onstrate the impact on costs and health outcomes of applying
8 disease management to medicare beneficiaries with diagnosed,
9 advanced-stage congestive heart failure, diabetes, or coronary
10 heart disease. In no case may the number of participants in the
11 project exceed 30,000 at any time.

12 (b) VOLUNTARY PARTICIPATION.—

13 (1) ELIGIBILITY.—Medicare beneficiaries are eligible
14 to participate in the project only if—

15 (A) they meet specific medical criteria dem-
16 onstrating the appropriate diagnosis and the advanced
17 nature of their disease;

18 (B) their physicians approve of participation in the
19 project; and

20 (C) they are not enrolled in a Medicare+Choice
21 plan.

22 (2) BENEFITS.—A beneficiary who is enrolled in the
23 project shall be eligible—

24 (A) for disease management services related to
25 their chronic health condition; and

26 (B) for payment for all costs for prescription
27 drugs without regard to whether or not they relate to
28 the chronic health condition, except that the project
29 may provide for modest cost-sharing with respect to
30 prescription drug coverage.

31 (c) CONTRACTS WITH DISEASE MANAGEMENT ORGANIZA-
32 TIONS.—

33 (1) IN GENERAL.—The Secretary shall carry out the
34 project through contracts with up to three disease manage-
35 ment organizations. The Secretary shall not enter into such
36 a contract with an organization unless the organization
37 demonstrates that it can produce improved health outcomes



1 and reduce aggregate medicare expenditures consistent
2 with paragraph (2).

3 (2) CONTRACT PROVISIONS.—Under such contracts—

4 (A) such an organization shall be required to pro-
5 vide for prescription drug coverage described in sub-
6 section (b)(2)(B);

7 (B) such an organization shall be paid a fee nego-
8 tiated and established by the Secretary in a manner so
9 that (taking into account savings in expenditures under
10 parts A and B of the medicare program) there will be
11 a net reduction in expenditures under the medicare
12 program as a result of the project; and

13 (C) such an organization shall guarantee, through
14 an appropriate arrangement with a reinsurance com-
15 pany or otherwise, the net reduction in expenditures
16 described in subparagraph (B).

17 (3) PAYMENTS.—Payments to such organizations shall
18 be made in appropriate proportion from the Trust Funds
19 established under title XVIII of the Social Security Act.

20 (d) PERMITTING REENROLLMENT UNDER MEDIGAP WITH-
21 OUT UNDERWRITING.—The provisions of subparagraphs (A)
22 and (C) section 1882(s)(3) of the Social Security Act (42
23 U.S.C. 1395ss(s)(3)) shall apply with respect to a beneficiary
24 who—

25 (A) was enrolled under a medicare supplemental policy
26 under section 1882 that provided for coverage of outpatient
27 prescription drugs,

28 (B) subsequently terminates such enrollment and enrolls,
29 for the first time, with a disease management organization
30 under the project, and

31 (C) the subsequent enrollment under subparagraph (B) is
32 terminated by the enrollee at any time during the demonstra-
33 tion project .

34 (e) DURATION.—The project shall last for not longer than
35 3 years.

36 (f) WAIVER.—The Secretary shall waive such provisions of
37 title XVIII of the Social Security Act as may be necessary to



1 provide for payment for services under the project in accord-
2 ance with subsection (c)(3).

3 (g) REPORT.—The Secretary shall submit to Congress an
4 interim report on the project not later than 2 years after the
5 date it is first implemented and a final report on the project
6 not later than 6 months after the date of its completion. Such
7 reports shall include information on the impact of the project
8 on costs and health outcomes and recommendations on the
9 cost-effectiveness of extending or expanding the project.

10 **SEC. 112. MEDPAC STUDY ON CONSUMER COALITIONS.**

11 (a) STUDY.—The Medicare Payment Advisory Commission
12 shall conduct a study that examines the use of consumer coali-
13 tions in the marketing of Medicare+Choice plans under the
14 medicare program. The study shall examine—

15 (1) the potential for increased efficiency in the medi-
16 care program through greater beneficiary knowledge of
17 their health care options, decreased marketing costs of
18 Medicare+Choice organizations, and creation of a group
19 market;

20 (2) the implications of Medicare+Choice and Medigap
21 plans offering medicare beneficiaries in the same geo-
22 graphic location different benefits and premiums based on
23 their affiliation with a consumer coalition;

24 (3) how coalitions should be governed, how they should
25 be accountable to the Secretary of Health and Human
26 Services, and how potential conflicts of interest in the ac-
27 tivities of consumer coalitions should be avoided; and

28 (4) how such coalitions should be funded.

29 (b) REPORT.—Not later than 1 year after the date of the
30 enactment of this Act, the Commission shall submit to Con-
31 gress a report on the study conducted under subsection (a).
32 The report shall include a recommendation on whether and how
33 a demonstration project might be conducted for the operation
34 of consumer coalitions under the medicare program.

35 (c) CONSUMER COALITION DEFINED.—For purposes of
36 this section, the term “consumer coalition” means a non-profit,
37 community-based organization that—



1 (1) provides information to medicare beneficiaries
2 about their health care options under the medicare pro-
3 gram; and

4 (2) negotiates with Medicare+Choice plans on benefits
5 and premiums for medicare beneficiaries who are members
6 or otherwise affiliated with the organization.

7 **TITLE II—PROVISIONS RELATING**
8 **TO PART A**
9 **Subtitle A—Inpatient Hospital**
10 **Services**

11 **SEC. 201. REVISION OF ACUTE CARE HOSPITAL PAY-**
12 **MENT UPDATE FOR 2001.**

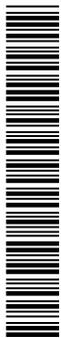
13 (a) IN GENERAL.—Section 1886(b)(3)(B)(i)(XVI) (42
14 U.S.C. 1395ww(b)(3)(B)(i)(XVI)), as amended by section 406
15 of BBRA, is amended by striking “minus 1.1 percentage points
16 for hospitals (other than sole community hospitals) in all areas,
17 and the market basket percentage increase for sole community
18 hospitals,” and inserting “for hospitals in all areas,”.

19 (b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR
20 2001.—Notwithstanding the amendment made by subsection
21 (a), for purposes of making payments for fiscal year 2001 for
22 inpatient hospital services furnished by subsection (d) hospitals
23 (as defined in section 1886(d)(1)(B) of the Social Security Act
24 (42 U.S.C. 1395ww(d)(1)(B)), the “applicable percentage in-
25 crease” referred to in section 1886(b)(3)(B)(i) of such Act (42
26 U.S.C. 1395ww(b)(3)(B)(i))—

27 (1) for discharges occurring on or after October 1,
28 2000, and before April 1, 2001, shall be determined in ac-
29 cordance with clause (XVI) of such section as in effect on
30 the day before the date of the enactment of this Act; and

31 (2) for discharges occurring on or after April 1, 2001,
32 and before October 1, 2001, shall be equal to—

33 (A) the market basket percentage increase plus
34 1.1 percentage points for hospitals (other than sole
35 community hospitals) in all areas; and



1 (B) the market basket percentage increase for sole
2 community hospitals.

3 (c) CONSIDERATION OF PRICE OF BLOOD AND BLOOD
4 PRODUCTS IN MARKET BASKET INDEX.—The Secretary of
5 Health and Human Services shall, when next (after the date
6 of the enactment of this Act) rebasing and revising the hospital
7 market basket index (as defined in section 1886(b)(3)(B)(iii) of
8 the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(iii))), con-
9 sider the prices of blood and blood products purchased by hos-
10 pitals and determine whether those prices are adequately re-
11 flected in such index.

12 (d) ADJUSTMENT FOR INPATIENT CASE MIX CHANGES.—

13 (1) IN GENERAL.—Section 1886(d)(3)(A) (42 U.S.C.
14 1395ww(d)(3)(A)) is amended by adding at the end the fol-
15 lowing new clause:

16 “(vi) Insofar as the Secretary determines that the ad-
17 justments under paragraph (4)(C)(i) for a previous fiscal
18 year (or estimates that such adjustments for a future fiscal
19 year) did (or are likely to) result in a change in aggregate
20 payments under this subsection during the fiscal year that
21 are a result of changes in the coding or classification of dis-
22 charges that do not reflect real changes in case mix, the
23 Secretary may adjust the average standardized amounts
24 computed under this paragraph for subsequent fiscal years
25 so as to eliminate the effect of such coding or classification
26 changes.”.

27 (2) EFFECTIVE DATE.—The amendment made by
28 paragraph (1) applies to discharges occurring on or after
29 October 1, 2001.

30 **SEC. 202. INCREASE IN REIMBURSEMENT FOR BAD**
31 **DEBT FOR QUALIFIED MEDICARE BENE-**
32 **FICIARIES.**

33 Section 1861(v)(1)(T)(iii) (42 U.S.C. 1395x(v)(1)(T)) is
34 amended by inserting before the period at the end the fol-
35 lowing: “(or with respect to coinsurance amounts for individ-
36 uals that the hospital demonstrates to the Secretary are quali-
37 fied medicare beneficiaries under title XIX, 44 percent for cost



1 reporting periods beginning in fiscal year 2001, 43 percent
2 such periods beginning in fiscal year 2002, 42 percent such pe-
3 riods beginning in fiscal year 2003, 41 percent such periods be-
4 ginning in fiscal year 2004, and 40 percent such periods begin-
5 ning in fiscal year 2005 and each succeeding fiscal year”.

6 **SEC. 203. ADDITIONAL MODIFICATION IN TRANSITION**
7 **FOR INDIRECT MEDICAL EDUCATION (IME)**
8 **PERCENTAGE ADJUSTMENT.**

9 (a) IN GENERAL.—Section 1886(d)(5)(B)(ii) (42 U.S.C.
10 1395ww(d)(5)(B)(ii)) is amended—

11 (1) in subclause (V), by striking “fiscal year 2001”
12 and inserting “each of fiscal years 2001 and 2002”; and

13 (2) in subclause (VI), by striking “2001” and insert-
14 ing “2002”.

15 (b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR
16 2001.—Notwithstanding paragraph (5)(B)(ii)(V) of section
17 1886(d) of the Social Security Act (42 U.S.C.
18 1395ww(d)(5)(B)(ii)(V)), for purposes of making payments for
19 subsection (d) hospitals (as defined in paragraph (1)(B) of
20 such section) with indirect costs of medical education, the indi-
21 rect teaching adjustment factor referred to in paragraph
22 (5)(B)(ii) of such section shall be determined, for discharges
23 occurring on or after April 1, 2001, and before October 1,
24 2001, as if “e” in paragraph (5)(B)(ii)(V) of such section
25 equalled 1.66 rather than 1.54.

26 (c) CONFORMING AMENDMENT RELATING TO DETERMINA-
27 TION OF STANDARDIZED AMOUNT.—Section 1886(d)(2)(C)(i)
28 (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended by inserting “ or
29 of section 202 of the Medicare Refinement and Benefits Im-
30 provement Act of 2000” after “Balanced Budget Refinement
31 Act of 1999”.

32 (d) CLERICAL AMENDMENTS.—Section 1886(d)(5)(B) (42
33 U.S.C. 1395ww(d)(5)(B)) is further amended by moving the in-
34 dentation of each of the following 2 ems to the left:

35 (1) Clauses (ii), (v), and (vi).

36 (2) Subclauses (I) through (VI) of clause (ii).



1 (3) Subclauses (I) and (II) of clause (vi) and the flush
2 sentence at the end of such clause.

3 **SEC. 204. DECREASE IN REDUCTIONS FOR DISPROPOR-**
4 **TIONATE SHARE HOSPITAL (DSH) PAY-**
5 **MENTS.**

6 (a) IN GENERAL.—Section 1886(d)(5)(F)(ix) (42 U.S.C.
7 1395ww(d)(5)(F)(ix)) is amended—

8 (1) in subclause (III), by striking “each of” and by in-
9 serting “and 2 percent, respectively” after “3 percent”; and

10 (2) in subclause (IV), by striking “4 percent” and in-
11 serting “3 percent”.

12 (b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR
13 2001.—Notwithstanding the amendment made by subsection
14 (a)(1), for purposes of making disproportionate share payments
15 for subsection (d) hospitals (as defined in section
16 1886(d)(1)(B) of the Social Security Act (42 U.S.C.
17 1395ww(d)(1)(B)) for fiscal year 2001, the additional payment
18 amount otherwise determined under clause (ii) of section
19 1886(d)(5)(F) of the Social Security Act (42 U.S.C.
20 1395ww(d)(5)(F))—

21 (1) for discharges occurring on or after October 1,
22 2000, and before April 1, 2001, shall be adjusted as pro-
23 vided by clause (ix)(III) of such section as in effect on the
24 day before the date of enactment of this Act; and

25 (2) for discharges occurring on or after April 1, 2001,
26 and before October 1, 2001, shall, instead of being reduced
27 by 3 percent as provided by clause (ix)(III) of such section
28 as in effect after the date of the enactment of this Act,
29 shall be reduced by 1 percent.

30 (c) CONFORMING AMENDMENTS RELATING TO DETER-
31 MINATION OF STANDARDIZED AMOUNT.—Section
32 1886(d)(2)(C)(iv) (42 U.S.C. 1395ww(d)(2)(C)(iv)), is
33 amended—

34 (1) by striking “1989 or” and inserting “1989,”; and

35 (2) by inserting “, or the enactment of section 203 of
36 the Medicare Refinement and Benefits Improvement Act of
37 2000” after “Omnibus Budget Reconciliation Act of 1990”.



1 (d) TECHNICAL AMENDMENT.—

2 (1) IN GENERAL.—Section 1886(d)(5)(F)(i) (42
3 U.S.C. 1395ww(d)(5)(F)(i)) is amended by striking “and
4 before October 1, 1997,”.

5 (2) EFFECTIVE DATE.—The amendment made by
6 paragraph (1) is effective as if included in the enactment
7 of BBA.

8 (e) REFERENCE TO CHANGES IN DSH FOR RURAL HOS-
9 PITALS.—For additional changes in the DSH program for rural
10 hospitals, see section 301.

11 **SEC. 205. INCREASE IN BASE PAYMENT TO PUERTO**
12 **RICO ACUTE CARE HOSPITALS.**

13 (a) IN GENERAL.—Section 1886(d)(9)(A) (42 U.S.C.
14 1395ww(d)(9)(A)) is amended—

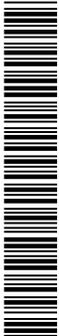
15 (1) in clause (i), by striking “on or after October 1,
16 1997, 50 percent” and all that follows through “75 per-
17 cent)” and inserting “on or after October 1, 2000, 25 per-
18 cent”; and

19 (2) in clause (ii), in the matter preceding subclause
20 (I), by striking “on or after October 1, 1997, 50 percent”
21 and all that follows through “25 percent)” and inserting
22 “on or after October 1, 2000, 75 percent”.

23 (b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR
24 2001.—

25 (1) IN GENERAL.—Notwithstanding the amendment
26 made by subsection (a), for purposes of making payments
27 for the operating costs of inpatient hospital services of a
28 Puerto Rico hospital for fiscal year 2001, the amount re-
29 ferred to in the matter preceding clause (i) of section
30 1886(d)(9)(A) of the Social Security Act (42 U.S.C.
31 1395ww(d)(9)(A))—

32 (A) for discharges occurring on or after October 1,
33 2000, and before April 1, 2001, shall be determined in
34 accordance with such section as in effect on the day be-
35 fore the date of enactment of this Act; and



1 (B) for discharges occurring on or after April 1,
2 2001, and before October 1, 2001, shall be
3 determined—

4 (i) using 0 percent of the Puerto Rico adjusted
5 DRG prospective payment rate referred to in clause
6 (i) of such section; and

7 (ii) using 100 percent of the discharge-weight-
8 ed average referred to in clause (ii) of such section.

9 (2) PUERTO RICO HOSPITAL.—For purposes of this
10 subsection, the term “Puerto Rico hospital” means a sub-
11 section (d) Puerto Rico hospital as defined in the last sen-
12 tence of section 1886(d)(9)(A) of the Social Security Act
13 (42 U.S.C. 1395ww(d)(9)(A)).

14 **SEC. 206. WAGE INDEX IMPROVEMENTS.**

15 (a) DURATION OF WAGE INDEX RECLASSIFICATION; USE
16 OF 3-YEAR WAGE DATA; .—Section 1886(d)(10)(D) (42
17 U.S.C. 1395ww(d)(10)(D)) is amended by adding at the end
18 the following new clauses:

19 “(v) Any decision of the Board to reclassify a subsection
20 (d) hospital for purposes of the adjustment factor described in
21 subparagraph (C)(i)(II) for fiscal year 2001 or any fiscal year
22 thereafter shall be effective for a period of 3 fiscal years, except
23 that the Board shall establish procedures under which a sub-
24 section (d) hospital may elect to terminate such reclassification
25 before the end of such period.

26 “(vi) Such guidelines shall provide that, in making deci-
27 sions on applications for reclassification for the purposes de-
28 scribed in clause (v) for fiscal year 2003 and any succeeding
29 fiscal year, the Board shall base any comparison of the average
30 hourly wage for the hospital with the average hourly wage for
31 hospitals in an area on—

32 “(I) an average of the average hourly wage amount for
33 the hospital from the most recently published hospital wage
34 survey data of the Secretary (as of the date on which the
35 hospital applies for reclassification) and such amount from
36 each of the two immediately preceding surveys; and



1 “(II) an average of the average hourly wage amount
2 for hospitals in such area from the most recently published
3 hospital wage survey data of the Secretary (as of the date
4 on which the hospital applies for reclassification) and such
5 amount from each of the two immediately preceding sur-
6 veys.”.

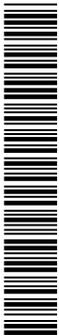
7 (b) PROCESS TO PERMIT STATE-WIDE WAGE INDEX CAL-
8 CULATION AND APPLICATION.—

9 (1) IN GENERAL.—The Secretary of Health and
10 Human Services shall establish a process (based on the
11 process utilized by the Secretary of Health and Human
12 Services under section 1848 of the Social Security Act (42
13 U.S.C. 1395w-4) for purposes of computing and applying
14 a Statewide geographic wage index) under which all the ge-
15 ographic areas in a State are treated as a single geographic
16 area for purposes of computing and applying the area wage
17 index under section 1886(d)(3)(E) of such Act (42 U.S.C.
18 1395ww(d)(3)(E)). Such process shall be established by Oc-
19 tober 1, 2001, for reclassifications beginning in fiscal year
20 2003.

21 (2) PROHIBITION ON INDIVIDUAL HOSPITAL RECLAS-
22 SIFICATION.—If the Secretary applies a Statewide geo-
23 graphic wage index under paragraph (1), any application
24 submitted by a hospital under section 1886(d)(10) of the
25 Social Security Act (42 U.S.C. 1395ww(d)(10)) for geo-
26 graphic reclassification shall not be considered.

27 (c) COLLECTION OF INFORMATION ON OCCUPATIONAL
28 MIX.—

29 (1) IN GENERAL.—The Secretary of Health and
30 Human Services shall provide for the collection of data
31 every 3 years on occupational mix for employees of each
32 subsection (d) hospital (as defined in section 1886(d)(1)(D)
33 of the Social Security Act, 42 U.S.C. 1395ww(d)(1)(D)) in
34 the provision of inpatient hospital services, in order to con-
35 struct an occupational mix adjustment in the hospital area
36 wage index applied under section 1886(d)(3)(E) of such
37 Act (42 U.S.C. 1395ww(d)(3)(E)).



1 (2) APPLICATION.—The third sentence of section
2 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)) is amended
3 by striking “To the extent determined feasible by the Sec-
4 retary, such survey shall measure” and inserting “Not less
5 often than once every 3 years the Secretary (through such
6 survey or otherwise) shall measure”.

7 (3) EFFECTIVE DATE.—The Secretary shall first com-
8 plete the collection of data under paragraph (1) and the
9 amendment made by paragraph (2) by not later than Sep-
10 tember 30, 2003, for application beginning October 1,
11 2004.

12 **SEC. 207. LIMITATION TO RESIDENTS IN ALLOPATHIC**
13 **AND OSTEOPATHIC MEDICINE IN APPLICA-**
14 **TION OF RESIDENT LIMITS.**

15 (a) IN GENERAL.—Section 1886(d)(5)(B)(vi) (42 U.S.C.
16 1395ww(d)(5)(B)(vi)) is amended by adding at the end the fol-
17 lowing: “Residents in a field other than allopathic or osteo-
18 pathic medicine shall not be taken into account in applying the
19 provisions of this clause and subsection (h)(4)(G).”.

20 (b) CONFORMING AMENDMENT.—Section 1886(h)(4)(G)(i)
21 (42 U.S.C. 1395ww(h)(4)(G)(i)) is amended by adding at the
22 end the following: “Residents in a field other than allopathic
23 or osteopathic medicine shall not be taken into account in ap-
24 plying the provisions of this clause and subsection
25 (d)(5)(B)(vi).”.

26 (c) EFFECTIVE DATE.—The amendments made by this
27 section apply to cost reporting periods beginning on or after
28 October 1, 2000.

29 **SEC. 208. PAYMENT FOR INPATIENT SERVICES OF REHA-**
30 **BILITATION HOSPITALS.**

31 (a) ASSISTANCE WITH ADMINISTRATIVE COSTS ASSOCI-
32 ATED WITH COMPLETION OF PATIENT ASSESSMENT.—Section
33 1886(j)(3)(B) (42 U.S.C. 1395ww(j)(3)(B)) is amended by
34 striking “98 percent” and inserting “100 percent for fiscal
35 year 2001 and 98 percent for fiscal year 2002”.

36 (b) ELECTION TO APPLY FULL PROSPECTIVE PAYMENT
37 RATE WITHOUT PHASE-IN.—



1 (1) IN GENERAL.—Paragraph (1) of section 1886(j)
2 (42 U.S.C. 1395ww(j)) is amended—

3 (A) in subparagraph (A), by inserting “other than
4 a facility making an election under subparagraph (F)”
5 before “in a cost reporting period”;

6 (B) in subparagraph (B), by inserting “or, in the
7 case of a facility making an election under subpara-
8 graph (F), for any cost reporting period described in
9 such subparagraph” after “2002,”; and

10 (C) by adding at the end the following new sub-
11 paragraph:

12 “(F) ELECTION TO APPLY FULL PROSPECTIVE
13 PAYMENT SYSTEM.—A rehabilitation facility may elect,
14 not later than 30 days before its first cost reporting pe-
15 riod for which the payment methodology under this
16 subsection applies to the facility, to have payment made
17 to the facility under this subsection under the provi-
18 sions of subparagraph (B) (rather than subparagraph
19 (A)) for each cost reporting period to which such pay-
20 ment methodology applies.”.

21 (2) CLARIFICATION.—Paragraph (3)(B) of such sec-
22 tion is amended by inserting “but not taking into account
23 any payment adjustment resulting from an election per-
24 mitted under paragraph (1)(F)” after “paragraphs (4) and
25 (6)”.

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

28 **SEC. 209. PAYMENT FOR INPATIENT SERVICES OF PSY-**
29 **CHIATRIC HOSPITALS.**

30 With respect to hospitals described in clause (i) of section
31 1886(d)(1)(B) of the Social Security Act (42 U.S.C.
32 1395ww(d)(1)(B)) and psychiatric units described in the mat-
33 ter following clause (v) of such section, in making incentive
34 payments to such hospitals under section 1886(b)(1)(A) of
35 such Act (42 U.S.C. 1395ww(b)(1)(A)) for cost reporting peri-
36 ods beginning on or after October 1, 2000, and before October
37 1, 2001, the Secretary of Health and Human Services, in



1 clause (ii) of such section, shall substitute “3 percent” for “2
2 percent”.

3 **SEC. 210. PAYMENT FOR INPATIENT SERVICES OF LONG-**
4 **TERM CARE HOSPITALS.**

5 (a) INCREASED TARGET AMOUNTS AND CAPS FOR LONG-
6 TERM CARE HOSPITALS BEFORE IMPLEMENTATION OF THE
7 PROSPECTIVE PAYMENT SYSTEM.—

8 (1) IN GENERAL.—Section 1886(b)(3) (42 U.S.C.
9 1395ww(b)(3)) is amended—

10 (A) in subparagraph (H)(ii)(III), by inserting
11 “subject to subparagraph (J)” after “2002,”; and

12 (B) by adding at the end the following new subpara-
13 graph:

14 “(J) For cost reporting periods beginning during fiscal
15 year 2001, for a hospital described in subsection
16 (d)(1)(B)(iv)—

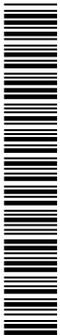
17 “(i) the limiting or cap amount otherwise determined
18 under subparagraph (H) shall be increased by 2 percent;
19 and

20 “(ii) the target amount otherwise determined under
21 subparagraph (A) (for a hospital not subject to such lim-
22 iting amount) shall be increased by 25 percent.”.

23 (2) APPLICATION.—The amendments made by sub-
24 section (a) and by section 122 of BBRA shall not be taken
25 into account in the development and implementation of the
26 prospective payment system under section 123 of BBRA.

27 (b) IMPLEMENTATION OF PROSPECTIVE PAYMENT SYS-
28 TEM FOR LONG-TERM CARE HOSPITALS.—

29 (1) MODIFICATION OF REQUIREMENT.—In developing
30 the prospective payment system for payment for inpatient
31 hospital services of long-term care hospitals described in
32 section 1886(d)(1)(B)(iv) of the Social Security Act (42
33 U.S.C. 1395ww(d)(1)(B)(iv)) under the medicare program
34 required under section 123 of BBRA, the Secretary of
35 Health and Human Services shall examine the feasibility
36 and the impact of basing payment under such a system on
37 the use of existing (or refined) hospital diagnosis-related



1 groups (DRGs) and the use of the most recently available
2 hospital discharge data.

3 (2) DEFAULT IMPLEMENTATION OF SYSTEM BASED
4 ON EXISTING DRG METHODOLOGY.—If the Secretary is un-
5 able to implement the prospective payment system for pay-
6 ment for inpatient hospital services of long-term care hos-
7 pitals required under such section 123 of the BBRA by Oc-
8 tober 1, 2002, the Secretary shall implement a prospective
9 payment system for such hospitals that bases payment
10 under such a system using existing hospital diagnosis-re-
11 lated groups (DRGs), consistent with paragraph (1) for
12 such services furnished on or after that date.

13 **Subtitle B—Adjustments to PPS Pay-**
14 **ments for Skilled Nursing Facilities**

15 **SEC. 221. ELIMINATION OF REDUCTION IN SKILLED**
16 **NURSING FACILITY (SNF) MARKET BASKET**
17 **UPDATE IN 2001.**

18 (a) IN GENERAL.—Section 1888(e)(4)(E)(ii) of the Social
19 Security Act (42 U.S.C. 1395yy(e)(4)(E)(ii)) is amended—

- 20 (1) by redesignating subclause (III) as subclause (IV).
- 21 (2) by striking subclause (II); and
- 22 (3) by inserting after subclause (I) the following new
23 subclauses:

24 “(II) for fiscal year 2001, the rate com-
25 puted for the previous fiscal year increased by
26 the skilled nursing facility market basket per-
27 centage change for the fiscal year involved;

28 “(III) for fiscal year 2002, the rate com-
29 puted for the previous fiscal year increased by
30 the skilled nursing facility market basket per-
31 centage change for the fiscal year involved
32 minus 1 percentage point; and”.

33 (b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR
34 2001.—Notwithstanding the amendments made by subsection
35 (a), for purposes of making payments for covered skilled nurs-
36 ing facility services under section 1888(e) of the Social Security



1 Act (42 U.S.C. 1395yy(e)) for fiscal year 2001, the Federal per
2 diem rate referred to in paragraph (4)(E)(ii) of such section—

3 (1) for the period beginning on October 1, 2000, and
4 ending on March 31, 2001, shall be the rate determined in
5 accordance with the law as in effect on the day before the
6 date of the enactment of this Act; and

7 (2) for the period beginning on April 1, 2001, and
8 ending on September 30, 2001, shall be the rate that would
9 have been determined under such section if “plus 1 per-
10 centage point” had been substituted for “minus 1 percent-
11 age point” under subclause (II) of such paragraph (as in
12 effect on the day before the date of the enactment of this
13 Act).

14 (c) RELATION TO TEMPORARY INCREASE IN BBRA.—The
15 increases provided under section 101 of BBRA (113 Stat.
16 1501A–325) shall be in addition to any increase resulting from
17 the amendments made by subsection (a).

18 (d) GAO REPORT ON ADEQUACY OF SNF PAYMENT
19 RATES.—The Comptroller General of the United States shall
20 submit to Congress by not later than July 1, 2002, a report
21 on the adequacy of medicare payment rates to skilled nursing
22 facilities and the extent to which medicare contributes to the
23 financial viability of such facilities. Such report shall take into
24 account the role of private payors, medicaid, and case mix on
25 the financial performance of these facilities, and shall include
26 an analysis (by specific RUG classification) of the number and
27 characteristics of such facilities.

28 (e) HCFA STUDY OF CLASSIFICATION SYSTEMS FOR SNF
29 RESIDENTS.—

30 (1) STUDY.—The Secretary of Health and Human
31 Services shall conduct a study of the different systems for
32 categorizing patients in medicare skilled nursing facilities
33 in a manner that accounts for the relative resource utiliza-
34 tion of different patient types.

35 (2) REPORT.—Not later than January 1, 2005, the
36 Secretary shall submit to Congress a report on the study
37 conducted under subsection (a). Such report shall include



1 such recommendations regarding changes in law as may be
2 appropriate.

3 **SEC. 222. INCREASE IN NURSING COMPONENT OF PPS**
4 **FEDERAL RATE.**

5 (a) IN GENERAL.—The Secretary of Health and Human
6 Services shall increase by 5 percent the nursing component of
7 the case-mix adjusted Federal prospective payment rate speci-
8 fied in Tables 3 and 4 of the final rule published in the Federal
9 Register by the Health Care Financing Administration on July
10 31, 2000 (65 Fed. Reg. 46770), effective for services furnished
11 on or after April 1, 2001, and before October 1, 2002.

12 (b) GAO AUDIT OF NURSING STAFF RATIOS.—

13 (1) AUDIT.—The Comptroller General of the United
14 States shall conduct an audit of nursing staffing ratios in
15 a representative sample of medicare skilled nursing facili-
16 ties. Such sample shall cover selected States and shall in-
17 clude broad representation with respect to size, ownership,
18 location, and medicare volume. Such audit shall include an
19 examination of payroll records and medicaid cost reports of
20 individual facilities.

21 (2) REPORT.—Not later than August 1, 2002, the
22 Comptroller General shall submit to Congress a report on
23 the audits conducted under paragraph (1). Such report
24 shall include an assessment of the impact of the increased
25 payments under this subtitle on increased nursing staff ra-
26 tios and shall make recommendations as to whether in-
27 creased payments under subsection (a) should be continued.

28 **SEC. 223. APPLICATION OF SNF CONSOLIDATED BILL-**
29 **ING REQUIREMENT LIMITED TO PART A**
30 **COVERED STAYS.**

31 (a) IN GENERAL.—Section 1862(a)(18) (42 U.S.C.
32 1395y(a)(18)) is amended by striking “or of a part of a facility
33 that includes a skilled nursing facility (as determined under
34 regulations),” and inserting “during a period in which the resi-
35 dent is provided covered post-hospital extended care services
36 (or, for services described in section 1861(s)(2)(D), which are



1 furnished to such an individual without regard to such pe-
2 riod),”.

3 (b) CONFORMING AMENDMENTS.—(1) Section
4 1842(b)(6)(E) (42 U.S.C. 1395u(b)(6)(E)) is amended—

5 (A) by inserting “by, or under arrangements made by,
6 a skilled nursing facility” after “furnished”;

7 (B) by striking “or of a part of a facility that includes
8 a skilled nursing facility (as determined under regula-
9 tions)”;

10 (C) by striking “(without regard to whether or not the
11 item or service was furnished by the facility, by others
12 under arrangement with them made by the facility, under
13 any other contracting or consulting arrangement, or other-
14 wise)”.

15 (2) Section 1842(t) (42 U.S.C. 1395u(t)) is amended by
16 striking “by a physician” and “or of a part of a facility that
17 includes a skilled nursing facility (as determined under regula-
18 tions),”.

19 (3) Section 1866(a)(1)(H)(ii)(I) (42 U.S.C.
20 1395cc(a)(1)(H)(ii)(I)) is amended by inserting after “who is
21 a resident of the skilled nursing facility” the following: “during
22 a period in which the resident is provided covered post-hospital
23 extended care services (or, for services described in section
24 1861(s)(2)(D), that are furnished to such an individual without
25 regard to such period)”.

26 (c) EFFECTIVE DATE.—The amendments made by sub-
27 sections (a) and (b) apply to services furnished on or after Jan-
28 uary 1, 2001.

29 (d) OVERSIGHT.—The Secretary of Health and Human
30 Services, through the Office of the Inspector General in the De-
31 partment of Health and Human Services or otherwise, shall
32 monitor payments made under part B of the title XVIII of the
33 Social Security Act for items and services furnished to resi-
34 dents of skilled nursing facilities during a time in which the
35 residents are not being provided medicare covered post-hospital
36 extended care services to ensure that there is not duplicate bill-
37 ing for services or excessive services provided.



SEC. 224. ADJUSTMENT OF REHABILITATION RUGS TO CORRECT ANOMALY IN PAYMENT RATES.

(a) ADJUSTMENT FOR REHABILITATION RUGS.—

(1) IN GENERAL.—For purposes of computing payments for covered skilled nursing facility services under paragraph (1) of section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)) for such services furnished on or after April 1, 2001, and before the date described in section 101(c)(2) of BBRA (113 Stat. 1501A–324), the Secretary of Health and Human Services shall increase by 6.7 percent the adjusted Federal per diem rate otherwise determined under paragraph (4) of such section (but for this section) for covered skilled nursing facility services for RUG–III rehabilitation groups described in paragraph (2) furnished to an individual during the period in which such individual is classified in such a RUG–III category.

(2) REHABILITATION GROUPS DESCRIBED.—The RUG–III rehabilitation groups for which the adjustment described in paragraph (1) applies are RUC, RUB, RUA, RVC, RVB, RVA, RHC, RHB, RHA, RMC, RMB, RMA, RLB, and RLA, as specified in Tables 3 and 4 of the final rule published in the Federal Register by the Health Care Financing Administration on July 31, 2000 (65 Fed. Reg. 46770).

(b) CORRECTION WITH RESPECT TO REHABILITATION RUGS.—

(1) IN GENERAL.—Section 101(b) of BBRA is amended by striking “CA1, RHC, RMC, and RMB” and inserting “and CA1”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) applies to services furnished on or after April 1, 2001.

(c) REVIEW BY OFFICE OF INSPECTOR GENERAL.—The Inspector General of the Department of Health and Human Services shall review the medicare payment structure for services classified within rehabilitation resource utilization groups (RUGs) (as in effect after the date of the enactment of the



1 BBRA) to assess whether payment incentives exist for the de-
 2 livery of inadequate care. Not later than October 1, 2001, the
 3 Inspector General shall submit to Congress a report on such re-
 4 view.

5 **SEC. 225. ESTABLISHMENT OF PROCESS FOR GEO-**
 6 **GRAPHIC RECLASSIFICATION.**

7 (a) ESTABLISH PROCESS.—The Secretary of Health and
 8 Human Services may establish a procedure for the geographic
 9 reclassification of a skilled nursing facility for purposes of pay-
 10 ment for covered skilled nursing facility services under the pro-
 11 spective payment system established under section 1888(e) of
 12 the Social Security Act (42 U.S.C. 1395yy(e)). Such procedure
 13 may be based upon the method for geographic reclassifications for
 14 inpatient hospitals established under section 1886(d)(10) of the
 15 Social Security Act (42 U.S.C. 1395ww(d)(10)).

16 (b) REQUIREMENT FOR SKILLED NURSING FACILITY
 17 WAGE DATA.—In no case may the Secretary implement the
 18 procedure under subsection (a) before such time as the Sec-
 19 retary has collected data necessary to establish an area wage
 20 index for skilled nursing facilities based on wage data from
 21 such facilities.

22 **Subtitle C—Hospice Care**

23 **SEC. 231. FULL MARKET BASKET INCREASE FOR 2001.**

24 (a) IN GENERAL.—Section 1814(i)(1)(C)(ii) (42 U.S.C.
 25 1395f(i)(1)(C)(ii)) is amended—

26 (1) by redesignating subclause (VII) as subclause
 27 (IX);

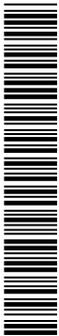
28 (2) in subclause (VI)—

29 (A) by striking “through 2002” and inserting
 30 “through 2000”; and

31 (B) by striking “ and” at the end; and

32 (3) by inserting after subclause (VI) the following new
 33 subclauses:

34 “(VII) for fiscal year 2001, the market basket per-
 35 centage increase for the fiscal year;



1 “(VIII) for fiscal year 2002, the market basket per-
2 centage increase for the fiscal year minus 1.0 percentage
3 points; and”.

4 (b) CONFORMING AMENDMENT TO BBRA.—Section
5 131(a) of BBRA (113 Stat. 1501A–333) is amended in the
6 matter preceding paragraph (1)—

7 (1) by striking “during fiscal years 2001 and 2002”
8 and inserting “during fiscal year 2002”; and

9 (2) by striking “for—” and all the follows through
10 “(2)” and inserting ”for” and adjusting the margin accord-
11 ingly.

12 (c) TRANSITION DURING FISCAL YEAR 2001.—Notwith-
13 standing the amendments made by subsection (a), for purposes
14 of making payments for hospice care under section 1814(i) of
15 the Social Security Act (42 U.S.C. 1395f(i)) for fiscal year
16 2001, the payment rates referred to in paragraph (1)(C) of
17 such section—

18 (1) for the period beginning on October 1, 2000, and
19 ending on March 31, 2001, shall be the rate determined in
20 accordance with the law as in effect on the day before date
21 of enactment of this Act; and

22 (2) for the period beginning on April 1, 2001, and
23 ending on September 30, 2001, shall be the rate that would
24 have been determined under paragraph (1) if “plus 1.0 per-
25 centage points” were substituted for “minus 1.0 percentage
26 points” under paragraph (1)(C)(ii)(VI) of such section for
27 fiscal year 2001.

28 (d) TECHNICAL AMENDMENT.—Section 1814(a)(7)(A)(ii)
29 (42 U.S.C. 1395f(a)(7)(A)(ii)) is amended by striking the pe-
30 riod at the end and inserting a semicolon.

31 (e) EFFECTIVE DATE.—The amendments made by sub-
32 section (b) shall take effect as if included in the enactment of
33 BBRA.

34 **SEC. 232. CLARIFICATION OF PHYSICIAN CERTIFI-**
35 **CATION.**

36 (a) CERTIFICATION BASED ON NORMAL COURSE OF ILL-
37 NESS.—Section 1814(a) (42 U.S.C. 1395f(a)) is amended by



1 adding at the end the following new sentence: “The certifi-
 2 cation regarding terminal illness of an individual under para-
 3 graph (7) shall be based on the physician’s or medical direc-
 4 tor’s clinical judgment regarding the normal course of the indi-
 5 vidual’s illness.”.

6 (b) EFFECTIVE DATE.—The amendment made by sub-
 7 section (a) applies to certifications made on or after the date
 8 of the enactment of this Act.

9 **SEC. 233. MEDPAC REPORT ON ACCESS TO, AND USE OF,**
 10 **HOSPICE BENEFIT.**

11 (a) IN GENERAL.—The Medicare Payment Advisory Com-
 12 mission shall conduct a study to examine the factors affecting
 13 the use of hospice benefits under the medicare program, includ-
 14 ing a delay in the time (relative to death) of entry into a hos-
 15 pice program, and differences in such use between urban and
 16 rural hospice programs and based upon the presenting condi-
 17 tion of the patient.

18 (b) REPORT.—Not later than 18 months after the date of
 19 the enactment of this Act, the Commission shall submit a re-
 20 port to the Secretary of Health and Human Services and the
 21 Congress on the study conducted under subsection (a), together
 22 with any recommendations for legislation that the Commission
 23 deems appropriate.

24 **Subtitle D—Other Provisions**

25 **SEC. 241. RELIEF FROM MEDICARE PART A LATE EN-**
 26 **ROLLMENT PENALTY FOR GROUP BUY-IN**
 27 **FOR STATE AND LOCAL RETIREES.**

28 (a) IN GENERAL.—Section 1818(d) (42 U.S.C. 1395i-
 29 2(d)) is amended—

30 (1) in subsection (c)(6), by inserting before the semi-
 31 colon at the end the following: “and shall be subject to re-
 32 duction in accordance with subsection (d)(6)”;

33 (2) by adding at the end of subsection (d) the fol-
 34 lowing new paragraph:

35 “(6)(A) In the case where a State, a political subdivi-
 36 sion of a State, or an agency or instrumentality of a State
 37 or political subdivision thereof determines to pay, for the



1 life of each individual, the monthly premiums due under
 2 paragraph (1) on behalf of each of the individuals in a
 3 qualified State or local government retiree group who meets
 4 the conditions of subsection (a), the amount of any increase
 5 otherwise applicable under section 1839(b) (as applied and
 6 modified by subsection (c)(6) of this section) with respect
 7 to the monthly premium for benefits under this part for an
 8 individual who is a member of such group shall be reduced
 9 by the total amount of taxes paid under section 3101(b) of
 10 the Internal Revenue Code of 1986 by such individual and
 11 under section 3111(b) by the employers of such individual
 12 on behalf of such individual with respect to employment (as
 13 defined in section 3121(b) of such Code).

14 “(B) For purposes of this paragraph, the term ‘quali-
 15 fied State or local government retiree group’ means all of
 16 the individuals who retire prior to a specified date that is
 17 before January 1, 2002, from employment in 1 or more oc-
 18 cupations or other broad classes of employees of—

- 19 “(i) the State;
- 20 “(ii) a political subdivision of the State; or
- 21 “(iii) an agency or instrumentality of the State or
 22 political subdivision of the State.”.

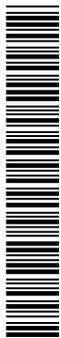
23 (b) EFFECTIVE DATE.—The amendment made by sub-
 24 section (a) applies to premiums for months beginning with July
 25 1, 2001.

26 **TITLE III—RURAL PROVIDER**
 27 **PROVISIONS**
 28 **Subtitle A—Rural Hospitals**

29 **SEC. 301. EQUITABLE TREATMENT FOR RURAL DIS-**
 30 **PROPORTIONATE SHARE HOSPITALS.**

31 (a) APPLICATION OF UNIFORM THRESHOLD.—Section
 32 1886(d)(5)(F)(v) (42 U.S.C. 1395ww(d)(5)(F)(v)) is
 33 amended—

34 (1) in subclause (II), by inserting “(or 15 percent, for
 35 discharges occurring on or after April 1, 2001)” after “30
 36 percent”;



1 (2) in subclause (III), by inserting “(or 15 percent, for
2 discharges occurring on or after April 1, 2001)” after “40
3 percent”; and

4 (3) in subclause (IV), by inserting “(or 15 percent, for
5 discharges occurring on or after April 1, 2001)” after “45
6 percent”.

7 (b) ADJUSTMENT OF PAYMENT FORMULAS.—

8 (1) SOLE COMMUNITY HOSPITALS.—Section
9 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended—

10 (A) in clause (iv)(VI), by inserting after “10 per-
11 cent” the following: “or, for discharges occurring on or
12 after April 1, 2001, is equal to the percent determined
13 in accordance with clause (x)”;

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

15 “(x) For purposes of clause (iv)(VI) (relating to sole com-
16 munity hospitals), in the case of a hospital for a cost reporting
17 period with a disproportionate patient percentage (as defined in
18 clause (vi)) that—

19 “(I) is less than 17.3, the disproportionate share ad-
20 justment percentage is determined in accordance with the
21 following formula: $(P-15)(.65) + 2.5$;

22 “(II) is equal to or exceeds 17.3, but is less than 30.0,
23 such adjustment percentage is equal to 4 percent; or

24 “(III) is equal to or exceeds 30, such adjustment per-
25 centage is equal to 10 percent,

26 where ‘P’ is the hospital’s disproportionate patient percentage
27 (as defined in clause (vi)).”.

28 (2) RURAL REFERRAL CENTERS.—Such section is fur-
29 ther amended—

30 (A) in clause (iv)(V), by inserting after “clause
31 (viii)” the following: “or, for discharges occurring on or
32 after April 1, 2001, is equal to the percent determined
33 in accordance with clause (xi)”;

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

35 “(xi) For purposes of clause (iv)(V) (relating to rural re-
36 ferral centers), in the case of a hospital for a cost reporting



1 period with a disproportionate patient percentage (as defined in
2 clause (vi)) that—

3 “(I) is less than 17.3, the disproportionate share ad-
4 justment percentage is determined in accordance with the
5 following formula: $(P-15)(.65) + 2.5$;

6 “(II) is equal to or exceeds 17.3, but is less than 30.0,
7 such adjustment percentage is equal to 4 percent; or

8 “(III) is equal to or exceeds 30, such adjustment per-
9 centage is determined in accordance with the following for-
10 mula: $(P-30)(.6) + 4$,

11 where ‘P’ is the hospital’s disproportionate patient percentage
12 (as defined in clause (vi)).’.

13 (3) SMALL RURAL HOSPITALS GENERALLY.—Such sec-
14 tion is further amended—

15 (A) in clause (iv)(III), by inserting after “4 per-
16 cent” the following: “or, for discharges occurring on or
17 after April 1, 2001, is equal to the percent determined
18 in accordance with clause (xii)”;

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

20 “(xii) For purposes of clause (iv)(III) (relating to small
21 rural hospitals generally), in the case of a hospital for a cost
22 reporting period with a disproportionate patient percentage (as
23 defined in clause (vi)) that—

24 “(I) is less than 17.3, the disproportionate share ad-
25 justment percentage is determined in accordance with the
26 following formula: $(P-15)(.65) + 2.5$;

27 “(II) is equal to or exceeds 17.3, such adjustment per-
28 centage is equal to 4 percent,

29 where ‘P’ is the hospital’s disproportionate patient percentage
30 (as defined in clause (vi)).’.

31 (4) HOSPITALS THAT ARE BOTH SOLE COMMUNITY
32 HOSPITALS AND RURAL REFERRAL CENTERS.—Such sec-
33 tion is further amended, in clause (iv)(IV), by inserting
34 after “clause (viii)” the following: “or, for discharges occur-
35 ing on or after April 1, 2001, the greater of the percent-
36 ages determined under clause (x) or (xi)”.



1 (5) URBAN HOSPITALS WITH LESS THAN 100 BEDS.—

2 Such section is further amended—

3 (A) in clause (iv)(II), by inserting after “5 per-
4 cent” the following: “or, for discharges occurring on or
5 after April 1, 2001, is equal to the percent determined
6 in accordance with clause (xiii)”;

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

8 “(xiii) For purposes of clause (iv)(II) (relating to urban
9 hospitals with less than 100 beds), in the case of a hospital for
10 a cost reporting period with a disproportionate patient percent-
11 age (as defined in clause (vi)) that—

12 “(I) is less than 17.3, the disproportionate share ad-
13 justment percentage is determined in accordance with the
14 following formula: $(P-15)(.65) + 2.5$;

15 “(II) is equal to or exceeds 17.3, but is less than 40.0,
16 such adjustment percentage is equal to 4 percent; or

17 “(III) is equal to or exceeds 40, such adjustment per-
18 centage is equal to 5 percent,

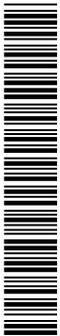
19 where ‘P’ is the hospital’s disproportionate patient percentage
20 (as defined in clause (vi)).”.

21 **SEC. 302. EXTENSION OF OPTION TO USE REBASED TAR-**
22 **GET AMOUNTS TO ALL SOLE COMMUNITY**
23 **HOSPITALS.**

24 (a) IN GENERAL.—Section 1886(b)(3)(I)(i) (42 U.S.C.
25 1395ww(b)(3)(I)(i)) is amended—

26 (1) in the matter preceding subclause (I), by striking
27 “for its cost reporting period beginning during 1999” and
28 all that follows through “for such target amount” and in-
29 serting “there shall be substituted for the amount other-
30 wise determined under subsection (d)(5)(D)(i), if such sub-
31 stitution results in a greater amount of payment under this
32 section for the hospital”;

33 (2) in subclause (I), by striking “target amount other-
34 wise applicable” and all that follows through “target
35 amount’” and inserting “the amount otherwise applicable
36 to the hospital under subsection (d)(5)(D)(i) (referred to in
37 this clause as the ‘subsection (d)(5)(D)(i) amount’)”; and



1 (3) in each of subclauses (II) and (III), by striking
2 “subparagraph (C) target amount” and inserting “sub-
3 section (d)(5)(D)(i) amount”.

4 (b) EFFECTIVE DATE.—The amendments made by this
5 section shall take effect as if included in the enactment of
6 BBRA.

7 **SEC. 303. UPDATING CRITERIA FOR MEDICARE DEPEND-**
8 **ENT HOSPITALS.**

9 (a) IN GENERAL.—Section 1886(d)(5)(G)(iv)(IV) (42
10 U.S.C. 1395ww(d)(5)(G)(iv)(IV)) is amended by inserting “or
11 during at least 2 of the 3 cost reporting periods beginning dur-
12 ing fiscal years 1996, 1997, or 1998” after “during the cost
13 reporting period beginning in fiscal year 1987”.

14 (b) EFFECTIVE DATE.—The amendment made by sub-
15 section (a) applies to discharges occurring on or after April 1,
16 2001.

17 **SEC. 304. OTHER RURAL HOSPITAL PROVISIONS.**

18 The Medicare Payment Advisory Commission, in its study
19 under section 411 of BBRA shall include in its analysis the im-
20 pact of volume on the per unit cost of rural hospitals with psy-
21 chiatric units and include in its report a recommendation on
22 whether special treatment may be warranted.

23 **Subtitle B—Critical Access Hospitals**

24 **SEC. 311. CLARIFICATION OF NO BENEFICIARY COST-**
25 **SHARING FOR CLINICAL DIAGNOSTIC LAB-**
26 **ORATORY TESTS FURNISHED BY CRITICAL**
27 **ACCESS HOSPITALS.**

28 (a) PAYMENT CLARIFICATION.—Section 1834(g) (42
29 U.S.C. 1395m(g)) is amended by adding at the end the fol-
30 lowing new paragraph:

31 “(4) NO BENEFICIARY COST-SHARING FOR CLINICAL
32 DIAGNOSTIC LABORATORY SERVICES.—No coinsurance, de-
33 ductible, copayment, or other cost sharing otherwise appli-
34 cable under this part shall apply with respect to clinical di-
35 agnostic laboratory services furnished as an outpatient crit-
36 ical access hospital service. Nothing in this title shall be
37 construed as providing for payment for clinical diagnostic



1 laboratory services furnished as part of outpatient critical
 2 access hospital services, other than on the basis described
 3 in this subsection.”.

4 (b) TECHNICAL AND CONFORMING AMENDMENTS.—

5 (1) Paragraphs (1)(D)(i) and (2)(D)(i) of section
 6 1833(a) (42 U.S.C. 1395l(a)(1)(D)(i); 1395l(a)(2)(D)(i))
 7 are each amended by striking “or which are furnished on
 8 an outpatient basis by a critical access hospital”.

9 (2) Section 403(d)(2) of BBRA (113 Stat. 1501A–
 10 371) is amended by striking “The amendment made by
 11 subsection (a) shall apply” and inserting “Paragraphs (1)
 12 through (3) of section 1834(g) of the Social Security Act
 13 (as amended by paragraph (1)) apply”.

14 (c) EFFECTIVE DATES.—The amendment made—

15 (1) by subsection (a) applies to services furnished on
 16 or after the date of the enactment of BBRA;

17 (2) by subsection (b)(1) applies as if included in the
 18 enactment of section 403(e)(1) of BBRA (113 Stat.
 19 1501A–371); and

20 (3) by subsection (b)(2) applies as if included in the
 21 enactment of section 403(d)(2) of BBRA (113 Stat.
 22 1501A–371).

23 **SEC. 312. ASSISTANCE WITH FEE SCHEDULE PAYMENT**
 24 **FOR PROFESSIONAL SERVICES UNDER ALL-**
 25 **INCLUSIVE RATE.**

26 (a) IN GENERAL.—Section 1834(g)(2)(B) (42 U.S.C.
 27 1395m(g)(2)(B)) is amended by inserting “110 percent of” be-
 28 fore “such amounts”.

29 (b) EFFECTIVE DATE.—The amendment made by sub-
 30 section (a) applies with respect to items and services furnished
 31 on or after April 1, 2001.

32 **SEC. 313. EXEMPTION OF CRITICAL ACCESS HOSPITAL**
 33 **SWING BEDS FROM SNF PPS.**

34 (a) IN GENERAL.—Section 1888(e)(7) Act (42 U.S.C.
 35 1395yy(e)(7)) is amended—

36 (1) in the heading, by striking “TRANSITION FOR” and
 37 inserting “TREATMENT OF”;



1 (2) in subparagraph (A), by striking “IN GENERAL.—
2 The” and inserting “TRANSITION.—Subject to subpara-
3 graph (C), the”;

4 (3) in subparagraph (A), by inserting “(other than
5 critical access hospitals)” after “facilities described in sub-
6 paragraph (B)”;

7 (4) in subparagraph (B), by striking “, for which pay-
8 ment” and all that follows up to the period; and

9 (5) by adding at the end the following:

10 “(C) EXEMPTION FROM PPS OF SWING-BED SERV-
11 ICES FURNISHED IN CRITICAL ACCESS HOSPITALS.—
12 The prospective payment system established under this
13 subsection shall not apply to services furnished by a
14 critical access hospital pursuant to an agreement under
15 section 1883.”.

16 (b) PAYMENT ON A REASONABLE COST BASIS FOR SWING
17 BED SERVICES FURNISHED BY CRITICAL ACCESS HOS-
18 PITALS.—Section 1883(a) (42 U.S.C 1395tt(a)) is amended—

19 (1) in paragraph (2)(A), by inserting “(other than a
20 critical access hospital)” after “any hospital”; and

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

22 “(3) Notwithstanding any other provision of this title,
23 a critical access hospital shall be paid for covered skilled
24 nursing facility services furnished under an agreement en-
25 tered into under this section on the basis of the reasonable
26 costs of such services (as determined under section
27 1861(v)).”.

28 (c) EFFECTIVE DATE.—The amendments made by this
29 section shall apply to cost reporting periods beginning on or
30 after the date of the enactment of this Act.

31 **SEC. 314. PAYMENT IN CRITICAL ACCESS HOSPITALS**
32 **FOR EMERGENCY ROOM ON-CALL PHYSI-**
33 **CIANS.**

34 (a) IN GENERAL.—Section 1834(g) (42 U.S.C.
35 1395m(g)), as amended by section 311(a), is further amended
36 by adding at the end the following new paragraph:



1 “(5) COVERAGE OF COSTS FOR EMERGENCY ROOM ON-
2 CALL PHYSICIANS.—In determining the reasonable costs of
3 outpatient critical access hospital services under para-
4 graphs (1) and (2)(A), the Secretary shall recognize as al-
5 lowable costs, amounts (as defined by the Secretary) for
6 reasonable compensation and related costs for emergency
7 room physicians who are on-call (as defined by the Sec-
8 retary) but who are not present on the premises of the crit-
9 ical access hospital involved, and are not otherwise fur-
10 nishing physicians’ services and are not on-call at any other
11 provider or facility.”.

12 (b) EFFECTIVE DATE.—The amendment made by sub-
13 section (a) applies to cost reporting periods beginning on or
14 after October 1, 2001.

15 **SEC. 315. TREATMENT OF AMBULANCE SERVICES FUR-**
16 **NISHED BY CERTAIN CRITICAL ACCESS HOS-**
17 **PITALS.**

18 (a) IN GENERAL.—Section 1834(l) (42 U.S.C. 1395m(l))
19 is amended by adding at the end the following new paragraph:

20 “(8) SERVICES FURNISHED BY CRITICAL ACCESS HOS-
21 PITALS.—Notwithstanding any other provision of this sub-
22 section, the Secretary shall pay the reasonable costs in-
23 curred in furnishing ambulance services if such services are
24 furnished—

25 “(A) by a critical access hospital (as defined in
26 section 1861(mm)(1)), or

27 “(B) by an entity that is owned and operated by
28 a critical access hospital,

29 but only if the critical access hospital or entity is the only
30 provider or supplier of ambulance services that is located
31 within a 35-mile drive of such critical access hospital.”.

32 (b) CONFORMING AMENDMENT.—Section 1833(a)(1) (42
33 U.S.C. 1395m(l)(a)(1)) is amended—

34 (1) by inserting “(i)” after “with respect to ambulance
35 service,”; and

36 (2) by inserting before the comma at the end the fol-
37 lowing: “and (ii) with respect to ambulance services de-



1 scribed in section 1834(l)(8), the amounts paid shall be the
 2 amounts determined under section 1834(g) for outpatient
 3 critical access hospital services”.

4 (c) EFFECTIVE DATE.—The amendments made by this
 5 section apply to cost reporting periods beginning on or after
 6 October 1, 2001.

7 **SEC. 316. CLARIFICATION OF CRITICAL ACCESS HOS-**
 8 **PITAL CRITERIA.**

9 (a) IN GENERAL.—Section 1820(c)(2)(B) (42 U.S.C.
 10 1395i-4(c)(2)(B)) is amended—

11 (1) by striking “and” at the end of clause (iv);

12 (2) by striking the period at the end of clause (v) and
 13 inserting “; and”; and

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

15 “(vi) does not have a distinct part rehabilita-
 16 tion unit or a distinct part psychiatric unit, as de-
 17 fined in the matter following clause (v) in section
 18 1886(d)(1)(B).”.

19 (b) EFFECTIVE DATE.—The amendments made by sub-
 20 section (a) are effective as if included in the enactment of
 21 BBA.

22 **Subtitle C—Other Rural Provisions**

23 **SEC. 321. ASSISTANCE FOR PROVIDERS OF AMBULANCE**
 24 **SERVICES IN RURAL AREAS.**

25 (a) TRANSITIONAL ASSISTANCE IN CERTAIN MILEAGE
 26 RATES.—Section 1834(l) (42 U.S.C. 1395m(l)) is amended by
 27 adding at the end the following new paragraph:

28 “(8) TRANSITIONAL ASSISTANCE FOR RURAL PRO-
 29 VIDERS.—In the case of ground ambulance services fur-
 30 nished on or after January 1, 2001, and before January 1,
 31 2004, for which the transportation originates in a rural
 32 area (as defined in section 1886(d)(2)(D)) or in a rural
 33 census tract of a metropolitan statistical area (as deter-
 34 mined under the most recent modification of the Goldsmith
 35 Modification, originally published in the Federal Register
 36 on February 27, 1992 (57 Fed. Reg. 6725)), the fee sched-
 37 ule established under this subsection shall provide that,



1 with respect to the payment rate for mileage for a trip
2 above 17 miles, and up to 50 miles, the rate otherwise es-
3 tablished shall be increased by not less than 1/2 of the addi-
4 tional payment per mile established for the first 17 miles
5 of such a trip originating in a rural area.”.

6 (b) GAO STUDY AND REPORT ON THE COSTS OF AMBU-
7 LANCE SERVICES FURNISHED IN RURAL AREAS.—

8 (1) STUDY.—The Comptroller General of the United
9 States shall conduct a study of the cost of efficiently pro-
10 viding ambulance services for trips originating in rural
11 areas, with special emphasis on collection of cost data from
12 rural providers.

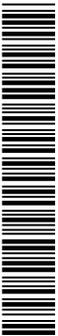
13 (2) REPORT.—Not later than June 30, 2002, the
14 Comptroller General shall submit to Congress a report on
15 the results of the study conducted under paragraph (1) and
16 shall include recommendations on steps that should be
17 taken to assure access to ambulance services for trips ori-
18 ginating in rural areas.

19 (c) ADJUSTMENT IN RURAL RATES.—In providing for ad-
20 justments under subparagraph (D) of section 1834(l)(2) of the
21 Social Security Act (42 U.S.C. 1395m(l)(2)) for years begin-
22 ning with 2004, the Secretary of Health and Human Services
23 shall take into consideration the recommendations contained in
24 the report under subsection (b)(2) and shall adjust the fee
25 schedule payment rates under such section for ambulance serv-
26 ices provided in low density rural areas based on the increased
27 cost (if any) of providing such services in such areas.

28 (d) EFFECTIVE DATE.—The amendment made by sub-
29 section (a) applies to services furnished on or after January 1,
30 2001. In applying such amendment to services furnished in
31 2001, the amount of the rate increase provided under such
32 amendment shall be equal to \$1.25 per mile.

33 **SEC. 322. TREATMENT OF CERTAIN PHYSICIAN PATHOL-**
34 **OGY SERVICES UNDER MEDICARE.**

35 (a) IN GENERAL.—When an independent laboratory fur-
36 nishes the technical component of a physician pathology service
37 to a fee-for-service medicare beneficiary who is an inpatient or



1 outpatient of a covered hospital, the Secretary of Health and
2 Human Services shall treat such component as a service for
3 which payment shall be made to the laboratory under section
4 1848 of the Social Security Act (42 U.S.C. 1395w-4) and not
5 as an inpatient hospital service for which payment is made to
6 the hospital under section 1886(d) of such Act (42 U.S.C.
7 1395ww(d)) or as an outpatient hospital service for which pay-
8 ment is made to the hospital under section 1833(t) of such Act
9 (42 U.S.C. 1395l(t)).

10 (b) DEFINITIONS.—For purposes of this section:

11 (1) COVERED HOSPITAL.—The term “covered hos-
12 pital” means, with respect to an inpatient or an outpatient,
13 a hospital—

14 (A) that had an arrangement with an independent
15 laboratory that was in effect as of July 22, 1999,
16 under which a laboratory furnished the technical com-
17 ponent of physician pathology services to fee-for-service
18 medicare beneficiaries who were hospital inpatients or
19 outpatients, respectively, and submitted claims for pay-
20 ment for such component to a medicare carrier (that
21 has a contract with the Secretary under section 1842
22 of the Social Security Act, 42 U.S.C. 1395u) and not
23 to such hospital; or

24 (B) that is located in a rural area (as defined in
25 section 1886(d)(2)(D) (42 U.S.C. 1395ww(d)(2)(D)))
26 and has fewer than 100 beds.

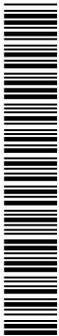
27 (2) FEE-FOR-SERVICE MEDICARE BENEFICIARY.—The
28 term “fee-for-service medicare beneficiary” means an indi-
29 vidual who—

30 (A) is entitled to benefits under part A, or enrolled
31 under part B, or both, of such title; and

32 (B) is not enrolled in any of the following:

33 (i) A Medicare+Choice plan under part C of
34 such title (42 U.S.C. 1395w-21 et seq.).

35 (ii) A plan offered by an eligible organization
36 under section 1876 of such Act (42 U.S.C.
37 1395mm).



1 (iii) A program of all-inclusive care for the el-
2 derly (PACE) under section 1894 of such Act (42
3 U.S.C. 1395eee).

4 (iv) A social health maintenance organization
5 (SHMO) demonstration project established under
6 section 4018(b) of the Omnibus Budget Reconcili-
7 ation Act of 1987 (Public Law 100-203).

8 (c) EFFECTIVE DATE.—This section applies to services
9 furnished during the 3-year period beginning on January 1,
10 2001.

11 (d) GAO REPORT.—

12 (1) STUDY.—The Comptroller General of the United
13 States shall conduct a study of the effects of the previous
14 provisions of this section on hospitals and laboratories and
15 access of fee-for-service medicare beneficiaries to the tech-
16 nical component of physician pathology services.

17 (2) REPORT.—Not later than April 1, 2003, the
18 Comptroller General shall submit to Congress a report on
19 such study. The report shall include recommendations
20 about whether such provisions should be extended after the
21 end of the period specified in subsection (c) for either or
22 both inpatient and outpatient hospital services, and wheth-
23 er the provisions should be extended to other hospitals.

24 **SEC. 323. FUNDING FOR GRANT PROGRAM FOR RURAL**
25 **HOSPITAL TRANSITION TO PROSPECTIVE**
26 **PAYMENT.**

27 Section 1820(g)(3) (42 U.S.C. 1395i-4(g)(3)) is amended
28 by adding at the end the following new subparagraph:

29 “(G) FUNDING.—There are hereby appropriated
30 from the Federal Hospital Insurance Trust Fund
31 \$25,000,000 for grants under this paragraph. Such
32 amount shall remain available for such purpose until
33 expended.”

34 **SEC. 324. EXPANSION OF MEDICARE PAYMENT FOR**
35 **TELEHEALTH SERVICES.**

36 (a) TIME LIMIT FOR BBA PROVISION.—Section 4206(a)
37 of BBA is amended by striking “Not later than January 1,



1 1999” and inserting “For services furnished on and after Jan-
2 uary 1, 1999, and before July 1, 2001”.

3 (b) EXPANSION OF MEDICARE PAYMENT FOR TELE-
4 HEALTH SERVICES.—

5 (1) IN GENERAL.—Section 1834 (42 U.S.C. 1395m) is
6 amended by added at the end the following new subsection:

7 “(m) PAYMENT FOR TELEHEALTH SERVICES.—

8 “(1) IN GENERAL.—The Secretary shall pay for eligi-
9 ble services that are furnished via a telecommunications
10 system by a physician (as defined in section 1861(r)) or a
11 practitioner (described in section 1842(b)(18)(C)), to an el-
12 igible telehealth individual enrolled under this part.

13 “(2) PAYMENT AMOUNT.—

14 “(A) DISTANT SITE.—The Secretary shall pay to
15 a physician or practitioner located at a distant site that
16 furnishes an eligible telehealth service to an eligible
17 telehealth individual an amount equal to the amount
18 that such physician or practitioner would have been
19 paid under this title had such service been furnished
20 without the use of a telecommunication system.

21 “(B) FACILITY FEE FOR ORIGINATING SITE.—
22 With respect to an eligible telehealth service, subject to
23 section 1833(a)(1)(T), there shall be paid to the origi-
24 nating site a facility fee equal to—

25 “(i) for the period July 1, 2001 through De-
26 cember 2001, and for 2002, \$20; and

27 “(ii) for a subsequent year, the facility fee
28 specified in clause (i) or this clause for the pre-
29 ceding year increased by the percentage increase in
30 the MEI (as defined in section 1842(i)(3)) for such
31 subsequent year.

32 “(C) TELEPRESENTER.—Except for psychiatric
33 services included in paragraph (4)(D), an eligible tele-
34 health individual shall be presented at the originating
35 site to a physician or practitioner at a distant site by—

36 “(i) a physician or practitioner (which may in-
37 clude a referring physician or practitioner), or



1 “(ii) a registered nurse who is licensed by the
2 State to practice nursing and is operating within
3 the scope of that license.

4 “(D) FEE SHARING AND PAYMENT OF PRE-
5 SENDER.—

6 “(i) Nothing in this title shall be construed as
7 requiring or prohibiting the physician or practi-
8 tioner at a distant site from sharing a portion of
9 the fee that such physician or practitioner receives
10 from the Secretary for an eligible telehealth service
11 with a physician or practitioner who serves as a
12 telepresenter at the originating site.

13 “(ii) Payment for a registered nurse who
14 serves as a telepresenter shall be made by the dis-
15 tant site physician or practitioner or originating
16 site facility that is the employer of such registered
17 nurse.

18 “(iii) The provisions of section 1877 shall
19 apply to payments that a physician or practitioner
20 at a distant site makes to a referring physician or
21 practitioner who does not serve as a telepresenter
22 at the originating site.

23 “(3) LIMITATION ON BENEFICIARY CHARGES.—

24 “(A) The provisions of section 1848(g) and sub-
25 paragraphs (A) and (B) of section 1842(b)(18) shall
26 apply to a physician or practitioner receiving payment
27 under this subsection in the same manner as they apply
28 to under such sections.

29 “(B) The provisions of section 1842(b)(18) shall
30 apply to originating sites receiving a facility fee in the
31 same manner as they apply to practitioners under such
32 section.

33 “(4) DEFINITIONS.—For purposes of this
34 subsection—

35 “(A) ELIGIBLE TELEHEALTH INDIVIDUAL.—The
36 term ‘eligible telehealth individual’ means an individual
37 enrolled under this part who receives an eligible tele-



1 health service furnished at an originating site (as de-
2 fined in subparagraph (C)).

3 “(B) DISTANT SITE.—The term ‘distant site’
4 means the site at which the physician or practitioner is
5 located at the time the service is provided via a tele-
6 communications system.

7 “(C) ORIGINATING SITE.—

8 “(i) IN GENERAL.—The term ‘originating site’
9 means only those sites described in clause (ii) at
10 which the eligible telehealth individual is located at
11 the time the service is furnished via a telecommuni-
12 cations system and only if such site is located in a
13 health professional shortage area under section
14 332(a)(1)(A) of the Public Health Service Act (42
15 U.S.C. 254e(a)(1)(A)) that is located in all or part
16 of rural area (as defined in section 1886(d)(2)(D)).

17 “(ii) SITES DESCRIBED.—The sites referred to
18 in clause (i) are the following sites:

19 “(I) The office of a physician or practi-
20 tioner.

21 “(II) A rural health clinic (as defined in
22 section 1861(aa)(s)).

23 “(III) A federally qualified health center
24 (as defined in section 1861(aa)(4)).

25 “(IV) A critical access hospital (as defined
26 in section 1861(mm)(1)).

27 “(D) ELIGIBLE TELEHEALTH SERVICES.—The
28 term ‘eligible telehealth services’ means professional
29 consultations, office visits, and office psychiatry serv-
30 ices (identified as of July 1, 2000, by HCPCS codes
31 99241–99275, 99201–99215, 90804–90809 and 90862
32 (and as subsequently modified by the Secretary)) and
33 any other similar consultation or office visit codes iden-
34 tified by the Secretary.”.

35 (c) CONFORMING AMENDMENT.—Section 1833(a)(1) (42
36 U.S.C. 1395l(1)) is amended—

37 (1) by striking “and (S)” and inserting “(S)”; and



1 (2) by inserting before the semicolon at the end the
 2 following: “, and (T) with respect to facility fees described
 3 in section 1834(m)(2)(B), the amounts paid shall be 80
 4 percent of the lesser of the actual charge or the amounts
 5 specified in such section”.

6 (d) GAO STUDY AND REPORT ON ADDITIONAL SERVICES
 7 AND SITES.—

8 (1) STUDY.—The Comptroller General of the United
 9 States shall conduct a study to identify services and origi-
 10 nating sites in addition to those described in the amend-
 11 ments made by subsection (b) that are appropriate for pay-
 12 ment via a telecommunications system. As part of the
 13 study, the Comptroller General shall evaluate and make
 14 recommendations on the use of store-and-forward tech-
 15 nology, the extent and appropriateness of fee-splitting
 16 among physicians and practitioners, and whether a telepre-
 17 senter should be required.

18 (2) REPORT.—Not later than 3 years after the date of
 19 enactment of this Act, the Comptroller General shall sub-
 20 mit to Congress a report on the study conducted under
 21 paragraph (1), together with such recommendations that
 22 the Comptroller General determines are appropriate.

23 (e) EFFECTIVE DATE.—The amendments made by sub-
 24 sections (b) and (c) shall be effective for services furnished on
 25 or after July 1, 2001.

26 **SEC. 325. EXPANDING ACCESS TO RURAL HEALTH CLIN-**
 27 **ICS.**

28 (a) IN GENERAL.—The matter in section 1833(f) (42
 29 U.S.C. 1395l(f)) preceding paragraph (1) is amended by strik-
 30 ing “rural hospitals” and inserting “hospitals”.

31 (b) EFFECTIVE DATE.—The amendment made by sub-
 32 paragraph (A) shall apply to services furnished on or after Oc-
 33 tober 1, 2000.



1 **TITLE IV—PROVISIONS RELATING**
 2 **TO PART B**
 3 **Subtitle A—Hospital Outpatient**
 4 **Services**

5 **SEC. 401. REVISION OF HOSPITAL OUTPATIENT PPS**
 6 **PAYMENT UPDATE.**

7 (a) IN GENERAL.—Section 1833(t)(3)(C)(iii) (42 U.S.C.
 8 1395l(t)(3)(C)(iii)) is amended by striking “in each of 2000,
 9 2001, and 2002” and inserting “in each of 2000 and 2002”.

10 (b) SPECIAL RULE FOR PAYMENT FOR 2001.—For pur-
 11 poses of making payments for 2001 for covered OPD services
 12 (as defined in paragraph (1)(B) of section 1833(t) of the Social
 13 Security Act (42 U.S.C. 1395l(t)), the “OPD fee schedule in-
 14 crease factor” referred to in paragraph (3)(C)(iii) of such
 15 section—

16 (1) for services furnished on or after January 1, 2001,
 17 and before July 1, 2001, shall be determined in accordance
 18 with such paragraph as in effect on the day before the date
 19 of enactment of this Act; and

20 (2) for services furnished on or after July 1, 2001,
 21 and before January 1, 2002, shall be equal to the OPD fee
 22 schedule increase factor under such paragraph plus 1 per-
 23 centage point.

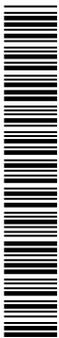
24 (c) ADJUSTMENT FOR CASE MIX CHANGES.—

25 (1) IN GENERAL.—Section 1833(t)(3)(C) (42 U.S.C.
 26 1395l(t)(3)(C)) is amended—

27 (A) by redesignating clause (iii) as clause (iv); and

28 (B) by inserting after clause (ii) the following new
 29 clause:

30 “(iii) ADJUSTMENT FOR SERVICE MIX
 31 CHANGES.—Insofar as the Secretary determines
 32 that the adjustments for service mix under para-
 33 graph (2) for a previous year (or estimates that
 34 such adjustments for a future year) did (or are
 35 likely to) result in a change in aggregate payments
 36 under this subsection during the year that are a re-



1 sult of changes in the coding or classification of
 2 covered OPD services that do not reflect real
 3 changes in service mix, the Secretary may adjust
 4 the conversion factor computed under this subpara-
 5 graph for subsequent years so as to eliminate the
 6 effect of such coding or classification changes.”.

7 (2) EFFECTIVE DATE.—The amendments made by
 8 paragraph (1) apply to covered OPD services furnished on
 9 or after January 1, 2002.

10 **SEC. 402. CLARIFYING PROCESS AND STANDARDS FOR**
 11 **DETERMINING ELIGIBILITY OF DEVICES FOR**
 12 **PASS-THROUGH PAYMENTS UNDER HOS-**
 13 **PITAL OUTPATIENT PPS.**

14 (a) IN GENERAL.—Section 1833(t)(6) (42 U.S.C.
 15 1395l(t)(6)) is amended—

16 (1) by redesignating subparagraphs (C) and (D) as
 17 subparagraphs (D) and (E), respectively; and

18 (2) by striking subparagraph (B) and inserting the fol-
 19 lowing:

20 “(B) USE OF CATEGORIES IN DETERMINING ELI-
 21 GIBILITY OF A DEVICE FOR PASS-THROUGH PAY-
 22 MENTS.—The following provisions apply for purposes of
 23 determining whether a medical device qualifies for addi-
 24 tional payments under clause (ii) or (iv) of subpara-
 25 graph (A):

26 “(i) ESTABLISHMENT OF INITIAL CAT-
 27 EGORIES.—The Secretary shall initially establish
 28 under this clause categories of medical devices
 29 based on type of device by April 1, 2001. Such cat-
 30 egories shall be established in a manner such that
 31 each medical device that meets the requirements of
 32 clause (ii) or (iv) of subparagraph (A) as of such
 33 date is included in such a category and no such de-
 34 vice is included in more than one category. For
 35 purposes of the preceding sentence, whether a med-
 36 ical device meets such requirements as of such date
 37 shall be determined on the basis of the program



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memoranda issued before such date or if the Secretary determines the medical device would have been included in the program memoranda but for the requirement of subparagraph (A)(iv)(I). The categories may be established under this clause by program memorandum or otherwise, after consultation with groups representing hospitals, manufacturers of medical devices, and other affected parties.

“(ii) ESTABLISHING CRITERIA FOR ADDITIONAL CATEGORIES.—

“(I) IN GENERAL.—The Secretary shall establish criteria that will be used for creation of additional categories (other than those established under clause (i)) through rulemaking (which may include use of an interim final rule with comment period).

“(II) STANDARD.—Such categories shall be established under this clause in a manner such that no medical device is described by more than one category. Such criteria shall include a test of whether the average cost of devices that would be included in a category and are in use at the time the category is established is not insignificant, as described in subparagraph (A)(iv)(II).

“(III) DEADLINE.—Criteria shall first be established under this clause by July 1, 2001. The Secretary may establish in compelling circumstances categories under this clause before the date such criteria are established.

“(IV) ADDING CATEGORIES.—The Secretary shall promptly establish a new category of medical device under this clause for any medical device that meets the requirements of subparagraph (A)(iv) and for which none of the



1 categories in effect (or that were previously in
2 effect) is appropriate.

3 “(iii) PERIOD FOR WHICH CATEGORY IS IN EF-
4 FECT.—A category of medical devices established
5 under clause (i) or clause (ii) shall be in effect for
6 a period of at least 2 years, but not more than 3
7 years, that begins—

8 “(I) in the case of a category established
9 under clause (i), on the first date on which
10 payment was made under this paragraph for
11 any device described by such category (includ-
12 ing payments made during the period before
13 April 1, 2001); and

14 “(II) in the case of any other category, on
15 the first date on which payment is made under
16 this paragraph for any medical device that is
17 described by such category.

18 “(iv) REQUIREMENTS TREATED AS MET.—A
19 medical device shall be treated as meeting the re-
20 quirements of subparagraph (A)(iv) if—

21 “(I) the device is described by a category
22 established and in effect under clause (i); or

23 “(II) the device is described by a category
24 established and in effect under clause (ii) and
25 an application under section 515 of the Federal
26 Food, Drug, and Cosmetic Act has been ap-
27 proved with respect to the device, or the device
28 has been cleared for market under section
29 510(k) of such Act, or the device is exempt
30 from the requirements of section 510(k) of
31 such Act pursuant to subsection (l) or (m) of
32 section 510 of such Act or section 520(g) of
33 such Act.

34 Nothing in this clause shall be construed as requir-
35 ing an application or prior approval (other than
36 that described in subclause (II)) in order for a de-
37 vice to qualify for payment under this paragraph.



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“(C) LIMITED PERIOD OF PAYMENT.—

“(i) DRUGS AND BIOLOGICALS.—The payment under this paragraph with respect to a drug or biological shall only apply during a period of at least 2 years, but not more than 3 years, that begins—

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

“(II) in the case of a drug or biological described in subparagraph (A)(iv) not described in subclause (I), on the first date on which payment is made under this part for the drug or biological as an outpatient hospital service.

“(ii) MEDICAL DEVICES.—Payment shall be made under this paragraph with respect to a medical device only if such device—

“(I) is described by a category of medical devices established and in effect under subparagraph (B); and

“(II) is provided as part of a service (or group of services) paid for under this subsection and provided during the period for which such category is in effect under such subparagraph.”.

(b) CONFORMING AMENDMENTS.—Section 1833(t) (42 U.S.C. 1395l(t)) is further amended—

(1) in paragraph (6)(A), by striking “the cost of the device, drug, or biological” and inserting “the cost of the drug or biological or the average cost of the category of devices”;

(2) in paragraph (6)(D) (as redesignated by subsection (a)(1)), by striking “subparagraph (D)(iii)” in the



1 matter preceding clause (i) and inserting “subparagraph
2 (E)(iii)”;

3 (3) in paragraph (12)(E), by striking “additional pay-
4 ments (consistent with paragraph (6)(B))” and inserting
5 “additional payments, the determination and deletion of
6 initial and new categories (consistent with subparagraphs
7 (B) and (C) of paragraph (6))”.

8 (c) EFFECTIVE DATE.—The amendments made by this
9 section take effect on the date of the enactment of this Act.

10 (d) TRANSITION.—In the case of a medical device provided
11 as part of a service (or group of services) furnished during the
12 period before initial categories are implemented under subpara-
13 graph (B)(i) of section 1833(t)(6) of the Social Security Act
14 (as amended by subsection (a)), payment shall be made for
15 such device under such section in accordance with the provi-
16 sions in effect before the date of the enactment of this Act, ex-
17 cept that payment shall also be made for such a device that
18 is not included in a program memorandum described in such
19 subparagraph if the Secretary determines that the device is
20 likely to be described by such an initial category or would have
21 been included in such program memoranda but for the require-
22 ment of subparagraph (A)(iv)(I) of that section.

23 **SEC. 403. APPLICATION OF OPD PPS TRANSITIONAL**
24 **CORRIDOR PAYMENTS TO CERTAIN HOS-**
25 **PITALS THAT DID NOT SUBMIT A 1996 COST**
26 **REPORT.**

27 (a) IN GENERAL.—Section 1833(t)(7)(F)(ii)(I) (42 U.S.C.
28 1395l(t)(7)(F)(ii)(I)) is amended by inserting “(or in the case
29 of a hospital that did not submit a cost report for such period,
30 during the first subsequent cost reporting period ending before
31 2001 for which the hospital submitted a cost report)” after
32 “1996”.

33 (b) EFFECTIVE DATE.—The amendment made by sub-
34 section (a) shall take effect as if included in the enactment of
35 BBRA.



1 **SEC. 404. APPLICATION OF RULES FOR DETERMINING**
2 **PROVIDER-BASED STATUS FOR CERTAIN EN-**
3 **TITIES.**

4 (a) GRANDFATHER.—Notwithstanding any other provision
5 of law, for purposes of making determinations of provider-based
6 status under title XVIII of the Social Security Act on or after
7 October 1, 2000, any facility or organization that is treated as
8 provider-based in relation to a hospital or critical access hos-
9 pital under such title as of October 1, 2000—

10 (1) shall continue to be treated as provider-based in
11 relation to such hospital or critical access hospital under
12 such title during the 2-year period beginning on October 1,
13 2000; and

14 (2) the requirements, limitations, and exclusions speci-
15 fied in paragraphs (d), (e), (f), and (h) of section 413.65
16 of title 42, Code of Federal Regulations shall not apply to
17 such facility or organization in relation to such hospital or
18 critical access hospital until after the end of such 2-year
19 period.

20 (b) TEMPORARY CRITERIA.—For purposes of title XVIII
21 of the Social Security Act—

22 (1) a facility or organization for which a determination
23 of provider-based status in relation to a hospital or critical
24 access hospital is requested on or after October 1, 2000,
25 and before October 1, 2002, may not be treated as not hav-
26 ing provider-based status in relation to such a hospital for
27 any period before a determination is made with respect to
28 such status pursuant to such request; and

29 (2) in making a determination with respect to such
30 status for any facility or organization in relationship to
31 such a hospital on or after October 1, 2000, the following
32 rules apply:

33 (A) The facility or organization shall be treated as
34 satisfying any requirements and standards for geo-
35 graphic location in relation to such a hospital if the fa-
36 cility or organization—



1 (i) satisfies the requirements of section
2 413.65(d)(7) of title 42, Code of Federal Regula-
3 tions (as in effect on October 1, 2000); or

4 (ii) is located not more than 35 miles from the
5 main campus of the hospital or critical access hos-
6 pital.

7 (B) The facility or organization shall be treated as
8 satisfying any of the requirements and standards for
9 geographic location in relation to such a hospital if the
10 facility or organization is owned and operated by a hos-
11 pital or critical access hospital that—

12 (i) is owned or operated by a unit of State or
13 local government, is a public or private nonprofit
14 corporation that is formally granted governmental
15 powers by a unit of State or local government, or
16 is a private hospital that has a contract with a
17 State or local government that includes the oper-
18 ation of clinics located off the main campus of the
19 hospital to assure access in a well-defined service
20 area to health care services for low-income individ-
21 uals who are not entitled to benefits under title
22 XVIII (or medical assistance under a State plan
23 under title XIX) of such Act; and

24 (ii) has a disproportionate share adjustment
25 percentage (as determined under section
26 1886(d)(5)(F) of such Act, 42 U.S.C.
27 1395ww(d)(5)(F)) greater than 11.75 percent or is
28 described in clause (i)(II) of such section.

29 (c) DEFINITIONS.—For purposes of this section, the terms
30 “hospital” and “critical access hospital” have the meanings
31 given such terms in subsections (e) and (mm)(1), respectively,
32 of section 1861 of the Social Security Act (42 U.S.C. 1395x)
33 .

34 **SEC. 405. TREATMENT OF CHILDREN’S HOSPITALS**
35 **UNDER PROSPECTIVE PAYMENT SYSTEM.**

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



1 (1) in the heading of paragraph (7)(D)(ii), by insert-
2 ing “AND CHILDREN’S HOSPITALS” after “CANCER HOS-
3 PITALS”; and

4 (2) in paragraphs (7)(D)(ii) and (11), by striking
5 “section 1886(d)(1)(B)(v)” and inserting “clause (iii) or
6 (v) of section 1886(d)(1)(B)”.

7 (b) EFFECTIVE DATE.—The amendments made by sub-
8 section (a) apply as if included in the enactment of section 202
9 of BBRA.

10 **Subtitle B—Other Services**

11 **SEC. 411. 1-YEAR EXTENSION OF MORATORIUM ON** 12 **THERAPY CAPS; REPORT ON STANDARDS** 13 **FOR SUPERVISION OF PHYSICAL THERAPY** 14 **ASSISTANTS.**

15 (a) IN GENERAL.—Section 1833(g)(4) (42 U.S.C.
16 1395l(g)(4)) is amended by striking “2000 and 2001.” and in-
17 serting “2000, 2001, and 2002.”.

18 (b) CONFORMING AMENDMENT TO CONTINUE FOCUSED
19 MEDICAL REVIEWS OF CLAIMS DURING MORATORIUM PE-
20 RIOD.—Section 221(a)(2) of BBRA is amended by striking
21 “(under the amendment made by paragraph (1)(B))”.

22 (c) STUDY ON STANDARDS FOR SUPERVISION OF PHYS-
23 ICAL THERAPIST ASSISTANTS.—

24 (1) STUDY.—The Secretary of Health and Human
25 Services shall conduct a study of the implications—

26 (A) of eliminating the “in the room” supervision
27 requirement for medicare payment for services of phys-
28 ical therapy assistants who are supervised by physical
29 therapists; and

30 (B) of such requirement on the cap imposed under
31 section 1833(g) of the Social Security Act (42 U.S.C.
32 1395l(g)) on physical therapy services.

33 (2) REPORT.—Not later than 18 months after the
34 date of the enactment of this Act, the Secretary shall sub-
35 mit to Congress a report on the study conducted under
36 paragraph (1).



1 **SEC. 412. UPDATE IN RENAL DIALYSIS COMPOSITE**
2 **RATE.**

3 (a) UPDATE.—

4 (1) IN GENERAL.—The last sentence of section
5 1881(b)(7) (42 U.S.C. 1395rr(b)(7)) is amended by strik-
6 ing “for such services furnished on or after January 1,
7 2001, by 1.2 percent” and inserting “for such services fur-
8 nished on or after January 1, 2001, by 2.4 percent”.

9 (2) CONSTRUCTION.—The enactment of the amend-
10 ment made by paragraph (1) shall not be construed as au-
11 thorizing any application for a exception under section
12 1881(b)(7) of the Social Security Act (42 U.S.C.
13 1395rr(b)(7)).

14 (b) DEVELOPMENT OF ESRD MARKET BASKET.—

15 (1) DEVELOPMENT.—The Secretary of Health and
16 Human Services shall collect data and develop an ESRD
17 market basket whereby the Secretary can estimate, before
18 the beginning of a year, the percentage by which the costs
19 for the year of the mix of labor and non-labor goods and
20 services included in the ESRD composite rate under section
21 1881(b)(7) of the Social Security Act (42 U.S.C.
22 1395rr(b)(7)) will exceed the costs of such mix of goods
23 and services for the preceding year. In developing such
24 index, the Secretary may take into account measures of
25 changes in—

26 (A) technology used in furnishing dialysis services;

27 (B) the manner or method of furnishing dialysis
28 services; and

29 (C) the amounts by which the payments under
30 such section for all services billed by a facility for a
31 year exceed the aggregate allowable audited costs of
32 such services for such facility for such year.

33 (2) REPORT.—The Secretary shall submit a report to
34 Congress on the index developed under paragraph (1) no
35 later than July 1, 2003, and shall include in the report rec-
36 ommendations on the appropriateness of an annual or peri-



1 odic update mechanism for renal dialysis services under the
2 medicare program based on such index.

3 (c) INCLUSION OF ADDITIONAL SERVICES IN COMPOSITE
4 RATE.—

5 (1) DEVELOPMENT.—The Secretary of Health and
6 Human Services shall develop a system which includes, to
7 the maximum extent feasible, in the composite rate used
8 for payment under section 1881(b)(7) of the Social Secu-
9 rity Act (42 U.S.C. 1395rr(b)(7)), payment for clinical di-
10 agnostic laboratory tests and drugs (other than drugs paid
11 under section 1881(b)(11)(B) of such Act (42 U.S.C.
12 1395rr(b)(11)(B)) that are routinely used in furnishing di-
13 alysis services to medicare beneficiaries but which are cur-
14 rently separately billable by renal dialysis facilities.

15 (2) REPORT.—The Secretary shall include, as part of
16 the report submitted under subsection (b)(2), a report on
17 the system developed under paragraph (1) and rec-
18 ommendations on the appropriateness of incorporating the
19 system into medicare payment for renal dialysis services.

20 (d) GAO STUDY ON ACCESS TO SERVICES.—The Comp-
21 troller General of the United States shall study access of medi-
22 care beneficiaries to renal dialysis services. Such study shall in-
23 clude whether there is a sufficient supply of facilities to furnish
24 needed renal dialysis services, whether medicare payment levels
25 are appropriate, taking into account audited costs of facilities
26 for all services furnished, to ensure continued access to such
27 services, and improvements in access (and quality of care) that
28 may result of the increased use of long nightly and short daily
29 hemodialysis modalities. The Comptroller General shall submit
30 a report to Congress on the study no later than January 1,
31 2003.

32 **SEC. 413. PAYMENT FOR AMBULANCE SERVICES.**

33 (a) RESTORATION OF FULL CPI INCREASE FOR 2001.—
34 Section 1834(l)(3)(B) (42 U.S.C. 1395m(l)(3)(B)) is amended
35 by striking “reduced in the case of 2001 and 2002” each place
36 it appears and inserting “reduced in the case of 2002”.



1 (b) EFFECTIVE DATE.—The amendment made by sub-
2 section (a) applies to services furnished on or after January 1,
3 2001.

4 **SEC. 414. AMBULATORY SURGICAL CENTERS.**

5 In and upon implementing a revised prospective payment
6 system for services of ambulatory surgical facilities under sec-
7 tion 1833(i) of the Social Security Act (42 U.S.C. 1395l(i))
8 which incorporates data from the 1999 Medicare cost survey or
9 a subsequent cost survey, the Secretary of Health and Human
10 Services shall implement such system in a manner as if the last
11 sentence of section 1833(i)(2)(C) of the Social Security Act (42
12 U.S.C. 1395l(i)(2)(C)) did not apply to fiscal year 2001 for the
13 portion of the payment made in accordance with such system.

14 **SEC. 415. FULL UPDATE FOR DURABLE MEDICAL EQUIP-**
15 **MENT.**

16 (a) IN GENERAL.—Section 1834(a)(14) (42 U.S.C.
17 1395m(a)(14)) is amended—

18 (1) by redesignating subparagraph (D) as subpara-
19 graph (F);

20 (2) in subparagraph (C)—

21 (A) by striking “through 2002” and inserting
22 “through 2000”; and

23 (B) by striking “ and” at the end; and

24 (3) by inserting after subparagraph (C) the following
25 new subparagraphs:

26 “(D) for 2001, the percentage increase in the con-
27 sumer price index for all urban consumers (U.S. city
28 average) for the 12-month period ending with June
29 2000;the market basket percentage increase for the fis-
30 cal year;

31 “(E) for 2002, 0 percentage points; and”.

32 (b) CONFORMING AMENDMENT TO BBRA.—(1) Sub-
33 section (a) of section 228 of BBRA (113 Stat. 1501A–356) is
34 amended in the matter preceding paragraph (1)—

35 (A) by striking “during 2001 and 2002” and inserting
36 “during 2002”; and



1 (B) by striking “for—” and all the follows through
2 “(2)” and inserting ”for” and adjusting the margin accord-
3 ingly.

4 (2) Subsection (b) of such section is amended in the mat-
5 ter preceding paragraph (1) by striking “increase—” and all
6 the follows through “(2)” and inserting ”for” and adjusting the
7 margin accordingly.

8 (c) EFFECTIVE DATE.—The amendments made by sub-
9 section (b) shall take effect as if included in the enactment of
10 BBRA.

11 **SEC. 416. FULL UPDATE FOR ORTHOTICS AND PROS-**
12 **THETICS.**

13 Section 1834(h)(4)(A) (42 U.S.C. 1395m(h)(4)(A)) is
14 amended—

15 (1) by redesignating clause (vi) as clause (viii);

16 (2) in clause (v)—

17 (A) by striking “through 2002” and inserting
18 “through 2000”; and

19 (B) by striking “and” at the end; and

20 (3) by inserting after clause (v) the following new
21 clause:

22 “(vi) for 2001, the percentage increase in the
23 consumer price index for all urban consumers (U.S.
24 city average) for the 12-month period ending with
25 June 2000;

26 “(vii) for 2002, 1 percent; and”.

27 **SEC. 417. ESTABLISHMENT OF SPECIAL PAYMENT PRO-**
28 **VISIONS AND REQUIREMENTS FOR PROS-**
29 **THETICS AND CERTAIN CUSTOM FAB-**
30 **RICATED ORTHOTIC ITEMS.**

31 (a) IN GENERAL.—Section 1834(h)(1) (42 U.S.C.
32 1395m(h)(1)) is amended by adding at the end the following:

33 “(F) SPECIAL PAYMENT RULES FOR CERTAIN
34 PROSTHETICS AND CUSTOM FABRICATED ORTHOTICS.—

35 “(i) IN GENERAL.—No payment shall be made
36 under this subsection for an item of prosthetics or
37 of custom fabricated orthotics described in clause

38 (ii) unless such item is—



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“(I) furnished by a qualified practitioner;
and

“(II) fabricated by a qualified practitioner
or a qualified supplier at a facility that meets
such criteria as the Secretary determines ap-
propriate.

“(ii) DESCRIPTION OF CUSTOM FABRICATED
ITEM.—

“(I) IN GENERAL.—An item described in
this clause is an item of custom fabricated
orthotics that requires education, training, and
experience to custom fabricate and that is in-
cluded in a list established by the Secretary in
subclause (II). Such an item does not include
shoes and shoe inserts.

“(II) LIST OF ITEMS.—The Secretary, in
consultation with appropriate experts in
orthotics (including national organizations rep-
resenting manufacturers of orthotics), shall es-
tablish and update as appropriate a list of
items to which this subparagraph applies. No
item may be included in such list unless the
item is individually fabricated for the patient
over a positive model of the patient.

“(iii) QUALIFIED PRACTITIONER DEFINED.—
In this subparagraph, the term ‘qualified practi-
tioner’ means a physician or other individual who—

“(I) is a qualified physical therapist or a
qualified occupational therapist;

“(II) in the case of a State that provides
for the licensing of orthotics and prosthetics, is
licensed in orthotics or prosthetics by the State
in which the item is supplied; or

“(III) in the case of a State that does not
provide for the licensing of orthotics and pros-
thetics, is specifically trained and educated to
provide or manage the provision of prosthetics



1 and custom-designed or fabricated orthotics,
2 and is certified by the American Board for Cer-
3 tification in Orthotics and Prosthetics, Inc. or
4 by the Board for Orthotist/Prosthetist Certifi-
5 cation, or is credentialed and approved by a
6 program that the Secretary determines, in con-
7 sultation with appropriate experts in orthotics
8 and prosthetics, has training and education
9 standards that are necessary to provide such
10 prosthetics and orthotics.

11 “(iv) QUALIFIED SUPPLIER DEFINED.—In this
12 subparagraph, the term ‘qualified supplier’ means
13 any entity that is accredited by the American
14 Board for Certification in Orthotics and Pros-
15 thetics, Inc. or by the Board for Orthotist/Pros-
16 thetist Certification, or accredited and approved by
17 a program that the Secretary determines has ac-
18 creditation and approval standards that are essen-
19 tially equivalent to those of such Board.”

20 (b) EFFECTIVE DATE.—Not later than one year after the
21 date of the enactment of this Act, the Secretary of Health and
22 Human Services shall promulgate revised regulations to carry
23 out the amendment made by subsection (a) using a negotiated
24 rulemaking process under subchapter III of chapter 5 of title
25 5, United States Code.

26 (c) GAO STUDY AND REPORT.—

27 (1) STUDY.—The Comptroller General of the United
28 States shall conduct a study on HCFA Ruling 96–1, issued
29 on September 1, 1996, with respect to distinguishing
30 orthotics from durable medical equipment under the medi-
31 care program. The study shall assess the following matters:

32 (A) The compliance of the Secretary of Health and
33 Human Services with the Administrative Procedures
34 Act (under chapter 5 of title 5, United States Code) in
35 making such ruling.

36 (B) The potential impact of such ruling on the
37 health care furnished to medicare beneficiaries under



1 the medicare program, especially those beneficiaries
2 with degenerative musculoskeletal conditions.

3 (C) The potential for fraud and abuse under the
4 medicare program if payment were provided for
5 orthotics used as a component of durable medical
6 equipment only when made under the special payment
7 provision for certain prosthetics and custom fabricated
8 orthotics under section 1834(h)(1)(F) of the Social Se-
9 curity Act, as added by subsection (a) and furnished by
10 qualified practitioners under that section.

11 (D) The impact on payments under titles XVIII
12 and XIX of the Social Security Act if such ruling were
13 overturned.

14 (2) REPORT TO CONGRESS.—Not later than 6 months
15 after the date of the enactment of this Act, the Comptroller
16 General shall submit to Congress a report on the study
17 conducted under paragraph (1).

18 **SEC. 418. REVISED PART B PAYMENT FOR DRUGS AND**
19 **BIOLOGICALS AND RELATED SERVICES.**

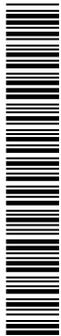
20 (a) RECOMMENDATIONS FOR REVISED PAYMENT METH-
21 ODOLOGY FOR DRUGS AND BIOLOGICALS.—

22 (1) STUDY.—

23 (A) IN GENERAL.—The Comptroller General of
24 the United States shall conduct a study on the reim-
25 bursement for drugs and biologicals under the current
26 medicare payment methodology (provided under section
27 1842(o) of the Social Security Act (42 U.S.C.
28 1395u(o)) and for related services under part B of title
29 XVIII of such Act. In the study, the Comptroller Gen-
30 eral shall—

31 (i) identify the average prices at which such
32 drugs and biologicals are acquired by physicians
33 and other suppliers;

34 (ii) quantify the difference between such aver-
35 age prices and the reimbursement amount under
36 such section; and



1 (iii) determine the extent to which (if any)
2 payment under such part is adequate to com-
3 pensate physicians, providers of services, or other
4 suppliers of such drugs and biologicals for costs in-
5 curred in the administration, handling, or storage
6 of such drugs or biologicals.

7 (B) CONSULTATION.—In conducting the study
8 under subparagraph (A), the Comptroller General shall
9 consult with physicians, providers of services, and sup-
10 pliers of drugs and biologicals under the medicare pro-
11 gram, as well as other organizations involved in the dis-
12 tribution of such drugs and biologicals to such physi-
13 cians, providers of services, and suppliers.

14 (2) REPORT.—Not later than 6 months after the date
15 of the enactment of this Act, the Comptroller General shall
16 submit to Congress and to the Secretary of Health and
17 Human Services a report on the study conducted under
18 this subsection, and shall include in such report rec-
19 ommendations for revised payment methodologies described
20 in paragraph (3).

21 (3) RECOMMENDATIONS FOR REVISED PAYMENT
22 METHODOLOGIES.—

23 (A) IN GENERAL.—The Comptroller General shall
24 provide specific recommendations for revised payment
25 methodologies for reimbursement for drugs and
26 biologicals and for related services under the medicare
27 program. The Comptroller General may include in the
28 recommendations—

29 (i) proposals to make adjustments under sub-
30 section (c) of section 1848 of the Social Security
31 Act (42 U.S.C. 1395w-4) for the practice expense
32 component of the physician fee schedule under such
33 section for the costs incurred in the administration,
34 handling, or storage of certain categories of such
35 drugs and biologicals, if appropriate; and

36 (ii) proposals for new payments to providers of
37 services or suppliers for such costs, if appropriate.



1 (B) ENSURING PATIENT ACCESS TO CARE.—In
 2 making recommendations under this paragraph, the
 3 Comptroller General shall ensure that any proposed re-
 4 vised payment methodology is designed to ensure that
 5 Medicare beneficiaries continue to have appropriate ac-
 6 cess to health care services under the Medicare pro-
 7 gram.

8 (C) MATTERS CONSIDERED.—The Comptroller
 9 General shall consider—

10 (i) the method and amount of reimbursement
 11 for similar drugs and biologicals made by large
 12 group health plans;

13 (ii) as a result of any revised payment method-
 14 ology, the potential for patients to receive inpatient
 15 or outpatient hospital services in lieu of services in
 16 a physician’s office; and

17 (iii) the effect of any revised payment method-
 18 ology on the delivery of drug therapies by hospital
 19 outpatient departments.

20 (D) COORDINATION WITH BBRA STUDY.—In pre-
 21 paring recommendations under this subsection, the
 22 Comptroller General shall conclude and take into ac-
 23 count the results of the study provided for under sec-
 24 tion 213(a) of BBRA (113 Stat. 1501A–350).

25 (b) IMPLEMENTATION OF NEW PAYMENT METHOD-
 26 OLOGY.—

27 (1) IN GENERAL.—Notwithstanding any other provi-
 28 sion of law, based on the recommendations contained in the
 29 report under subsection (a), the Secretary of Health and
 30 Human Services, subject to paragraph (2), shall revise the
 31 payment methodology under section 1842(o) of the Social
 32 Security Act (42 U.S.C. 1395u(o)) for drugs and
 33 biologicals furnished under part B of the medicare pro-
 34 gram. To the extent the Secretary determines appropriate,
 35 the Secretary may provide for the adjustments to payments
 36 amounts referred to in subsection (a)(3)(A)(i) or additional
 37 payments referred to in subsection (a)(2)(A)(ii).



1 (b) REPORT.—Not later than one year after the date of
 2 the enactment of this Act, the Comptroller General shall submit
 3 to Congress a report on the study conducted under subsection
 4 (a).

5 **TITLE V—PROVISIONS RELATING**
 6 **TO PARTS A AND B**
 7 **Subtitle A—Home Health Services**

8 **SEC. 501. 1-YEAR ADDITIONAL DELAY IN APPLICATION**
 9 **OF 15 PERCENT REDUCTION ON PAYMENT**
 10 **LIMITS FOR HOME HEALTH SERVICES.**

11 (a) IN GENERAL.—Section 1895(b)(3)(A)(i) (42 U.S.C.
 12 1395fff(b)(3)(A)(i)) is amended—

13 (1) by redesignating subparagraph (II) as subpara-
 14 graph (III);

15 (2) in subparagraph (III), as redesignated, by striking
 16 “described in subclause (I)” and inserting “described in
 17 subclause (II)”; and

18 (3) by inserting after subclause (I) the following new
 19 subclause:

20 “(II) For the 12-month period beginning
 21 after the period described in subclause (I), such
 22 amount (or amounts) shall be equal to the
 23 amount (or amounts) determined under sub-
 24 clause (I), updated under subparagraph (B).”.

25 (b) CHANGE IN REPORT.—Section 302(c) of BBRA is
 26 amended—

27 (1) by striking “Not later than” and all that follows
 28 through “(42 U.S.C. 1395fff)” and inserting “Not later
 29 than April 1, 2002”; and

30 (2) by striking “Secretary ” and inserting “Comp-
 31 troller General of the United States”.

32 **SEC. 502. RESTORATION OF FULL HOME HEALTH MAR-**
 33 **KET BASKET UPDATE FOR HOME HEALTH**
 34 **SERVICES FOR FISCAL YEAR 2001.**

35 (a) IN GENERAL.—Section 1861(v)(1)(L)(x) (42 U.S.C.
 36 1395x(v)(1)(L)(x)) is amended—

37 (1) by striking “2001,”; and



1 (2) by adding at the end the following: “With respect
2 to cost reporting periods beginning during fiscal year 2001,
3 the update to any limit under this subparagraph shall be
4 the home health market basket.”.

5 (b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR 2001
6 BASED ON ADJUSTED PROSPECTIVE PAYMENT AMOUNTS.—

7 (1) IN GENERAL.—Notwithstanding the amendments
8 made by subsection (a), for purposes of making payments
9 under section 1895(b) of the Social Security Act (42
10 U.S.C. 1395fff(b)) for home health services for fiscal year
11 2001, the Secretary of Health and Human Services shall—

12 (A) with respect to episodes and visits ending on
13 or after October 1, 2000, and before April 1, 2001, use
14 the final standardized and budget neutral prospective
15 payment amounts for 60 day episodes and standardized
16 average per visit amounts for fiscal year 2001 as pub-
17 lished by the Secretary in Federal Register of the July
18 3, 2000 (65 F.R. 41128–41214); and

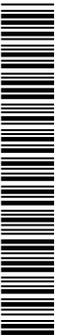
19 (B) with respect to episodes and visits ending on
20 or after April 1, 2001, and before October 1, 2001, use
21 such amounts increased by 1.7 percent, an actuarially
22 determined amount that represents the different dis-
23 tributions of episodes and visits in the first and second
24 6 month periods of fiscal year 2001 due to implementa-
25 tion of the home health prospective payment system
26 under section 1895 of such Act (42 U.S.C. 1395fff).

27 (2) NO EFFECT ON OTHER PAYMENTS OR DETERMINA-
28 TIONS.—The Secretary shall not take the provisions of
29 paragraph (1) into account for purposes of payments, de-
30 terminations, or budget neutrality adjustments under sec-
31 tion 1895 of the Social Security Act.

32 (c) ADJUSTMENT FOR CASE MIX CHANGES.—

33 (1) IN GENERAL.—Section 1895(b)(3)(B) (42 U.S.C.
34 1395fff(b)(3)(B)) is amended by adding at the end the fol-
35 lowing new clause:

36 “(vi) ADJUSTMENT FOR CASE MIX
37 CHANGES.—Insofar as the Secretary determines



1 that the adjustments under paragraph (4)(A)(i) for
2 a previous fiscal year (or estimates that such ad-
3 justments for a future fiscal year) did (or are likely
4 to) result in a change in aggregate payments under
5 this subsection during the fiscal year that are a re-
6 sult of changes in the coding or classification of
7 different units of services that do not reflect real
8 changes in case mix, the Secretary may adjust the
9 standard prospective payment amount (or amounts)
10 under paragraph (3) for subsequent fiscal years so
11 as to eliminate the effect of such coding or classi-
12 fication changes.”.

13 (2) EFFECTIVE DATE.—The amendment made by
14 paragraph (1) applies to episodes concluding on or after
15 October 1, 2001.

16 **SEC. 503. TEMPORARY TWO-MONTH EXTENSION OF**
17 **PERIODIC INTERIM PAYMENTS.**

18 (a) TEMPORARY EXTENSION.—Notwithstanding subsection
19 (d) of section 4603 of BBA, as amended by section 5101(c)(2)
20 of the Tax and Trade Relief Extension Act of 1998 (contained
21 in division J of Public Law 105–277)), the amendments made
22 by subsection (b) of such section shall not take effect until De-
23 cember 1, 2000, in the case of a home health agency that was
24 receiving periodic interim payments under section 1815(e)(2)
25 as of September 30, 2000.

26 (b) PAYMENT RULE.—The amount of such periodic in-
27 terim payment made to a home health agency by reason of sub-
28 section (a) during each of November and December, 2000, shall
29 be equal to the amount of such payment made to the agency
30 in October, 2000. Such amount of payment shall be included
31 in the settlement of the last cost report for the home health
32 agency under the payment system in effect prior to the imple-
33 mentation of the prospective payment system under section
34 1895(b) of the Social Security Act (42 U.S.C. 1395fff(b)).



1 **SEC. 504. USE OF TELEHEALTH IN DELIVERY OF HOME**
2 **HEALTH SERVICES.**

3 Section 1895 (42 U.S.C. 1395fff) is amended by adding
4 at the end the following new subsection:

5 “(e) CONSTRUCTION RELATED TO HOME HEALTH SERV-
6 ICES.—Nothing in this section shall be construed as preventing
7 a home health agency furnishing a home health unit of service
8 for which payment is made under the prospective payment sys-
9 tem established by this section for such units of service from
10 furnishing services via a telecommunication system if such
11 services—

12 “(1) do not substitute for home health services ordered
13 as part of a plan of care certified by a physician pursuant
14 to section 1814(a)(2)(C); and

15 “(2) are not considered a home health visit for pur-
16 poses of eligibility or payment under this title.”.

17 **SEC. 505. STUDY ON COSTS TO HOME HEALTH AGENCIES**
18 **OF PURCHASING NONROUTINE MEDICAL**
19 **SUPPLIES.**

20 (a) STUDY.—The Comptroller General of the United
21 States shall conduct a study on variations in prices paid by
22 home health agencies furnishing home health services under the
23 medicare program in purchasing nonroutine medical supplies,
24 including ostomy supplies, and volumes if such supplies used,
25 shall determine the effect (if any) of variations on prices and
26 volumes in the provision of such services.

27 (b) REPORT.—Not later than October 1, 2001, the
28 Comptroller General shall submit to Congress a report on
29 the study conducted under subsection (a), and shall include
30 in the report recommendations respecting whether payment
31 for nonroutine medical supplies furnished in connection
32 with home health services should be made separately from
33 the prospective payment system for such services.

34 **SEC. 506. TREATMENT OF BRANCH OFFICES; GAO STUDY**
35 **ON SUPERVISION OF HOME HEALTH CARE**
36 **PROVIDED IN ISOLATED RURAL AREAS.**

37 (a) TREATMENT OF BRANCH OFFICES.—



1 (1) IN GENERAL.—Notwithstanding any other provi-
2 sion of law, in determining for purposes of title XVIII of
3 the Social Security Act whether an office of a home health
4 agency constitutes a branch office or a separate home
5 health agency, neither the time nor distance between a par-
6 ent office of the home health agency and a branch office
7 shall be the sole determinant of a home health agency’s
8 branch office status.

9 (2) CONSIDERATION OF FORMS OF TECHNOLOGY IN
10 DEFINITION OF SUPERVISION.—The Secretary of Health
11 and Human Services may include forms of technology in
12 determining what constitutes “supervision” for purposes of
13 determining a home health agency’s branch office status
14 under paragraph (1).

15 (b) GAO STUDY.—

16 (1) STUDY.—The Comptroller General of the United
17 States shall conduct a study of the provision of adequate
18 supervision to maintain quality of home health services de-
19 livered under the medicare program in isolated rural areas.
20 The study shall evaluate the methods that home health
21 agency branches and subunits use to maintain adequate su-
22 pervision in the delivery of services to clients residing in
23 those areas, how these methods of supervision compare to
24 requirements that subunits independently meet medicare
25 conditions of participation, and the resources utilized by
26 subunits to meet such conditions.

27 (2) REPORT.—Not later than January 1, 2002, the
28 Comptroller General shall submit to Congress a report on
29 the study conducted under paragraph (1). The report shall
30 include recommendations on whether exceptions are needed
31 for subunits and branches of home health agencies under
32 the medicare program to maintain access to the home
33 health benefit or whether alternative policies should be de-
34 veloped to assure adequate supervision and access and rec-
35 ommendations on whether a national standard for super-
36 vision is appropriate.



Subtitle B—Direct Graduate Medical Education

SEC. 511. INCREASE IN FLOOR FOR DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS.

Section 1886(h)(2)(D)(iii) (42 U.S.C. 1395ww(h)(2)(D)(iii)) is amended—

(1) in the heading, by striking “IN FISCAL YEAR 2001 AT 70 PERCENT OF” and inserting “FOR”; and

(2) by inserting after “70 percent” the following: “, and for the cost reporting period beginning during fiscal year 2002 shall not be less than 85 percent.”.

SEC. 512. CHANGE IN DISTRIBUTION FORMULA FOR MEDICARE+CHOICE-RELATED NURSING AND ALLIED HEALTH EDUCATION COSTS.

(a) IN GENERAL.—Section 1886(l)(2)(C) (42 U.S.C. 1395ww(l)(2)(C)) is amended by striking all that follows “multiplied by” and inserting the following: “the ratio of—

“(i) the product of (I) the Secretary’s estimate of the ratio of the amount of payments made under section 1861(v) to the hospital for nursing and allied health education activities for the hospital’s cost reporting period ending in the second preceding fiscal year, to the hospital’s total inpatient-bed days for such period, and (II) the total number of inpatient-bed days (as established by the Secretary) for such period which are attributable to services furnished to individuals who are enrolled under a risk sharing contract with an eligible organization under section 1876 and who entitled to part A or with a Medicare+Choice organization under part C; to

“(ii) the sum of the products determined under clause (i) for such cost reporting periods.”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to portions of cost reporting periods occurring on or after January 1, 2001.



Subtitle C—Changes in Medicare Coverage and Appeals Process

SEC. 521. REVISIONS TO MEDICARE APPEALS PROCESS.

(a) CONDUCT OF RECONSIDERATIONS OF DETERMINATIONS BY INDEPENDENT CONTRACTORS.—Section 1869 (42 U.S.C. 1395ff) is amended to read as follows:

“DETERMINATIONS; APPEALS

“SEC. 1869. (a) INITIAL DETERMINATIONS.—

“(1) PROMULGATIONS OF REGULATIONS.—The Secretary shall promulgate regulations and make initial determinations with respect to benefits under part A or part B in accordance with those regulations for the following:

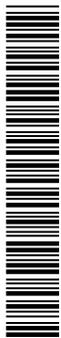
“(A) The initial determination of whether an individual is entitled to benefits under such parts.

“(B) The initial determination of the amount of benefits available to the individual under such parts.

“(C) Any other initial determination with respect to a claim for benefits under such parts, including an initial determination by the Secretary that payment may not be made, or may no longer be made, for an item or service under such parts, an initial determination made by a utilization and quality control peer review organization under section 1154(a)(2), and an initial determination made by an entity pursuant to a contract with the Secretary to administer provisions of this title or title XI.

“(2) DEADLINES FOR MAKING INITIAL DETERMINATIONS.—

“(A) IN GENERAL.—Subject to subparagraph (B), in promulgating regulations under paragraph (1), initial determinations shall be concluded by not later than the 45-day period beginning on the date the Secretary receives a claim for benefits from an individual as described in paragraph (1). Notice of such determination shall be mailed to the individual filing the claim before the conclusion of such 45-day period.



1 “(B) CLEAN CLAIMS.—Subparagraph (A) shall not
 2 apply with respect to any claim that is subject to the
 3 requirements of section 1816(c)(2) or section
 4 1842(c)(2).

5 “(b) APPEAL RIGHTS.—

6 “(1) IN GENERAL.—

7 “(A) RECONSIDERATION OF INITIAL DETERMINA-
 8 TION.—Subject to subparagraph (D), any individual
 9 dissatisfied with any initial determination under sub-
 10 section (a)(1) shall be entitled to reconsideration of the
 11 determination, and, subject to subparagraphs (D) and
 12 (E), a hearing thereon by the Secretary to the same ex-
 13 tent as is provided in section 205(b) and to judicial re-
 14 view of the Secretary’s final decision after such hearing
 15 as is provided in section 205(g).

16 “(B) REPRESENTATION BY PROVIDER OR SUP-
 17 PLIER.—

18 “(i) IN GENERAL.—Sections 206(a), 1102,
 19 and 1871 shall not be construed as authorizing the
 20 Secretary to prohibit an individual from being rep-
 21 resented under this section by a person that fur-
 22 nishes or supplies the individual, directly or indi-
 23 rectly, with services or items, solely on the basis
 24 that the person furnishes or supplies the individual
 25 with such a service or item.

26 “(ii) MANDATORY WAIVER OF RIGHT TO PAY-
 27 MENT FROM BENEFICIARY.—Any person that fur-
 28 nishes services or items to an individual may not
 29 represent an individual under this section with re-
 30 spect to the issue described in section 1879(a)(2)
 31 unless the person has waived any rights for pay-
 32 ment from the beneficiary with respect to the serv-
 33 ices or items involved in the appeal.

34 “(iii) PROHIBITION ON PAYMENT FOR REP-
 35 RESENTATION.—If a person furnishes services or
 36 items to an individual and represents the individual
 37 under this section, the person may not impose any



1 financial liability on such individual in connection
2 with such representation.

3 “(iv) REQUIREMENTS FOR REPRESENTATIVES
4 OF A BENEFICIARY.—The provisions of section
5 205(j) and section 206 (regarding representation of
6 claimants) shall apply to representation of an indi-
7 vidual with respect to appeals under this section in
8 the same manner as they apply to representation of
9 an individual under those sections.

10 “(C) SUCCESSION OF RIGHTS IN CASES OF AS-
11 SIGNMENT.—The right of an individual to an appeal
12 under this section with respect to an item or service
13 may be assigned to the provider of services or supplier
14 of the item or service upon the written consent of such
15 individual using a standard form established by the
16 Secretary for such an assignment.

17 “(D) TIME LIMITS FOR FILING APPEALS.—

18 “(i) RECONSIDERATIONS.—Reconsideration
19 under subparagraph (A) shall be available only if
20 the individual described in subparagraph (A) files
21 notice with the Secretary to request reconsideration
22 by not later than 180 days after the individual re-
23 ceives notice of the initial determination under sub-
24 section (a)(1) or within such additional time as the
25 Secretary may allow.

26 “(ii) HEARINGS CONDUCTED BY THE SEC-
27 RETARY.—The Secretary shall establish in regula-
28 tions time limits for the filing of a request for a
29 hearing by the Secretary in accordance with provi-
30 sions in sections 205 and 206.

31 “(E) AMOUNTS IN CONTROVERSY.—

32 “(i) IN GENERAL.—A hearing (by the Sec-
33 retary) shall not be available to an individual under
34 this section if the amount in controversy is less
35 than \$100, and judicial review shall not be avail-
36 able to the individual if the amount in controversy
37 is less than \$1,000.



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“(ii) AGGREGATION OF CLAIMS.—In determining the amount in controversy, the Secretary, under regulations, shall allow two or more appeals to be aggregated if the appeals involve—

“(I) the delivery of similar or related services to the same individual by one or more providers of services or suppliers, or

“(II) common issues of law and fact arising from services furnished to two or more individuals by one or more providers of services or suppliers.

“(F) EXPEDITED PROCEEDINGS.—

“(i) EXPEDITED DETERMINATION.—In the case of an individual who has received notice by a provider of services that the provider of services plans—

“(I) to terminate services provided to an individual and a physician certifies that failure to continue the provision of such services is likely to place the individual’s health at significant risk, or

“(II) to discharge the individual from the provider of services,

the individual may request, in writing or orally, an expedited determination or an expedited reconsideration of an initial determination made under subsection (a)(1), as the case may be, and the Secretary shall provide such expedited determination or expedited reconsideration.

“(ii) EXPEDITED HEARING.—In a hearing by the Secretary under this section, in which the moving party alleges that no material issues of fact are in dispute, the Secretary shall make an expedited determination as to whether any such facts are in dispute and, if not, shall render a decision expeditiously.



1 “(G) REOPENING AND REVISION OF DETERMINA-
2 TIONS.—The Secretary may reopen or revise any initial
3 determination or reconsidered determination described
4 in this subsection under guidelines established by the
5 Secretary in regulations.

6 “(c) CONDUCT OF RECONSIDERATIONS BY INDEPENDENT
7 CONTRACTORS.—

8 “(1) IN GENERAL.—The Secretary shall enter into
9 contracts with qualified independent contractors to conduct
10 reconsiderations of initial determinations made under sub-
11 paragraphs (B) and (C) of subsection (a)(1). Contracts
12 shall be for an initial term of three years and shall be re-
13 newable on a triennial basis thereafter.

14 “(2) QUALIFIED INDEPENDENT CONTRACTOR.—For
15 purposes of this subsection, the term ‘qualified independent
16 contractor’ means an entity or organization that is inde-
17 pendent of any organization under contract with the Sec-
18 retary that makes initial determinations under subsection
19 (a)(1), and that meets the requirements established by the
20 Secretary consistent with paragraph (3).

21 “(3) REQUIREMENTS.—Any qualified independent con-
22 tractor entering into a contract with the Secretary under
23 this subsection shall meet the all of the following require-
24 ments:

25 “(A) IN GENERAL.—The qualified independent
26 contractor shall perform such duties and functions and
27 assume such responsibilities as may be required by the
28 Secretary to carry out the provisions of this subsection,
29 and shall have sufficient training and expertise in med-
30 ical science and legal matters to make reconsiderations
31 under this subsection.

32 “(B) RECONSIDERATIONS.—

33 “(i) IN GENERAL.—The qualified independent
34 contractor shall review initial determinations. In
35 the case an initial determination made with respect
36 to whether an item or service is reasonable and
37 necessary for the diagnosis or treatment of illness



1 or injury (under section 1862(a)(1)(A)), such re-
 2 view shall include consideration of the facts and
 3 circumstances of the initial determination by a
 4 panel of physicians or other appropriate health care
 5 professionals and any decisions with respect to the
 6 reconsideration shall be based on applicable valid
 7 medical science.

8 “(ii) EFFECT OF NATIONAL OR LOCAL COV-
 9 ERAGE DETERMINATIONS.—

10 “(I) IN GENERAL.—If the Secretary has
 11 promulgated a national coverage determination
 12 or a local coverage determination that was
 13 made pursuant to the requirements established
 14 under the third sentence of section 1862(a),
 15 such determination shall be binding on the
 16 qualified independent contractor in making a
 17 decision with respect to a reconsideration under
 18 this section.

19 “(II) ABSENCE OF NATIONAL OR LOCAL
 20 COVERAGE DETERMINATION.—In the absence
 21 of such a national coverage determination or
 22 local coverage determination, the qualified inde-
 23 pendent contractor shall make a decision with
 24 respect to the reconsideration based on applica-
 25 ble valid medical science.

26 “(C) DEADLINES FOR DECISIONS.—

27 “(i) RECONSIDERATIONS.—Except as provided
 28 in clause (iii), the qualified independent contractor
 29 shall conduct and conclude a reconsideration under
 30 subparagraph (B), and mail the notice of the deci-
 31 sion with respect to the reconsideration by not later
 32 than the end of the 45-day period beginning on the
 33 date a request for reconsideration has been timely
 34 filed.

35 “(ii) CONSEQUENCES OF FAILURE TO MEET
 36 DEADLINE.—In the case of a failure by the quali-
 37 fied independent contractor to mail the notice of



1 the decision by the end of the period described in
 2 clause (i), the party requesting the reconsideration
 3 or appeal may request a hearing before the Sec-
 4 retary, notwithstanding any requirements for a re-
 5 considered determination for purposes of the par-
 6 ty's right to such hearing.

7 “(iii) EXPEDITED RECONSIDERATIONS.—The
 8 qualified independent contractor shall perform an
 9 expedited reconsideration under subsection
 10 (b)(1)(F) as follows:

11 “(I) DEADLINE FOR DECISION.—Notwith-
 12 standing section 216(j), not later than 1 day
 13 after the date the qualified independent con-
 14 tractor has received a request for such recon-
 15 sideration and has received such medical or
 16 other records needed for such reconsideration,
 17 the qualified independent contractor shall pro-
 18 vide notice (by telephone and in writing) to the
 19 individual and the provider of services and at-
 20 tending physician of the individual of the re-
 21 sults of the reconsideration. Such reconsider-
 22 ation shall be conducted regardless of whether
 23 the provider of services or supplier will charge
 24 the individual for continued services or whether
 25 the individual will be liable for payment for
 26 such continued services.

27 “(II) CONSULTATION WITH BENE-
 28 FICIARY.—In such reconsideration, the quali-
 29 fied independent contractor shall solicit the
 30 views of the individual involved.

31 “(D) LIMITATION ON INDIVIDUAL REVIEWING DE-
 32 TERMINATIONS.—

33 “(i) PHYSICIANS AND HEALTH CARE PROFES-
 34 SIONAL.—No physician or health care professional
 35 under the employ of a qualified independent con-
 36 tractor may review—



1 “(I) determinations regarding health care
 2 services furnished to a patient if the physician
 3 or health care professional was directly respon-
 4 sible for furnishing such services; or

5 “(II) determinations regarding health care
 6 services provided in or by an institution, orga-
 7 nization, or agency, if the physician or any
 8 member of the family of the physician or health
 9 care professional has, directly or indirectly, a
 10 significant financial interest in such institution,
 11 organization, or agency.

12 “(ii) FAMILY DESCRIBED.—For purposes of
 13 this paragraph, the family of a physician or health
 14 care professional includes the spouse (other than a
 15 spouse who is legally separated from the physician
 16 or health care professional under a decree of di-
 17 vorce or separate maintenance), children (including
 18 stepchildren and legally adopted children), grand-
 19 children, parents, and grandparents of the physi-
 20 cian or health care professional.

21 “(E) EXPLANATION OF DECISION.—Any decision
 22 with respect to a reconsideration of a qualified inde-
 23 pendent contractor shall be in writing, and shall include
 24 a detailed explanation of the decision as well as a dis-
 25 cussion of the pertinent facts and applicable regulations
 26 applied in making such decision, and in the case of a
 27 determination of whether an item or service is reason-
 28 able and necessary for the diagnosis or treatment of ill-
 29 ness or injury (under section 1862(a)(1)(A)) an expla-
 30 nation of the medical and scientific rational for the de-
 31 cision.

32 “(F) NOTICE REQUIREMENTS.—Whenever a quali-
 33 fied independent contractor makes a decision with re-
 34 spect to a reconsideration under this subsection, the
 35 qualified independent contractor shall promptly notify
 36 the entity responsible for the payment of claims under
 37 part A or part B of such decision.



1 “(G) DISSEMINATION OF DECISIONS ON RECON-
 2 SIDERATIONS.—Each qualified independent contractor
 3 shall make available all decisions with respect to recon-
 4 siderations of such qualified independent contractors to
 5 fiscal intermediaries (under section 1816), carriers
 6 (under section 1842), peer review organizations (under
 7 part B of title XI), Medicare+Choice organizations of-
 8 fering Medicare+Choice plans under part C, other enti-
 9 ties under contract with the Secretary to make initial
 10 determinations under part A or part B or title XI, and
 11 to the public. The Secretary shall establish a method-
 12 ology under which qualified independent contractors
 13 shall carry out this subparagraph.

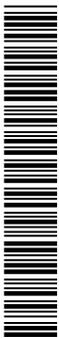
14 “(H) ENSURING CONSISTENCY IN DECISIONS.—
 15 Each qualified independent contractor shall monitor its
 16 decisions with respect to reconsiderations to ensure the
 17 consistency of such decisions with respect to requests
 18 for reconsideration of similar or related matters.

19 “(I) DATA COLLECTION.—

20 “(i) IN GENERAL.—Consistent with the re-
 21 quirements of clause (ii), a qualified independent
 22 contractor shall collect such information relevant to
 23 its functions, and keep and maintain such records
 24 in such form and manner as the Secretary may re-
 25 quire to carry out the purposes of this section and
 26 shall permit access to and use of any such informa-
 27 tion and records as the Secretary may require for
 28 such purposes.

29 “(ii) TYPE OF DATA COLLECTED.—Each quali-
 30 fied independent contractor shall keep accurate
 31 records of each decision made, consistent with
 32 standards established by the Secretary for such
 33 purpose. Such records shall be maintained in an
 34 electronic database in a manner that provides for
 35 identification of the following:

36 “(I) Specific claims that give rise to ap-
 37 peals.



1 “(II) Situations suggesting the need for
2 increased education for providers of services,
3 physicians, or suppliers.

4 “(III) Situations suggesting the need for
5 changes in national or local coverage policy.

6 “(IV) Situations suggesting the need for
7 changes in local medical review policies.

8 “(iii) ANNUAL REPORTING.—Each qualified
9 independent contractor shall submit annually to the
10 Secretary (or otherwise as the Secretary may re-
11 quest) records maintained under this paragraph for
12 the previous year.

13 “(J) HEARINGS BY THE SECRETARY.—The quali-
14 fied independent contractor shall (i) prepare such infor-
15 mation as is required for an appeal of a decision of the
16 contractor with respect to a reconsideration to the Sec-
17 retary for a hearing, including as necessary, expla-
18 nations of issues involved in the decision and relevant
19 policies, and (ii) participate in such hearings as re-
20 quired by the Secretary.

21 “(4) NUMBER OF QUALIFIED INDEPENDENT CONTRAC-
22 TORS.—The Secretary shall enter into contracts with not
23 fewer than 12 qualified independent contractors under this
24 subsection.

25 “(5) LIMITATION ON QUALIFIED INDEPENDENT CON-
26 TRACTOR LIABILITY.—No qualified independent contractor
27 having a contract with the Secretary under this subsection
28 and no person who is employed by, or who has a fiduciary
29 relationship with, any such qualified independent contractor
30 or who furnishes professional services to such qualified
31 independent contractor, shall be held by reason of the per-
32 formance of any duty, function, or activity required or au-
33 thorized pursuant to this subsection or to a valid contract
34 entered into under this subsection, to have violated any
35 criminal law, or to be civilly liable under any law of the
36 United States or of any State (or political subdivision



1 thereof) provided due care was exercised in the perform-
2 ance of such duty, function, or activity.

3 “(d) DEADLINES FOR HEARINGS BY THE SECRETARY.—

4 “(1) HEARING BY ADMINISTRATIVE LAW JUDGE.—

5 “(A) IN GENERAL.—Except as provided in sub-
6 paragraph(B) , an administrative law judge shall con-
7 duct and conclude a hearing on a decision of a qualified
8 independent contractor under subsection (c) and render
9 a decision on such hearing by not later than the end
10 of the 90-day period beginning on the date a request
11 for hearing has been timely filed.

12 “(B) WAIVER OF DEADLINE BY PARTY SEEKING
13 HEARING.—The 90-day period under subparagraph (A)
14 shall not apply in the case of a motion or stipulation
15 by the party requesting the hearing to waive such pe-
16 riod.

17 “(2) DEPARTMENTAL APPEALS BOARD REVIEW.—

18 “(A) IN GENERAL.—The Departmental Appeals
19 Board of the Department of Health and Human Serv-
20 ices shall conduct and conclude a review of the decision
21 on a hearing described in paragraph (1) and make a
22 decision or remand the case to the administrative law
23 judge for reconsideration by not later than the end of
24 the 90-day period beginning on the date a request for
25 review has been timely filed.

26 “(B) DAB HEARING PROCEDURE.—In reviewing a
27 decision on a hearing under this paragraph, the De-
28 partmental Appeals Board shall review the case de
29 novo.

30 “(3) CONSEQUENCES OF FAILURE TO MEET DEAD-
31 LINES.—

32 “(A) HEARING BY ADMINISTRATIVE LAW
33 JUDGE.—In the case of a failure by an administrative
34 law judge to render a decision by the end of the period
35 described in paragraph (1), the party requesting the
36 hearing may request a review by the Departmental Ap-
37 peals Board of the Department of Health and Human



1 Services, notwithstanding any requirements for a hear-
2 ing for purposes of the party’s right to such a review.

3 “(B) DEPARTMENTAL APPEALS BOARD REVIEW.—
4 In the case of a failure by the Departmental Appeals
5 Board to render a decision by the end of the period de-
6 scribed in paragraph (2), the party requesting the hear-
7 ing may seek judicial review, notwithstanding any re-
8 quirements for a hearing for purposes of the party’s
9 right to such judicial review.

10 “(e) ADMINISTRATIVE PROVISIONS.—

11 “(1) LIMITATION ON REVIEW OF CERTAIN REGULA-
12 TIONS.—A regulation or instruction which relates to a
13 method for determining the amount of payment under part
14 B and which was initially issued before January 1, 1981,
15 shall not be subject to judicial review.

16 “(2) OUTREACH.—The Secretary shall perform such
17 outreach activities as are necessary to inform individuals
18 entitled to benefits under this title and providers of services
19 and suppliers with respect to their rights of, and the proc-
20 ess for, appeals made under this section. The Secretary
21 shall use the toll-free telephone number maintained by the
22 Secretary under section 1804 to provide information re-
23 garding appeal rights and respond to inquiries regarding
24 the status of appeals.

25 “(3) CONTINUING EDUCATION REQUIREMENT FOR
26 QUALIFIED INDEPENDENT CONTRACTORS AND ADMINIS-
27 TRATIVE LAW JUDGES.—The Secretary shall provide to
28 each qualified independent contractor, and, in consultation
29 with the Commissioner of Social Security, to administrative
30 law judges that decide appeals of reconsiderations of initial
31 determinations or other decisions or determinations under
32 this section, such continuing education with respect to cov-
33 erage of items and services under this title or policies of
34 the Secretary with respect to part B of title XI as is nec-
35 essary for such qualified independent contractors and ad-
36 ministrative law judges to make informed decisions with re-
37 spect to appeals.



1 “(4) REPORTS.—

2 “(A) ANNUAL REPORT TO CONGRESS.—The Sec-
3 retary shall submit to Congress an annual report de-
4 scribing the number of appeals for the previous year,
5 identifying issues that require administrative or legisla-
6 tive actions, and including any recommendations of the
7 Secretary with respect to such actions. The Secretary
8 shall include in such report an analysis of determina-
9 tions by qualified independent contractors with respect
10 to inconsistent decisions and an analysis of the causes
11 of any such inconsistencies.

12 “(B) SURVEY.—Not less frequently than every 5
13 years, the Secretary shall conduct a survey of a valid
14 sample of individuals entitled to benefits under this
15 title who have filed appeals of determinations under
16 this section, providers of services, and suppliers to de-
17 termine the satisfaction of such individuals or entities
18 with the process for appeals of determinations provided
19 for under this section and education and training pro-
20 vided by the Secretary with respect to that process.
21 The Secretary shall submit to Congress a report de-
22 scribing the results of the survey, and shall include any
23 recommendations for administrative or legislative ac-
24 tions that the Secretary determines appropriate.”.

25 (b) APPLICABILITY OF REQUIREMENTS AND LIMITATIONS
26 ON LIABILITY OF QUALIFIED INDEPENDENT CONTRACTORS TO
27 MEDICARE+CHOICE INDEPENDENT APPEALS CONTRAC-
28 TORS.—Section 1852(g)(4) (42 U.S.C. 1395w-22(e)(3)) is
29 amended by adding at the end the following: “The provisions
30 of section 1869(c)(5) shall apply to independent outside entities
31 under contract with the Secretary under this paragraph.”.

32 **SEC. 522. REVISIONS TO MEDICARE COVERAGE PROC-**
33 **ESS.**

34 (a) REVIEW OF DETERMINATIONS.—Section 1869 (42
35 U.S.C. 1395ff), as amended by section 521, is further amended
36 by adding at the end the following new subsection:

37 “(f) REVIEW OF COVERAGE DETERMINATIONS.—



1 “(1) NATIONAL COVERAGE DETERMINATIONS.—

2 “(A) IN GENERAL.—Review of any national cov-
3 erage determination shall be subject to the following
4 limitations:

5 “(i) Such a determination shall not be re-
6 viewed by any administrative law judge.

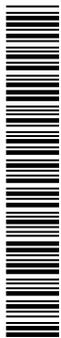
7 “(ii) Such a determination shall not be held
8 unlawful or set aside on the ground that a require-
9 ment of section 553 of title 5, United States Code,
10 or section 1871(b) of this title, relating to publica-
11 tion in the Federal Register or opportunity for pub-
12 lic comment, was not satisfied.

13 “(iii) Upon the filing of a complaint by an ag-
14 grievied party, such a determination shall be re-
15 viewed by the Departmental Appeals Board of the
16 Department of Health and Human Services. In
17 conducting such a review, the Departmental Ap-
18 peals Board shall review the record and shall per-
19 mit discovery and the taking of evidence to evaluate
20 the reasonableness of the determination. In review-
21 ing such a determination, the Departmental Ap-
22 peals Board shall defer only to the reasonable find-
23 ings of fact, reasonable interpretations of law, and
24 reasonable applications of fact to law by the Sec-
25 retary.

26 “(iv) A decision of the Departmental Appeals
27 Board constitutes a final agency action and is sub-
28 ject to judicial review.

29 “(B) DEFINITION OF NATIONAL COVERAGE DE-
30 TERMINATION.—For purposes of this section, the term
31 ‘national coverage determination’ means a determina-
32 tion by the Secretary respecting whether or not a par-
33 ticular item or service is covered nationally under this
34 title, including such a determination under 1862(a)(1).

35 “(2) LOCAL COVERAGE DETERMINATION.—



1 “(A) IN GENERAL.—Review of any local coverage
2 determination shall be subject to the following limita-
3 tions:

4 “(i) Upon the filing of a complaint by an ag-
5 grievied party, such a determination shall be re-
6 viewed by an administrative law judge of the Social
7 Security Administration. The administrative law
8 judge shall review the record and shall permit dis-
9 covery and the taking of evidence to evaluate the
10 reasonableness of the determination. In reviewing
11 such a determination, the administrative law judge
12 shall defer only to the reasonable findings of fact,
13 reasonable interpretations of law, and reasonable
14 applications of fact to law by the Secretary.

15 “(ii) Such a determination may be reviewed by
16 the Departmental Appeals Board of the Depart-
17 ment of Health and Human Services.

18 “(iii) A decision of the Departmental Appeals
19 Board constitutes a final agency action and is sub-
20 ject to judicial review.

21 “(B) DEFINITION OF LOCAL COVERAGE DETER-
22 MINATION.—For purposes of this section, the term
23 ‘local coverage determination’ means a determination
24 by a fiscal intermediary or a carrier under part A or
25 part B, as applicable, respecting whether or not a par-
26 ticular item or service is covered under such parts, in
27 accordance with 1862(a)(1)(A).

28 “(3) NO MATERIAL ISSUES OF FACT IN DISPUTE.—In
29 the case of review of a determination under paragraph
30 (1)(A)(iii) or (2)(A)(i) where the moving party alleges that
31 there are no material issues of fact in dispute, and alleges
32 that the only issue is the constitutionality of a provision of
33 this title, or that a regulation, determination, or ruling by
34 the Secretary is invalid, the moving party may seek review
35 by a court of competent jurisdiction.

36 “(4) PENDING NATIONAL COVERAGE DETERMINA-
37 TIONS.—



1 “(A) IN GENERAL.—In the event the Secretary
 2 has not issued a national coverage or noncoverage de-
 3 termination with respect to a particular type or class
 4 of items or services, an affected party may submit to
 5 the Secretary a request to make such a determination
 6 with respect to such items or services. By not later
 7 than the end of the 90-day period beginning on the
 8 date the Secretary receives such a request (notwith-
 9 standing the receipt by the Secretary of new evidence
 10 (if any) during such 90-day period), the Secretary shall
 11 take one of the following actions:

12 “(i) Issue a national coverage determination,
 13 with or without limitations.

14 “(ii) Issue a national noncoverage determina-
 15 tion.

16 “(iii) Issue a determination that no national
 17 coverage or noncoverage determination is appro-
 18 priate as of the end of such 90-day period with re-
 19 spect to national coverage of such items or services.

20 “(iv) Issue a notice that states that the Sec-
 21 retary has not completed a review of the request
 22 for a national coverage determination and that in-
 23 cludes an identification of the remaining steps in
 24 the Secretary’s review process and a deadline by
 25 which the Secretary will complete the review and
 26 take an action described in subclause (I), (II), or
 27 (III).

28 “(B) In the case of an action described in clause
 29 (i)(IV), if the Secretary fails to take an action referred
 30 to in such clause by the deadline specified by the Sec-
 31 retary under such clause, then the Secretary is deemed
 32 to have taken an action described in clause (i)(III) as
 33 of the deadline.

34 “(C) When issuing a determination under clause
 35 (i), the Secretary shall include an explanation of the
 36 basis for the determination. An action taken under
 37 clause (i) (other than subclause (IV)) is deemed to be



1 a national coverage determination for purposes of re-
2 view under subparagraph (A).

3 “(5) STANDING.—An action under this section seeking
4 review of a national coverage determination or local cov-
5 erage determination may be initiated only by one (or more)
6 of the following aggrieved persons, or classes of persons:

7 “(A) Individuals entitled to benefits under part A,
8 or enrolled under part B, or both, who are in need of
9 the items or services that are the subject of the cov-
10 erage determination.

11 “(B) Persons, or classes of persons, who make,
12 manufacture, offer, supply, make available, or provide
13 such items and services that may be marketed for the
14 intended use that is the subject of the determination.

15 “(6) PUBLICATION ON THE INTERNET OF DECISIONS
16 OF HEARINGS OF THE SECRETARY.—Each decision of a
17 hearing by the Secretary with respect to a national cov-
18 erage determination shall be made public, and the Sec-
19 retary shall publish each decision on the Medicare Internet
20 site of the Department of Health and Human Services. The
21 Secretary shall remove from such decision any information
22 that would identify any individual, provider of services, or
23 supplier.

24 “(7) ANNUAL REPORT ON NATIONAL COVERAGE DE-
25 TERMINATIONS.—

26 “(A) IN GENERAL.—Not later than December 1 of
27 each year, beginning in 2001, the Secretary shall sub-
28 mit to Congress a report that sets forth a detailed com-
29 pilation of the actual time periods that were necessary
30 to complete and fully implement national coverage de-
31 terminations that were made in the previous fiscal year
32 for items, services, or medical devices not previously
33 covered as a benefit under this title, including, with re-
34 spect to each new item, service, or medical device, a
35 statement of the time taken by the Secretary to make
36 and implement the necessary coverage, coding, and
37 payment determinations, including the time taken to



1 complete each significant step in the process of making
2 and implementing such determinations.

3 “(B) PUBLICATION OF REPORTS ON THE INTER-
4 NET.—The Secretary shall publish each report sub-
5 mitted under clause (i) on the medicare Internet site of
6 the Department of Health and Human Services.”.

7 (b) ESTABLISHMENT OF A PROCESS FOR COVERAGE DE-
8 TERMINATIONS.—Section 1862(a) (42 U.S.C. 1395y(a)) is
9 amended by adding at the end the following new sentence: “In
10 making a national coverage determination (as defined in para-
11 graph (1)(B) of section 1869(f)) or a local coverage determina-
12 tion (as defined in paragraph (2)(B) of such section) the Sec-
13 retary shall ensure that the public is afforded notice and oppor-
14 tunity to comment prior to implementation by the Secretary of
15 the determination; advisory committee meetings with respect to
16 the determination are made on the record; in making the deter-
17 mination, the Secretary has considered applicable medical, tech-
18 nical, and scientific evidence with respect to the subject matter
19 of the determination; and in the determination, provide a clear
20 statement of the basis for the determination (including re-
21 sponses to comments received from the public), the assump-
22 tions underlying that basis, and make available to the public
23 the data (other than proprietary data) considered in making
24 the determination.”.

25 (c) IMPROVEMENTS TO THE MEDICARE ADVISORY COM-
26 MITTEE PROCESS.—Section 1114 (42 U.S.C. 1314) is amended
27 by adding at the end the following new subsection:

28 “(i)(1) Any advisory committee appointed under sub-
29 section (f) to advise the Secretary on matters relating to the
30 interpretation, application, or implementation of section
31 1862(a)(1) shall assure the full participation of a nonvoting
32 member in the deliberations of the advisory committee, and
33 shall provide such nonvoting member access to all information
34 and data made available to voting members of the advisory
35 committee, other than information that—

36 “(A) is exempt from disclosure pursuant to subsection
37 (a) of section 552 of title 5, United States Code, by reason



1 of subsection (b)(4) of such section (relating to trade se-
2 crets); or

3 “(B) the Secretary determines would present a conflict
4 of interest relating to such nonvoting member.

5 “(2) If an advisory committee described in paragraph (1)
6 organizes into panels of experts according to types of items or
7 services considered by the advisory committee, any such panel
8 of experts may report any recommendation with respect to such
9 items or services directly to the Secretary without the prior ap-
10 proval of the advisory committee or an executive committee
11 thereof.”.

12 **Subtitle D—Veterans Subvention** 13 **Demonstration Project**

14 **SEC. 531. VETERANS ACCESS TO SERVICES UNDER THE** 15 **MEDICARE PROGRAM.**

16 (a) PURPOSE.—The purpose of this section is to establish
17 a program that permits medicare-eligible veterans (with priority
18 for those veterans who have a service-connected disability or
19 are financially needy), whose access to medical care from the
20 Department of Veterans Affairs has been historically limited
21 because of geographic remoteness, to receive medicare benefits
22 through a service network of providers established by the De-
23 partment of Veterans Affairs.

24 (b) IN GENERAL.—Title XVIII of the Social Security Act
25 is amended by adding at the end the following new section:

26 “IMPROVING VETERANS’ ACCESS TO SERVICES

27 “SEC. 1897. (a) DEFINITIONS.—In this section:

28 “(1) ADMINISTERING SECRETARIES.—The term ‘ad-
29 ministering Secretaries’ means the Secretary of Health and
30 Human Services and the Secretary of Veterans Affairs act-
31 ing jointly.

32 “(2) DEMONSTRATION PROJECT; PROJECT.—The
33 terms ‘demonstration project’ and ‘project’ mean the dem-
34 onstration project established under this section with re-
35 spect to category A and category C medicare-eligible vet-
36 erans.

37 “(3) MEDICARE-ELIGIBLE VETERANS.—



1 “(A) CATEGORY A MEDICARE-ELIGIBLE VET-
2 ERAN.—The term ‘category A medicare-eligible veteran’
3 means an individual—

4 “(i) who is a veteran (as defined in section
5 101(2) of title 38, United States Code) and is de-
6 scribed in paragraph (1) or (2) of section 1710(a)
7 of title 38, United States Code; and

8 “(ii) who is entitled to hospital insurance ben-
9 efits under part A of the medicare program and is
10 enrolled in the supplementary medical insurance
11 program under part B of the medicare program.

12 “(B) CATEGORY C MEDICARE-ELIGIBLE VET-
13 ERAN.—The term ‘category C medicare-eligible veteran’
14 means an individual who—

15 “(i) is a veteran (as defined in section 101(2)
16 of title 38, United States Code) and is described in
17 section 1710(a)(3) of title 38, United States Code;
18 and

19 “(ii) is entitled to hospital insurance benefits
20 under part A of the medicare program and is en-
21 rolled in the supplementary medical insurance pro-
22 gram under part B of the medicare program.

23 “(4) MEDICARE HEALTH CARE SERVICES.—The term
24 ‘medicare health care services’ means items or services cov-
25 ered under part B of this title.

26 “(5) TRUST FUND.—The term ‘trust fund’ means the
27 Federal Supplementary Medical Insurance Trust Fund es-
28 tablished in section 1841.

29 “(b) DEMONSTRATION PROJECT.—

30 “(1) IN GENERAL.—

31 “(A) ESTABLISHMENT.—The administering Secre-
32 taries may establish a demonstration project (under an
33 agreement entered into by the administering Secre-
34 taries) under which the Secretary of Health and
35 Human Services shall reimburse the Secretary of Vet-
36 erans Affairs, from the trust fund, for medicare health
37 care services furnished to category A and category C



1 medicare eligible veterans. Under the project, category
 2 A medicare-eligible veterans shall have priority in en-
 3 rollment under the project carried out in a site des-
 4 ignated under paragraph (2).

5 “(B) AGREEMENT.—An agreement entered into
 6 under subparagraph (A) shall include at a minimum—

7 “(i) a description of the benefits to be pro-
 8 vided to the participants of the project established
 9 under this section;

10 “(ii) a description of the eligibility rules for
 11 participation in the project, including any cost
 12 sharing requirements;

13 “(iii) a description of the process for enrolling
 14 veterans for participation in the project, which
 15 process may, to the extent practicable, be adminis-
 16 tered in the same or similar manner to the reg-
 17 istration process established to implement section
 18 1705 of title 38, United States Code;

19 “(iv) a description of how the project will sat-
 20 isfy the requirements under this title;

21 “(v) a description of how reimbursement re-
 22 quirements under subsection (g) and maintenance
 23 of effort requirements under subsection (h) will be
 24 implemented in the project;

25 “(vi) a statement that all data of the Depart-
 26 ment of Veterans Affairs and of the Department of
 27 Health and Human Services that the administering
 28 Secretaries determine is necessary to conduct inde-
 29 pendent estimates and audits of the maintenance of
 30 effort requirement, the annual reconciliation, and
 31 related matters required under the project shall be
 32 available to the administering Secretaries;

33 “(vii) a description of any requirement that
 34 the Secretary of Health and Human Services
 35 waives pursuant to subsection (d);

36 “(viii) a requirement that the Secretary of
 37 Veterans Affairs undertake and maintain outreach



1 and marketing activities, consistent with capacity
2 limits under the project, for category A medicare-
3 eligible veterans;

4 “(ix) a description of how the administering
5 Secretaries shall conduct the data matching pro-
6 gram under subparagraph (F), including the fre-
7 quency of updates to the comparisons performed
8 under subparagraph (F)(ii); and

9 “(x) a statement by the Secretary of Veterans
10 Affairs that the type or amount of health care serv-
11 ices furnished under chapter 17 of title 38, United
12 States Code, to veterans who are entitled to bene-
13 fits under part A or enrolled under part B, or both,
14 shall not be reduced by reason of the project.

15 “(C) COST-SHARING.—Notwithstanding any provi-
16 sion of title 38, United States Code, in order—

17 “(i) to maintain and broaden access to serv-
18 ices,

19 “(ii) to encourage appropriate use of services,
20 and

21 “(iii) to control costs,

22 the Secretary of Veterans Affairs may establish enroll-
23 ment fees and copayment requirements under this sec-
24 tion consistent with subsection (d)(1). Such fees and
25 requirements shall apply only in the case of category C
26 medicare-eligible veterans, and may vary based on in-
27 come.

28 “(D) HEALTH CARE BENEFITS.—The admin-
29 istering Secretaries shall prescribe the minimum health
30 care benefits to be provided under the project to medi-
31 care-eligible veterans enrolled in the project. Those ben-
32 efits shall include at least all medicare health care serv-
33 ices.

34 “(E) ESTABLISHMENT OF SERVICE NETWORKS.—

35 “(i) USE OF VA OUTPATIENT CLINICS.—The
36 Secretary of Veterans Affairs, to the extent prac-
37 ticable, shall use outpatient clinics of the Depart-



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ment of Veterans Affairs in providing services under the project.

“(ii) AUTHORITY TO CONTRACT FOR SERVICES.—The Secretary of Veterans Affairs may enter into contracts and arrangements with entities (such as private practitioners, providers of services, preferred provider organizations, and health care plans) for the provision of medicare health care services for which such Secretary is responsible for providing under the project and shall take into account the existence of qualified practitioners and providers in the areas in which the project is being conducted. Under such contracts and arrangements, the Secretary of Veterans Affairs shall require the entities to furnish such information as the Secretary of Health and Human Services determines is necessary to carry out this section.

“(F) DATA MATCH.—

“(i) ESTABLISHMENT OF DATA MATCHING PROGRAM.—The administering Secretaries shall establish a data matching program under which there is an exchange of information of the Department of Veterans Affairs and of the Department of Health and Human Services as is necessary to identify veterans who are entitled to benefits under part A and enrolled under part B, in order to carry out this section. The provisions of section 552a of title 5, United States Code, shall apply with respect to such matching program only to the extent the administering Secretaries find it feasible and appropriate in carrying out this section in a timely and efficient manner.

“(ii) PERFORMANCE OF DATA MATCH.—The administering Secretaries, using the data matching program established under clause (i), shall perform a comparison in order to identify veterans who are entitled to benefits under part A and enrolled



1 under part B. To the extent the administering Sec-
 2 retaries deem appropriate to carry out this section,
 3 the comparison and identification may distinguish
 4 among such veterans by category of veterans, by
 5 entitlement to benefits under this title, or by other
 6 characteristics.

7 “(iii) DEADLINE FOR FIRST DATA MATCH.—
 8 The administering Secretaries shall first perform a
 9 comparison under clause (ii) by not later than Feb-
 10 ruary 1, 2001.

11 “(iv) CERTIFICATION BY INSPECTOR GEN-
 12 ERAL.—

13 “(I) IN GENERAL.—The administering
 14 Secretaries may not conduct the project unless
 15 the Inspector General of the Department of
 16 Health and Human Services certifies to Con-
 17 gress that the administering Secretaries have
 18 established the data matching program under
 19 clause (i) and have performed a comparison
 20 under clause (ii).

21 “(II) DEADLINE FOR CERTIFICATION.—
 22 Not later than April 1, 2001, the Inspector
 23 General of the Department of Health and
 24 Human Services shall submit to Congress a re-
 25 port containing the certification under sub-
 26 clause (I) or the denial of such certification.

27 “(2) NUMBER OF SITES.—The demonstration project
 28 shall be conducted in no more than 6 geographic service
 29 areas of the Department of Veterans Affairs, designated by
 30 the Secretary of Veterans Affairs after review of all such
 31 areas, as follows:

32 “(A) SITE REQUIREMENTS.—Each site shall—

33 “(i) have such technology and infrastructure
 34 to meet data collection requirements under this sec-
 35 tion;

36 “(ii) have a sufficiently large number of cat-
 37 egory A and category C medicare-eligible veterans



1 residing in the area to ensure sufficient demand for
2 participation in the project in the area;

3 “(iii) have the capacity to manage the project
4 successfully; and

5 “(iv) be geographically remote or inaccessible
6 from the medical center of the Department of Vet-
7 erans Affairs that is closest to the residences of
8 medicare-eligible veterans residing in the area.

9 “(B) ADDITIONAL CONSIDERATIONS.—In addition
10 to the requirements under subparagraph (A), the ad-
11 ministering Secretaries—

12 “(i) shall consider designating at least one site
13 that is in an area proximate to a medical center of
14 the Department of Veterans Affairs which, as a re-
15 sult of a change in mission, does not furnish inpa-
16 tient hospital care; and

17 “(ii) if feasible, shall designate one site in a
18 rural area.

19 “(3) RESTRICTION.—Funds from the project shall not
20 be used for—

21 “(A) the construction of any treatment facility of
22 the Department of Veterans Affairs; or

23 “(B) the renovation, expansion, or other construc-
24 tion at such a facility.

25 “(4) IMPLEMENTATION OF PROJECT.—The admin-
26 istering Secretaries may implement the project no earlier
27 than October 1, 2001, and subject to the following:

28 “(A) Subsection (b)(1)(F)(iv) (relating to certifi-
29 cation to Congress by the Inspector General of the De-
30 partment of Health and Human Services that the ad-
31 ministering Secretaries have established the data
32 matching program and conducted a data match).

33 “(B) Paragraph (5) (relating to submittal to Con-
34 gress by the Secretary of Veterans Affairs of a report
35 on steps that Secretary will take to maintain level of
36 health care services furnished by that Secretary at a
37 site).



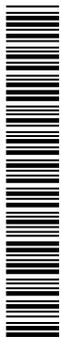
1 “(C) Subsection (h)(1)(B)(iii)(II) (relating to cer-
 2 tification to Congress by the Inspector General of the
 3 Department of Health and Human Services that the
 4 Secretary of Veterans Affairs has improved its informa-
 5 tion management system to permit the Secretary of
 6 Veterans Affairs to identify the costs incurred by the
 7 Department of Veterans Affairs in providing medicare
 8 health care services under the project to medicare-eligi-
 9 ble veterans in a reasonably reliable and accurate man-
 10 ner).

11 The administering Secretaries may implement the project
 12 through the publication of regulations that take effect on
 13 an interim basis, after notice and pending opportunity for
 14 public comment.

15 “(5) REPORT ON MAINTENANCE OF LEVEL OF
 16 HEALTH CARE SERVICES.—

17 “(A) IN GENERAL.—The Secretary of Veterans
 18 Affairs may not implement the project at a site des-
 19 ignated under paragraph (2) unless, by not later than
 20 90 days before the date of the implementation, the Sec-
 21 retary of Veterans Affairs submits to Congress and to
 22 the Comptroller General of the United States a report
 23 that contains the information described in subpara-
 24 graph (B). The Secretary of Veterans Affairs shall pe-
 25 riodically update the report required under this para-
 26 graph as appropriate.

27 “(B) INFORMATION DESCRIBED.—For purposes of
 28 subparagraph (A), the information described in this
 29 subparagraph is a description of the operation of the
 30 project at the sites designated and of the steps to be
 31 taken by the Secretary of Veterans Affairs to prevent
 32 the reduction of the type or amount of health care serv-
 33 ices furnished under chapter 17 of title 38, United
 34 States Code, to veterans who are entitled to benefits
 35 under part A or enrolled under part B, or both, within
 36 the geographic service area of the Department of Vet-



1 erans Affairs in which the sites are located by reason
2 of the project.

3 “(c) CREDITING OF PAYMENTS.—A payment received by
4 the Secretary of Veterans Affairs under the project shall be
5 credited to the applicable Department of Veterans Affairs med-
6 ical care appropriation (and within that appropriation). Any
7 such payment received during a fiscal year for services provided
8 in a prior fiscal year may be obligated by the Secretary of Vet-
9 erans Affairs during the fiscal year in which the payment is re-
10 ceived.

11 “(d) APPLICATION OF CERTAIN MEDICARE REQUIRE-
12 MENTS.—

13 “(1) AUTHORITY.—Except as provided under para-
14 graph (2), the project shall meet applicable requirements
15 for providers of medicare health care services, and other re-
16 quirements for receiving medicare payments, except that
17 the prohibition of payments to Federal providers of services
18 under sections 1814(c) and 1835(d), and paragraphs (2)
19 and (3) of section 1862(a) shall not apply.

20 “(2) WAIVER.—The Secretary of Health and Human
21 Services is authorized to waive any requirement described
22 under paragraph (1), or approve equivalent or alternative
23 ways of meeting such a requirement, but only if such waiv-
24 er or approval—

25 “(A) reflects the unique status of the Department
26 of Veterans Affairs as an agency of the Federal Gov-
27 ernment; and

28 “(B) is necessary to carry out the project.

29 “(e) INSPECTOR GENERAL.—Nothing in the agreement
30 entered into under subsection (b) shall limit the Inspector Gen-
31 eral of the Department of Health and Human Services from in-
32 vestigating any matters regarding the expenditure of funds
33 under this title for the project, including compliance with the
34 provisions of this title and all other relevant laws.

35 “(f) VOLUNTARY PARTICIPATION.—Participation of a cat-
36 egory A Medicare-eligible veteran or a category C medicare-eli-
37 gible veteran in the project shall be voluntary.



1 “(g) PAYMENTS BASED ON MEDICARE PAYMENT
2 RATES.—

3 “(1) IN GENERAL.—Subject to the succeeding provi-
4 sions of this subsection and in accordance with the terms
5 of an agreement under subsection (b)(1)(A), the Secretary
6 of Health and Human Services shall reimburse the Sec-
7 retary of Veterans Affairs for services provided under the
8 project for the cost of the Secretary of Veterans Affairs in
9 providing services under the project but not to exceed an
10 amount that is estimated to be equivalent to the amount
11 that otherwise would have been expended under part B for
12 such services if provided other than under the project.

13 “(2) PERIODIC PAYMENTS FROM MEDICARE PART B
14 TRUST FUND.—Payments under this subsection shall be
15 made from the trust fund on a periodic basis consistent
16 with the periodicity of payments made under this title.

17 “(3) CAP ON REIMBURSEMENT AMOUNTS.—The aggre-
18 gate amount to be reimbursed under this subsection pursu-
19 ant to the agreement entered into between the admin-
20 istering Secretaries under subsection (b) with respect to a
21 fiscal year in which the project is operating is as follows:

22 “(A) For the first fiscal year, a total of
23 \$30,000,000.

24 “(B) For the second fiscal year, a total of
25 \$40,000,000.

26 “(C) For the third and each succeeding fiscal
27 year, a total of \$60,000,000.

28 “(h) MAINTENANCE OF EFFORT.—

29 “(1) MONITORING EFFECT OF PROJECT ON COSTS TO
30 MEDICARE PROGRAM.—

31 “(A) IN GENERAL.—The administering Secre-
32 taries, in consultation with the Comptroller General of
33 the United States, shall closely monitor the expendi-
34 tures made under this title for category A and C medi-
35 care-eligible veterans compared to the expenditures that
36 would have been made for such veterans if the project
37 had not been conducted. An agreement entered into by



1 the administering Secretaries under subsection (b) shall
 2 require the Department of Veterans Affairs to maintain
 3 overall the level of effort for services covered under this
 4 title to such categories of veterans by reference to a
 5 base year or years as determined by the administering
 6 Secretaries.

7 “(B) DETERMINATION OF MEASURE OF COSTS OF
 8 HEALTH CARE BENEFITS.—

9 “(i) IMPROVEMENT OF INFORMATION MANAGE-
 10 MENT SYSTEM.—The Secretary of Veterans Affairs
 11 shall improve its information management system
 12 to enable that Secretary to identify costs incurred
 13 by the Department of Veterans Affairs in providing
 14 medicare health care services for purposes of meet-
 15 ing the requirements with respect to maintenance
 16 of effort under an agreement under subsection
 17 (b)(1)(A).

18 “(ii) IDENTIFICATION OF MEDICARE HEALTH
 19 CARE SERVICES.—The Secretary of Health and
 20 Human Services shall provide such assistance as is
 21 necessary for the Secretary of Veterans Affairs to
 22 determine which health care services furnished by
 23 the Secretary of Veterans Affairs qualify as medi-
 24 care health care services.

25 “(iii) CERTIFICATION BY HHS INSPECTOR
 26 GENERAL.—

27 “(I) REQUEST FOR CERTIFICATION.—The
 28 Secretary of Veterans Affairs may request the
 29 Inspector General of the Department of Health
 30 and Human Services to make a certification to
 31 Congress that the Secretary of Veterans Affairs
 32 has improved its information management sys-
 33 tem under clause (i) to permit the Secretary of
 34 Veterans Affairs to identify the costs described
 35 in such clause in a reasonably reliable and ac-
 36 curate manner.



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“(II) DEADLINE FOR CERTIFICATION.—
Not later than 60 days after the Secretary of
Veterans Affairs requests a certification under
subclause (I), the Inspector General of the De-
partment of Health and Human Services shall
submit to Congress a report containing the cer-
tification under subclause (I) or a denial of
such certification.

“(C) MAINTENANCE OF LEVEL OF EFFORT.—

“(i) REPORT BY SECRETARY OF VETERANS AF-
FAIRS ON BASIS FOR CALCULATION.—Not later
than the date that is 60 days after the date on
which the administering Secretaries enter into an
agreement under subsection (b)(1)(A), the Sec-
retary of Veterans Affairs shall submit to Congress
and the Comptroller General of the United States
a report explaining the methodology used and basis
for calculating the level of effort of the Department
of Veterans Affairs under the project.

“(ii) REPORT BY COMPTROLLER GENERAL.—
Not later than the date that is 180 days after the
date described in clause (i), the Comptroller Gen-
eral of the United States shall submit to Congress
and the administering Secretaries a report setting
forth the Comptroller General’s findings, conclu-
sion, and recommendations with respect to the re-
port submitted by the Secretary of Veterans Affairs
under clause (i).

“(iii) RESPONSE BY SECRETARY OF VETERANS
AFFAIRS.—Not later than 60 days after the date
described in clause (ii), the Secretary of Veterans
Affairs shall submit to Congress a report setting
forth that Secretary’s response to the report sub-
mitted by the Comptroller General under clause
(ii).

“(D) ANNUAL REPORT BY THE COMPTROLLER
GENERAL.—Not later than December 31 of each year



1 during which the project is conducted, the Comptroller
 2 General of the United States shall submit to Congress
 3 and to the administering Secretaries a report on the ex-
 4 tent, if any, to which the costs of the Secretary of
 5 Health and Human Services under the medicare pro-
 6 gram under this title increased during the preceding
 7 fiscal year as a result of the project.

8 “(2) REQUIRED RESPONSE IN CASE OF INCREASE IN
 9 COSTS.—

10 “(A) IN GENERAL.—If the administering Secre-
 11 taries find, based on paragraph (1), that the expendi-
 12 tures under the medicare program under this title in-
 13 creased (or are expected to increase) during a fiscal
 14 year because of the project, the administering Secre-
 15 taries shall take such steps as may be needed—

16 “(i) to recoup for the medicare program the
 17 amount of such increase in expenditures; and

18 “(ii) to prevent any such increase in the fu-
 19 ture.

20 “(B) STEPS.—Such steps—

21 “(i) under subparagraph (A)(i) shall include
 22 payment of the amount of such increased expendi-
 23 tures by the Secretary of Veterans Affairs from the
 24 medical care appropriation for the Department of
 25 Veterans Affairs for the fiscal year involved to the
 26 trust fund; and

27 “(ii) under subparagraph (A)(ii) shall include
 28 lowering the amount of payment under the project
 29 under subsection (g)(1).

30 “(i) EVALUATION AND REPORTS.—

31 “(1) INDEPENDENT EVALUATION BY GAO.—

32 “(A) IN GENERAL.—The Comptroller General of
 33 the United States shall conduct evaluations of the
 34 project, and shall submit to Congress and to the ad-
 35 ministering Secretaries annual reports on the project.

36 “(B) FIRST REPORT.—The first report for the
 37 project under subparagraph (A) shall be submitted not



1 later than 12 months after the date on which the Sec-
2 retary of Veterans Affairs first provides services under
3 the project.

4 “(C) CONTENTS.—The evaluation and reports
5 under this paragraph for the project shall include an
6 assessment, based on an agreement entered into under
7 subsection (b), of the following:

8 “(i) Any savings or costs to the medicare pro-
9 gram under this title resulting from the project.

10 “(ii) The cost to the Department of Veterans
11 Affairs of providing care to category A medicare-el-
12 igible veterans and to category C medicare-eligible
13 veterans under the project.

14 “(iii) An analysis of how such project affects
15 the overall accessibility of medical care through the
16 Department of Veterans Affairs, and a description
17 of the unintended effects (if any) upon the patient
18 enrollment system under section 1705 of title 38,
19 United States Code.

20 “(iv) Compliance by the Department of Vet-
21 erans Affairs with the requirements under this
22 title.

23 “(v) The number of category A medicare-eli-
24 gible veterans or category C medicare-eligible vet-
25 erans, respectively, opting to participate in the
26 project instead of receiving health benefits through
27 another health insurance plan (including benefits
28 under this title).

29 “(vi) A list of the health insurance plans and
30 programs that were the primary payers for medi-
31 care-eligible veterans during the year prior to their
32 participation in the project, and the distribution of
33 their previous enrollment in such plans and pro-
34 grams.

35 “(vii) Any impact of the project on private
36 health care providers and beneficiaries under this
37 title that are not enrolled in the project.



1 “(viii) An assessment of the access to care and
2 quality of care for medicare-eligible veterans under
3 the project.

4 “(ix) An analysis of whether, and in what
5 manner, easier access to medical centers of the De-
6 partment of Veterans Affairs affects the number of
7 category A medicare-eligible veterans or C medi-
8 care-eligible veterans, respectively, receiving medi-
9 care health care services.

10 “(x) Any impact of the project on the access
11 to care for category A medicare-eligible veterans or
12 C medicare-eligible veterans who did not enroll in
13 the project and for other individuals entitled to
14 benefits under this title.

15 “(xi) A description of the difficulties (if any)
16 experienced by the Department of Veterans Affairs
17 in managing the project.

18 “(xii) Any additional elements specified in an
19 agreement entered into under subsection (b).

20 “(xiii) Any additional elements that the Comp-
21 troller General of the United States determines is
22 appropriate to assess regarding the project.

23 “(2) REPORTS BY SECRETARIES ON PROJECT WITH
24 RESPECT TO MEDICARE-ELIGIBLE VETERANS.—Not later
25 than 6 months after the date of the submission of the re-
26 port by the Comptroller General of the United States on
27 the third year of the operation of the project, the admin-
28 istering Secretaries shall submit to Congress a report con-
29 taining their recommendation as to—

30 “(A) whether there is a cost to the health care
31 program under this title in conducting the project
32 under this section;

33 “(B) whether to discontinue the project; and

34 “(C) whether the terms and conditions of the
35 project should otherwise be continued (or modified)
36 with respect to medicare-eligible veterans.”.



1 (c) REPEAL OF PLAN REQUIREMENT.—Subsection (b) of
2 section 4015 of the BBA (relating to an implementation plan
3 for Veterans subvention) is repealed.

4 **Subtitle E—Improving Access to New** 5 **Technologies**

6 **SEC. 541. PROCESS FOR MAKING AND IMPLEMENTING** 7 **HCPCS CODING MODIFICATIONS.**

8 (a) IN GENERAL.—Notwithstanding any other provision of
9 title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.),
10 the Secretary of Health and Human Services shall—

11 (1) accept applications for HCPCS level II code modi-
12 fications from the public throughout the year, and make
13 determinations with respect to such applications expedi-
14 tiously;

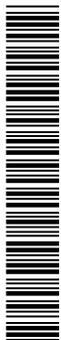
15 (2) incorporate modifications to HCPCS level II codes
16 that are approved during the 3 months preceding the last
17 month of a calendar quarter into the payment systems es-
18 tablished under such title (including the medicare fee
19 schedule data base) not later than the first day of the fol-
20 lowing calendar quarter;

21 (3) to the extent practicable, ensure that the meetings
22 of the Alpha-Numeric Editorial Panel are open to the pub-
23 lic and that decisions of the Panel, and the rational under-
24 lying such decisions, are promptly made available to the
25 public; and

26 (4) ensure that such Panel meets not less frequently
27 than quarterly.

28 (b) ELIMINATION OF REQUIREMENT FOR MARKETING EX-
29 PERIENCE.—Notwithstanding any other provision of title XVIII
30 of the Social Security Act, the Secretary of Health and Human
31 Services may not require a minimum period of marketing expe-
32 rience with respect to a drug or device as a condition of consid-
33 eration or approval of a recommendation for an HCPCS level
34 II modification for such drug or device.

35 (c) DEFINITION.—For purposes of this section, the term
36 “HCPCS level II code modification” means any change to the
37 alphanumeric codes for items not included in level I or level III



1 of the Health Care Financing Administration Common Proce-
2 dure Coding System (HCPCS).

3 (d) EFFECTIVE DATE.—The provisions of this section take
4 effect on January 1, 2001.

5 **SEC. 542. ESTABLISHMENT OF PROCEDURES FOR MEDI-**
6 **CARE CODING AND PAYMENT DETERMINA-**
7 **TIONS FOR NEW CLINICAL DIAGNOSTIC LAB-**
8 **ORATORY TESTS AND OTHER ITEMS ON A**
9 **FEE SCHEDULE.**

10 (a) IN GENERAL.—Not later than one year after the date
11 of the enactment of this Act, the Secretary of Health and
12 Human Services shall establish procedures for coding and pay-
13 ment determinations for the categories of new clinical diag-
14 nostic laboratory tests and new durable medical equipment
15 under part B of the title XVIII of the Social Security Act (42
16 U.S.C. 1395 et seq.) consistent with the procedures established
17 for implementing coding modifications for HCPCS level II (as
18 modified in section 541). In establishing such procedures, the
19 Secretary shall—

20 (1) provide for public participation at any hearing or
21 any meeting at which a coding or payment determination
22 is made; and

23 (2) make available to the public the basis of the deter-
24 mination, and any assumptions underlying that basis, and
25 the data (other than proprietary data) considered in mak-
26 ing the determination.

27 (b) ESTABLISHING PAYMENT RATES FOR NEW LAB
28 TESTS.—Section 1833(h) (42 U.S.C. 1395l(h)) is amended by
29 adding at the end the following:

30 “(8)(A) Notwithstanding paragraphs (1), (2), and (4), in
31 the case of a clinical diagnostic laboratory test with respect to
32 which a new or substantially revised code is assigned under the
33 Health Care Financing Administration Common Procedure
34 Coding System (hereafter referred to as ‘HCPCS’) on or after
35 January 1, 2001, the Secretary shall establish payment rates
36 in accordance with subparagraph (B) or (C).

37 “(B) In the case of a clinical diagnostic laboratory test de-
38 scribed in subparagraph (A) with respect to which the Sec-



1 retary proposes to base payment on the fee schedule amounts
2 determined under paragraph (1) and the national limitation
3 amount determined under paragraph (4) for 1 or more clinical
4 diagnostic laboratory tests that are similar clinically and with
5 respect to the use of resources, the Secretary shall—

6 “(i) cause to have published in the Federal Register
7 not later than July 1 of each calendar year (beginning with
8 calendar year 2001) the Secretary’s proposal with respect
9 to the appropriate fee schedule amounts and national limi-
10 tation amount for such test for the following calendar year;
11 and

12 “(ii) provide an opportunity for the public to comment
13 on such proposal.

14 “(C)(i) In the case of a clinical diagnostic laboratory test
15 described in subparagraph (A) with respect to which there is
16 no similar test or tests (as described in subparagraph (B))—

17 “(I) payment under this subsection shall be made on
18 the on the basis of the prevailing charge level for the test
19 for a locality or area (determined without regard to the
20 percentage limitation or the base year referred to in para-
21 graph (2)(A)); and

22 “(II) the limitation amounts referred to in subsection
23 (a)(1)(D)(i), subsection (a)(2)(D)(i), and paragraph (4)(B)
24 shall not apply;

25 until the beginning of the third full calendar year that begins
26 on or after the date on which an HCPCS code is first assigned
27 with respect to such test, or, if later, the beginning of the first
28 calendar year that begins on or after the date on which the
29 Secretary determines that there are sufficient claims data to
30 establish a limitation amount under paragraph (4)(B).

31 “(ii) Notwithstanding paragraph (2)(A), the Secretary
32 shall—

33 “(I) set the fee schedules under paragraph (1) for a
34 clinical diagnostic laboratory test described in clause (i) for
35 any calendar year beginning after the base year at 60 per-
36 cent of the prevailing charge level for such test for the ap-
37 plicable region, State, or area for the base year, adjusted



1 annually (to become effective on January 1 of each year)
2 by the percentage increase or decrease in the Consumer
3 Price Index for All Urban Consumers (United States city
4 average), and subject to such other adjustments as the Sec-
5 retary determines are justified by technological changes;
6 and

7 “(II) determine the limitation amount referred to in
8 subsection (a)(1)(D)(i) and subsection (a)(2)(D)(i), for
9 such test based on the fee schedules set under subclause (I)
10 and without regard to the limitation under paragraph
11 (4)(B).

12 “(iii) For purposes of clause (ii), the term ‘base year’
13 means, with respect to a clinical diagnostic laboratory test, the
14 last full calendar year during which payment for such test was
15 determined in accordance with clause (i).”.

16 (c) REPORT ON PROCEDURES USED FOR ADVANCED, IM-
17 PROVED TECHNOLOGIES.—Not later than 1 year after the date
18 of the enactment of this Act, the Secretary of Health and
19 Human Services shall submit to Congress a report that identi-
20 fies the specific procedures used by the Secretary under part
21 B of title XVIII of the Social Security Act to adjust payments
22 for clinical diagnostic laboratory tests and durable medical
23 equipment which are classified to existing codes where, because
24 of an advance in technology with respect to the test or equip-
25 ment, there has been a significant increase or decrease in the
26 resources used in the test or in the manufacture of the equip-
27 ment, and there has been a significant improvement in the per-
28 formance of the test or equipment. The report shall include
29 such recommendations for changes in law as may be necessary
30 to assure fair and appropriate payment levels under such part
31 for such improved tests and equipment as reflects increased
32 costs necessary to produce improved results.

33 (d) PROHIBITION.—The Secretary of Health and Human
34 Services may not assign a code for a new clinical diagnostic
35 laboratory test that differs from the code recommended by the
36 American Medical Association Common Procedure Terminology
37 Editorial Panel and results in lower payment than would be



1 made if the Secretary accepted such recommendation solely on
2 the basis that the test is a test that may be performed by a
3 laboratory with a certificate of waiver under section 353(d)(2)
4 of the Public Health Service Act (42 U.S.C. 263a(d)(2)).

5 **SEC. 543. RETENTION OF HCPCS LEVEL III CODES.**

6 (a) IN GENERAL.—The Secretary of Health and Human
7 Services shall maintain and continue the use of level III codes
8 of the HCPCS coding system (as such system was in effect on
9 August 16, 2000) through December 31, 2003, and shall make
10 such codes available to the public.

11 (b) DEFINITION.—For purposes of this section, the term
12 “HCPCS Level III codes” means the alphanumeric codes for
13 local use under the Health Care Financing Administration
14 Common Procedure Coding System (HCPCS).

15 **SEC. 544. RECOGNITION OF NEW MEDICAL TECH-**
16 **NOLOGIES UNDER INPATIENT HOSPITAL**
17 **PPS.**

18 (a) EXPEDITING RECOGNITION OF NEW TECHNOLOGIES
19 INTO INPATIENT PPS CODING SYSTEM.—

20 (1) REPORT.—Not later than April 1, 2001, the Sec-
21 retary of Health and Human Services shall submit to Con-
22 gress a report on methods of expeditiously incorporating
23 new medical services and technologies into the clinical cod-
24 ing system used with respect to payment for inpatient hos-
25 pital services furnished under the medicare program under
26 title XVIII of the Social Security Act, together with a de-
27 tailed description of the Secretary’s preferred methods to
28 achieve this purpose.

29 (2) IMPLEMENTATION.—Not later than October 1,
30 2001, the Secretary shall implement the preferred methods
31 described in the report transmitted pursuant to paragraph
32 (1) .

33 (b) ENSURING APPROPRIATE PAYMENTS FOR HOSPITALS
34 INCORPORATING NEW MEDICAL SERVICES AND TECH-
35 NOLOGIES.—



1 (1) ESTABLISHMENT OF MECHANISM.—Section
 2 1886(d)(5) (42 U.S.C. 1395ww(d)(5)) is amended by add-
 3 ing at the end the following new subparagraphs:

4 “(K)(i) Effective for discharges beginning on or
 5 after October 1, 2001, the Secretary shall establish a
 6 mechanism to recognize the costs of new medical serv-
 7 ices and technologies under the payment system estab-
 8 lished under this subsection. Such mechanism shall be
 9 established after notice and opportunity for public com-
 10 ment (in the publications required by subsection (e)(5)
 11 for a fiscal year or otherwise).

12 “(ii) The mechanism established pursuant to
 13 clause (i) shall—

14 “(I) apply to a new medical service or tech-
 15 nology if, based on the estimated costs incurred
 16 with respect to discharges involving such service or
 17 technology, the DRG prospective payment rate oth-
 18 erwise applicable to such discharges under this sub-
 19 section is inadequate;

20 “(II) provide for the collection of data with re-
 21 spect to the costs of a new medical service or tech-
 22 nology described in subclause (I) for a period of not
 23 less than two years and not more than three years
 24 beginning on the date on which an inpatient hos-
 25 pital code is issued with respect to the service or
 26 technology;

27 “(III) subject to paragraph (4)(C)(iii), provide
 28 for additional payment to be made under this sub-
 29 section with respect to discharges involving a new
 30 medical service or technology described in subclause
 31 (I) that occur during the period described in sub-
 32 clause (II) in an amount that adequately reflects
 33 the estimated average cost of such service or tech-
 34 nology; and

35 “(IV) provide that discharges involving such a
 36 service or technology that occur after the close of
 37 the period described in subclause (II) will be classi-



1 fied within a new or existing diagnosis-related
2 group with a weighting factor under paragraph
3 (4)(B) that is derived from cost data collected with
4 respect to discharges occurring during such period.

5 “(iii) For purposes of clause (ii)(II), the term ‘in-
6 patient hospital code’ means any code that is used with
7 respect to inpatient hospital services for which payment
8 may be made under this subsection and includes an al-
9 phanumeric code issued under the International Classi-
10 fication of Diseases, 9th Revision, Clinical Modification
11 (‘ICD–9–CM’) and its subsequent revisions.

12 “(iv) For purposes of clause (ii)(III), the term ‘ad-
13 ditional payment’ means, with respect to a discharge
14 for a new medical service or technology described in
15 clause (ii)(I), an amount that exceeds the prospective
16 payment rate otherwise applicable under this subsection
17 to discharges involving such service or technology that
18 would be made but for this subparagraph.

19 “(v) The requirement under clause (ii)(III) for an
20 additional payment may be satisfied by means of a
21 new-technology group (described in subparagraph (L)),
22 an add-on payment, a payment adjustment, or any
23 other similar mechanism for increasing the amount oth-
24 erwise payable with respect to a discharge under this
25 subsection. The Secretary may not establish a separate
26 fee schedule for such additional payment for such serv-
27 ices and technologies, by utilizing a methodology estab-
28 lished under subsection (a) or (h) of section 1834 to
29 determine the amount of such additional payment, or
30 by other similar mechanisms or methodologies.

31 “(vi) For purposes of this subparagraph and sub-
32 paragraph (L), a medical service or technology will be
33 considered a ‘new medical service or technology’ if the
34 service or technology meets criteria established by the
35 Secretary after notice and an opportunity for public
36 comment.



1 “(L)(i) In establishing the mechanism under sub-
2 paragraph (K), the Secretary may establish new-tech-
3 nology groups into which a new medical service or tech-
4 nology will be classified if, based on the estimated aver-
5 age costs incurred with respect to discharges involving
6 such service or technology, the DRG prospective pay-
7 ment rate otherwise applicable to such discharges
8 under this subsection is inadequate.

9 “(ii) Such groups—

10 “(I) shall not be based on the costs associated
11 with a specific new medical service or technology;
12 but

13 “(II) shall, in combination with the applicable
14 standardized amounts and the weighting factors as-
15 signed to such groups under paragraph (4)(B), re-
16 flect such cost cohorts as the Secretary determines
17 are appropriate for all new medical services and
18 technologies that are likely to be provided as inpa-
19 tient hospital services in a fiscal year.

20 “(iii) The methodology for classifying specific hos-
21 pital discharges within a diagnosis-related group under
22 paragraph (4)(A) or a new-technology group shall pro-
23 vide that a specific hospital discharge may not be clas-
24 sified within both a diagnosis-related group and a new-
25 technology group.”.

26 (2) PRIOR CONSULTATION.—The Secretary of Health
27 and Human Services shall consult with groups representing
28 hospitals, physicians, and manufacturers of new medical
29 technologies before publishing the notice of proposed rule-
30 making required by section 1886(d)(5)(K)(i) of the Social
31 Security Act (as added by paragraph (1)).

32 (3) CONFORMING AMENDMENT.—Section
33 1886(d)(4)(C)(i) (42 U.S.C. 1395ww(d)(4)(C)(i)) is
34 amended by striking “technology,” and inserting “tech-
35 nology (including a new medical service or technology under
36 paragraph (5)(K)),”.



Subtitle F—Other Provisions

SEC. 551. EXTENSION OF ADVISORY OPINION AUTHORITY.

Section 1128D(b)(6) (42 U.S.C. 1320a-7d(b)(6)) is amended by striking “ and before the date which is 4 years after such date of enactment”.

SEC. 552. CHANGE IN ANNUAL MEDPAC REPORTING.

(a) REVISION OF DEADLINES FOR SUBMISSION OF REPORTS.—

(1) IN GENERAL.—Section 1805(b)(1) (42 U.S.C. 1395b-6(b)(1)) is amended—

(A) in subparagraph (C), by striking “March 1 of each year (beginning with 1998),” and inserting “March 15 of each year;” and

(B) in subparagraph (D), by striking “June 1 of each year (beginning with 1998),” and inserting “June 15 of each year;”.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) apply beginning with 2001.

(b) REQUIREMENT FOR ON THE RECORD VOTES ON RECOMMENDATIONS.—Section 1805(b) (42 U.S.C. 1395b-6(b)) is amended by adding at the end the following new paragraph:

“(7) VOTING AND REPORTING REQUIREMENTS.—With respect to each recommendation contained in a report submitted under paragraph (1), each member of the Commission shall vote on the recommendation, and the Commission shall include, by member, the results of that vote in the report containing the recommendation.”.

SEC. 553. DEVELOPMENT OF PATIENT ASSESSMENT INSTRUMENTS.

(a) DEVELOPMENT.—

(1) IN GENERAL.—Not later than January 1, 2005, the Secretary of Health and Human Services shall submit to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate a report on the development of standard instruments for the assessment of the



1 health and functional status of patients, for whom items
2 and services described in subsection (b) are furnished, and
3 include in the report a recommendation on the use of such
4 standard instruments for payment purposes.

5 (2) DESIGN FOR COMPARISON OF COMMON ELE-
6 MENTS.—The Secretary shall design such standard instru-
7 ments in a manner such that—

8 (A) elements that are common to the items and
9 services described in subsection (b) may be readily com-
10 parable and are statistically compatible;

11 (B) only elements necessary to meet program ob-
12 jectives are collected; and

13 (C) the standard instruments supersede any other
14 assessment instrument used before that date.

15 (3) CONSULTATION.—In developing an assessment in-
16 strument under paragraph (1), the Secretary shall consult
17 with the Medicare Payment Advisory Commission, the
18 Agency for Healthcare Research and Quality, and qualified
19 organizations representing providers of services and sup-
20 pliers under title XVIII.

21 (b) DESCRIPTION OF SERVICES.—For purposes of sub-
22 section (a), items and services described in this subsection are
23 those items and services furnished to individuals entitled to
24 benefits under part A, or enrolled under part B, or both of title
25 XVIII of the Social Security Act for which payment is made
26 under such title, and include the following:

27 (1) Inpatient and outpatient hospital services.

28 (2) Inpatient and outpatient rehabilitation services.

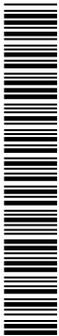
29 (3) Covered skilled nursing facility services.

30 (4) Home health services.

31 (5) Physical or occupational therapy or speech-lan-
32 guage pathology services.

33 (6) Items and services furnished to such individuals
34 determined to have end stage renal disease.

35 (7) Partial hospitalization services and other mental
36 health services.



1 (8) Any other service for which payment is made
2 under such title as the Secretary determines to be appro-
3 priate.

4 **TITLE VI—MEDICARE+CHOICE RE-**
5 **FORMS AND OTHER MANAGED**
6 **CARE REFORMS**

7 **Subtitle A—Medicare+Choice**

8 **Payment Reforms**

9 **SEC. 601. INCREASE IN NATIONAL PER CAPITA**
10 **MEDICARE+CHOICE GROWTH PERCENTAGE**
11 **IN 2001 AND 2002.**

12 Section 1853(c)(6)(B) of the Social Security Act (42
13 U.S.C. 1395w-23(c)(6)(B)) is amended—

14 (1) in clause (iv), by striking “for 2001, 0.5 percent-
15 age points” and inserting “for 2001, 0 percentage points”;
16 and

17 (2) in clause (v), by striking “for 2002, 0.3 percentage
18 points” and inserting “for 2002, 0 percentage points”.

19 **SEC. 602. MODIFICATION OF BUDGET NEUTRALITY AD-**
20 **JUSTMENTS.**

21 Section 1853(c)(1)(A) (42 U.S.C. 1395w-23(c)(1)(A)) is
22 amended by adding at the end the following: “With respect to
23 years beginning on or after January 1, 2001, in no case shall
24 the budget neutrality adjustment provided for in the previous
25 sentence result in a reduction of the payment amount that
26 would otherwise be made under this subparagraph but for such
27 adjustment.”.

28 **SEC. 603. INCREASE IN MINIMUM PAYMENT AMOUNT.**

29 Section 1853(c)(1)(B)(ii) (42 U.S.C. 1395w-
30 23(c)(1)(B)(ii)) is amended—

31 (1) by striking “(ii) For a succeeding year” and in-
32 serting “(ii)(I) Subject to subclause (II), for a succeeding
33 year”; and

34 (2) by adding at the end the following new subclause:

35 “(II) For 2001 for any of the 50 States and
36 the District of Columbia, \$450.”.



1 **SEC. 604. INCREASE IN MINIMUM PERCENTAGE IN-**
2 **CREASE.**

3 Section 1853(c)(1)(C)(ii) (42 U.S.C. 1395w-
4 23(c)(1)(C)(ii)) is amended by inserting “(or 104 percent in
5 the case of 2001)” after “102 percent”.

6 **SEC. 605. ALLOWING MOVEMENT TO 50:50 PERCENT**
7 **BLEND.**

8 Section 1853(c)(2) (42 U.S.C. 1395w-23(c)(2)) is
9 amended—

10 (1) by striking the period at the end of subparagraph
11 (F) and inserting a semicolon; and

12 (2) by adding after and below subparagraph (F) the
13 following:

14 “except that a Medicare+Choice organization may elect to
15 apply subparagraph (F) (rather than subparagraph (D) or
16 (E)) for both 2001 and 2002 or for 2002.”.

17 **SEC. 606. INCREASED PAYMENT FOR AREAS WITH TWO**
18 **OR FEWER MEDICARE+CHOICE CONTRACTS.**

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

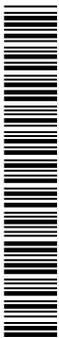
20 (1) in subsection (a)(1)(A), by striking “and (i)” and
21 inserting “(i), and (j)”;

22 (2) by adding at the end the following new subsection:

23 “(j) INCREASED PAYMENT FOR AREAS WITH 2 OR FEWER
24 MEDICARE+CHOICE CONTRACTS.—For months during 2002,
25 2003, 2004, and 2005, in the case of a Medicare+Choice pay-
26 ment area in which there is no more than two contracts entered
27 into under this part as of July 1 before the beginning of the
28 year involved, the amount of the monthly payment otherwise
29 made under this section (taking into account, if applicable, sub-
30 section (i)) shall be increased by ½ percentage point of the
31 total monthly payment otherwise computed for such payment
32 area.”.

33 **SEC. 607. PERMITTING HIGHER NEGOTIATED RATES IN**
34 **CERTAIN MEDICARE+CHOICE PAYMENT**
35 **AREAS BELOW NATIONAL AVERAGE.**

36 Section 1853(c)(1) (42 U.S.C. 1395w-23(c)(1)) is
37 amended—



1 (1) in the matter before subparagraph (A), by striking
2 “or (C)” and inserting “(C), or (D)”; and

3 (2) by adding at the end the following new subpara-
4 graph:

5 “(D) PERMITTING HIGHER RATES THROUGH NE-
6 GOTIATION.—

7 “(i) IN GENERAL.—For each year beginning
8 with 2004, in the case of a Medicare+Choice pay-
9 ment area for which the Medicare+Choice capita-
10 tion rate under this paragraph would otherwise be
11 less than the United States per capita cost
12 (USPCC), as calculated by the Secretary, a
13 Medicare+Choice organization may negotiate with
14 the Secretary an annual per capita rate that—

15 “(I) reflects an annual rate of increase up
16 to the rate of increase specified in clause (ii);

17 “(II) takes into account audited current
18 data supplied by the organization on its ad-
19 justed community rate (as defined in section
20 1854(f)(3)); and

21 “(III) does not exceed the United States
22 per capita cost, as projected by the Secretary
23 for the year involved.

24 “(ii) MAXIMUM RATE DESCRIBED.—The rate
25 of increase specified in this clause for a year is the
26 rate of inflation in private health insurance for the
27 year involved, as projected by the Secretary, and
28 includes such adjustments as may be necessary—

29 “(I) to reflect the demographic character-
30 istics in the population under this title; and

31 “(II) to eliminate the costs of items and
32 services not covered under this title.”.

33 **SEC. 608. 10-YEAR PHASE-IN OF RISK ADJUSTMENT.**

34 Section 1853(a)(3)(C)(ii) (42 U.S.C. 1395w-
35 23(c)(1)(C)(ii)) is amended—

36 (1) in subclause (I), by striking “and 2001” and in-
37 serting “and each succeeding year through the first year in



1 which risk adjustment is based on data from inpatient hos-
2 pital and ambulatory settings”; and

3 (2) by amending subclause (II) to read as follows:

4 “(II) beginning after such first year, inso-
5 far as such risk adjustment is based on data
6 from inpatient hospital and ambulatory set-
7 tings, the methodology shall be phased in equal
8 increments over a 10 year period (beginning
9 with such first year).”.

10 **SEC. 609. TRANSITION TO REVISED MEDICARE+CHOICE**
11 **PAYMENT RATES.**

12 (a) ANNOUNCEMENT OF REVISED MEDICARE+CHOICE
13 PAYMENT RATES.—Within 2 weeks after the date of the enact-
14 ment of this Act, the Secretary of Health and Human Services
15 shall determine, and shall announce (in a manner intended to
16 provide notice to interested parties) Medicare+Choice capita-
17 tion rates under section 1853 of the Social Security Act (42
18 U.S.C. 1395w-23) for 2001, revised in accordance with the
19 provisions of this Act.

20 (b) REENTRY INTO PROGRAM PERMITTED FOR
21 MEDICARE+CHOICE PROGRAMS IN 2000.—A Medicare+Choice
22 organization that provided notice to the Secretary of Health
23 and Human Services before the date of the enactment of this
24 Act that it was terminating its contract under part C of title
25 XVIII of the Social Security Act or was reducing the service
26 area of a Medicare+Choice plan offered under such part shall
27 be permitted to continue participation under such part, or to
28 maintain the service area of such plan, for 2001 if it provides
29 the Secretary with the information described in section
30 1854(a)(1) of the Social Security Act (42 U.S.C. 1395w-
31 24(a)(1)) within four weeks after the date of the enactment of
32 this Act.

33 (c) REVISED SUBMISSION OF PROPOSED PREMIUMS AND
34 RELATED INFORMATION.—If—

35 (1) a Medicare+Choice organization provided notice to
36 the Secretary of Health and Human Services as of July 3,
37 2000, that it was renewing its contract under part C of



1 title XVIII of the Social Security Act for all or part of the
2 service area or areas served under its current contract, and

3 (2) any part of the service area or areas addressed in
4 such notice includes a county for which the
5 Medicare+Choice capitation rate under section 1853(e) of
6 such Act (42 U.S.C. 1395w-23(e)) for 2001, as determined
7 under subsection (a), is higher than the rate previously de-
8 termined for such year,

9 such organization shall revise its submission of the information
10 described in section 1854(a)(1) of the Social Security Act (42
11 U.S.C. 1395w-24(a)(1)), and shall submit such revised infor-
12 mation to the Secretary, within 3 weeks after the date revised
13 rates are announced by the Secretary under subsection (a).

14 (d) DISREGARD OF NEW RATE ANNOUNCEMENT IN AP-
15 PLYING PASS-THROUGH FOR NEW NATIONAL COVERAGE DE-
16 TERMINATIONS.—For purposes of applying section 1852(a)(5)
17 of the Social Security Act (42 U.S.C. 1395w-22(a)(5)), the an-
18 nouncement of revised rates under subsection (a) shall not be
19 treated as an announcement under section 1853(b) of such Act
20 (42 U.S.C. 1395w-23(b)).

21 **SEC. 610. ADJUSTMENT IN PAYMENT FOR**
22 **MEDICARE+CHOICE ENROLLEES WITH END-**
23 **STAGE RENAL DISEASE.**

24 (a) IN GENERAL.—Section 1853(a)(1)(B) (42 U.S.C.
25 1395w-23(a)(1)(B)) is amended by inserting after the second
26 sentence the following: “Such separate rates shall be adjusted
27 for the risk factor of age and may be adjusted for such other
28 factors as the Secretary determines to be appropriate so as to
29 ensure actuarial equivalence. Such separate rates shall continue
30 to be used and so adjusted until such time as the Secretary im-
31 plements a risk adjustment system pursuant to paragraph (3)
32 that utilizes data from inpatient hospital stays and from ambu-
33 latory sites.”.

34 (b) EFFECTIVE DATE.—The amendment made by sub-
35 section (a) applies for rates for months beginning on or after
36 January 1, 2001.



1 **SEC. 611. REPORT ON INCLUSION OF CERTAIN COSTS OF**
 2 **THE DEPARTMENT OF VETERANS AFFAIRS**
 3 **AND MILITARY FACILITY SERVICES IN CAL-**
 4 **CULATING MEDICARE+CHOICE PAYMENT**
 5 **RATES.**

6 The Secretary of Health and Human Services shall report
 7 to the Congress by not later than January 1, 2003, on a meth-
 8 od to phase-in the costs of military facility services furnished
 9 by the Department of Veterans Affairs, and the costs of mili-
 10 tary facility services furnished by the Department of Defense,
 11 to medicare-eligible beneficiaries in the calculation of an area’s
 12 Medicare+Choice capitation payment. Such report shall include
 13 on a county-by-county basis—

14 (1) the actual or estimated cost of such services to
 15 medicare-eligible beneficiaries;

16 (2) the change in Medicare+Choice capitation pay-
 17 ment rates if such costs are included in the calculation of
 18 payment rates;

19 (3) one or more proposals for the implementation of
 20 payment adjustments to Medicare+Choice plans in coun-
 21 ties where the payment rate has been affected due to the
 22 failure to calculate the cost of such services to medicare-
 23 eligible beneficiaries; and

24 (4) a system to ensure that when a Medicare+Choice
 25 enrollee receives covered services through a facility of the
 26 Department of Veterans Affairs or the Department of De-
 27 fense there is an appropriate payment recovery to the medi-
 28 care program.

29 **Subtitle B—Other Medicare+Choice**
 30 **Reforms**

31 **SEC. 621. PAYMENT OF ADDITIONAL AMOUNTS FOR NEW**
 32 **BENEFITS COVERED DURING A CONTRACT**
 33 **TERM.**

34 (a) IN GENERAL.—Section 1853(c)(7) (42 U.S.C. 1395w-
 35 23(e)(7)) is amended to read as follows:

36 “(7) ADJUSTMENT FOR NATIONAL COVERAGE DETER-
 37 MINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—If
 38 the Secretary makes a determination with respect to cov-



1 erage under this title or there is a change in benefits re-
2 quired to be provided under this part that the Secretary
3 projects will result in a significant increase in the costs to
4 Medicare+Choice of providing benefits under contracts
5 under this part (for periods after any period described in
6 section 1852(a)(5)), the Secretary shall adjust appro-
7 priately the payments to such organizations under this
8 part. Such projection and adjustment shall be based on an
9 analysis by the Chief Actuary of the actuarial costs associ-
10 ated with the new benefits.”.

11 (b) CONFORMING AMENDMENT.—Section 1852(a)(5) (42
12 U.S.C. 1395w–22(a)(5)) is amended—

13 (1) in the heading, by inserting “AND LEGISLATIVE
14 CHANGES IN BENEFITS” after “NATIONAL COVERAGE DE-
15 TERMINATIONS”;

16 (2) by inserting “or legislative change in benefits re-
17 quired to be provided under this part” after “national cov-
18 erage determination”;

19 (3) in subparagraph (A), by inserting “or legislative
20 change in benefits” after “such determination”;

21 (4) in subparagraph (B), by inserting “or legislative
22 change” after “if such coverage determination”; and

23 (5) by adding at the end the following:

24 “The projection under the previous sentence shall be based
25 on an analysis by the Chief Actuary of the actuarial costs
26 associated with the coverage determination or changes in
27 benefits.”.

28 (c) EFFECTIVE DATE.—The amendments made by this
29 section are effective on the date of the enactment of this Act
30 and apply to determinations and changes in law occurring on
31 or after such date.

32 **SEC. 622. RESTRICTION ON IMPLEMENTATION OF SIG-**
33 **NIFICANT NEW REGULATORY REQUIRE-**
34 **MENTS MID-YEAR.**

35 (a) IN GENERAL.—Section 1856(b) (42 U.S.C. 1395w–
36 26(b)) is amended by adding at the end the following para-
37 graph:



1 “(4) PROHIBITION OF MID-YEAR IMPLEMENTATION OF
2 SIGNIFICANT NEW REGULATORY REQUIREMENTS.—The
3 Secretary may not implement, other than at the beginning
4 of a calendar year, regulations under this section that im-
5 pose new, significant regulatory requirements on a
6 Medicare+Choice organization or plan.”.

7 (b) EFFECTIVE DATE.—The amendment made by sub-
8 section (a) takes effect on the date of the enactment of this
9 Act.

10 **SEC. 623. TIMELY APPROVAL OF MARKETING MATERIAL**
11 **THAT FOLLOWS MODEL MARKETING LAN-**
12 **GUAGE.**

13 (a) IN GENERAL.—Section 1851(h) (42 U.S.C. 1395w-
14 21(h)) is amended—

15 (1) in paragraph (1)(A), by inserting “(or 10 days in
16 the case described in paragraph (5))” after “45 days”; and

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

18 “(5) SPECIAL TREATMENT OF MARKETING MATERIAL
19 FOLLOWING MODEL MARKETING LANGUAGE.—In the case
20 of marketing material of an organization that uses pro-
21 posed model language specified by the Secretary, the period
22 specified in paragraph (1)(A) shall be reduced from 45
23 days to 10 days.”.

24 (b) EFFECTIVE DATE.—The amendments made by sub-
25 section (a) apply to marketing material submitted on or after
26 January 1, 2001.

27 **SEC. 624. AVOIDING DUPLICATIVE REGULATION.**

28 (a) IN GENERAL.—Section 1856(b)(3)(B) (42 U.S.C.
29 1395w-26(b)(3)(B)) is amended—

30 (1) in clause (i), by inserting “(including cost-sharing
31 requirements)” after “Benefit requirements”; and

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

33 “(iv) Requirements relating to marketing ma-
34 terials, summaries and schedules of benefits, and
35 other documentation regarding a Medicare+Choice
36 plan.”.



1 (b) EFFECTIVE DATE.—The amendments made by sub-
2 section (a) take effect on the date of the enactment of this Act.

3 **SEC. 625. ELECTION OF UNIFORM LOCAL COVERAGE**
4 **POLICY FOR MEDICARE+CHOICE PLAN COV-**
5 **ERING MULTIPLE LOCALITIES.**

6 Section 1852(a)(2) (42 U.S.C. 1395w-22(a)(2)) is amend-
7 ed by adding at the end the following new subparagraph:

8 “(C) ELECTION OF UNIFORM COVERAGE POL-
9 ICY.—A Medicare+Choice organization that offers a
10 Medicare+Choice plan in an area in which more than
11 one local coverage policy is applied with respect to dif-
12 ferent parts of the area, the organization may elect to
13 have the local coverage policy for the part of the area
14 that is most beneficial to Medicare+Choice enrollees
15 (as identified by the Secretary) apply with respect to
16 all Medicare+Choice enrollees enrolled in the plan.”.

17 **SEC. 626. PROVIDING CHOICE FOR SKILLED NURSING**
18 **FACILITY SERVICES UNDER THE**
19 **MEDICARE+CHOICE PROGRAM.**

20 (a) IN GENERAL.—Section 1852 (42 U.S.C. 1395w-22) is
21 amended by adding at the end the following new subsection:

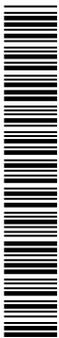
22 “(I) RETURN TO HOME SKILLED NURSING FACILITIES
23 FOR COVERED POST-HOSPITAL EXTENDED CARE SERVICES.—

24 “(1) ENSURING RETURN TO HOME SNF.—

25 “(A) IN GENERAL.—A Medicare+Choice organiza-
26 tion offering a Medicare+Choice plan that provides for
27 coverage of post-hospital extended care services shall
28 provide for such coverage through a home skilled nurs-
29 ing facility if the following conditions are met:

30 “(i) ENROLLEE ELECTION.—The enrollee
31 elects to receive such coverage through such facil-
32 ity.

33 “(ii) SNF AGREEMENT.—The facility has a
34 contract with the Medicare+Choice organization
35 for the provision of such services, or the facility
36 agrees to accept substantially similar payment
37 under the same terms and conditions that apply to
38 similarly situated skilled nursing facilities that are



1 under contract with the Medicare+Choice organiza-
 2 tion for the provision of such services and through
 3 which the enrollee would otherwise receive such
 4 services.

5 “(B) MANNER OF PAYMENT TO HOME SNF.—The
 6 organization shall provide payment to the home skilled
 7 nursing facility consistent with the contract or the
 8 agreement described in subparagraph (A)(ii), as the
 9 case may be.

10 “(2) NO LESS FAVORABLE COVERAGE.—The coverage
 11 provided under paragraph (1) (including scope of services,
 12 cost-sharing, and other criteria of coverage) shall be no less
 13 favorable to the enrollee than the coverage that would be
 14 provided to the enrollee with respect to a skilled nursing fa-
 15 cility the post-hospital extended care services of which are
 16 otherwise covered under the Medicare+Choice plan.

17 “(3) RULE OF CONSTRUCTION.—Nothing in this sub-
 18 section shall be construed to do the following:

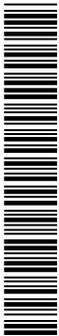
19 “(A) To require coverage through a skilled nursing
 20 facility that is not otherwise qualified to provide bene-
 21 fits under part A for medicare beneficiaries not enrolled
 22 in a Medicare+Choice plan.

23 “(B) To prevent a skilled nursing facility from re-
 24 fusing to accept, or imposing conditions upon the ac-
 25 ceptance of, an enrollee for the receipt of post-hospital
 26 extended care services.

27 “(4) DEFINITIONS.—In this subsection:

28 “(A) HOME SKILLED NURSING FACILITY.—The
 29 term ‘home skilled nursing facility’ means, with respect
 30 to an enrollee who is entitled to receive post-hospital
 31 extended care services under a Medicare+Choice plan,
 32 any of the following skilled nursing facilities:

33 “(i) SNF RESIDENCE AT TIME OF ADMIS-
 34 SION.—The skilled nursing facility in which the en-
 35 rollee resided at the time of admission to the hos-
 36 pital preceding the receipt of such post-hospital ex-
 37 tended care services.



1 “(ii) SNF IN CONTINUING CARE RETIREMENT
 2 COMMUNITY.—A skilled nursing facility that is pro-
 3 viding such services through a continuing care re-
 4 tirement community (as defined in subparagraph
 5 (B)) which provided residence to the enrollee at the
 6 time of such admission.

7 “(iii) SNF RESIDENCE OF SPOUSE AT TIME OF
 8 DISCHARGE.—The skilled nursing facility in which
 9 the spouse of the enrollee is residing at the time of
 10 discharge from such hospital.

11 “(B) CONTINUING CARE RETIREMENT COMMUNITY
 12 DEFINED.—The term ‘continuing care retirement com-
 13 munity’ means, with respect to an enrollee in a
 14 Medicare+Choice plan, an arrangement under which
 15 housing and health-related services are provided (or ar-
 16 ranged) through an organization for the enrollee under
 17 an agreement that is effective for the life of the en-
 18 rollee or for a specified period.”.

19 (b) EFFECTIVE DATE.—The amendment made by sub-
 20 section (a) applies with respect to contracts entered into or re-
 21 newed on or after the date of enactment of this Act.

22 **Subtitle C—Other Managed Care**
 23 **Reforms**

24 **SEC. 631. 1-YEAR EXTENSION OF SOCIAL HEALTH MAIN-**
 25 **TENANCE ORGANIZATION (SHMO) DEM-**
 26 **ONSTRATION PROJECT.**

27 Section 4018(b)(1) of the Omnibus Budget Reconciliation
 28 Act of 1987, as amended by section 531(a)(1) of BBRA, is
 29 amended by striking “18 months” and inserting “30 months”.

30 **SEC. 626. PROVIDING CHOICE FOR SKILLED NURSING**
 31 **FACILITY SERVICES UNDER THE**
 32 **MEDICARE+CHOICE PROGRAM.**

33 (a) IN GENERAL.—Section 1852 (42 U.S.C. 1395w-22) is
 34 amended by adding at the end the following new subsection:

35 “(l) RETURN TO HOME SKILLED NURSING FACILITIES
 36 FOR COVERED POST-HOSPITAL EXTENDED CARE SERVICES.—

37 “(1) ENSURING RETURN TO HOME SNF.—



1 “(A) IN GENERAL.—A Medicare+Choice organiza-
 2 tion offering a Medicare+Choice plan that provides for
 3 coverage of post-hospital extended care services shall
 4 provide for such coverage through a home skilled nurs-
 5 ing facility if the following conditions are met:

6 “(i) ENROLLEE ELECTION.—The enrollee
 7 elects to receive such coverage through such facil-
 8 ity.

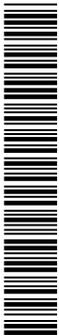
9 “(ii) SNF AGREEMENT.—The facility has a
 10 contract with the Medicare+Choice organization
 11 for the provision of such services, or the facility
 12 agrees to accept substantially similar payment
 13 under the same terms and conditions that apply to
 14 similarly situated skilled nursing facilities that are
 15 under contract with the Medicare+Choice organiza-
 16 tion for the provision of such services and through
 17 which the enrollee would otherwise receive such
 18 services.

19 “(B) MANNER OF PAYMENT TO HOME SNF.—The
 20 organization shall provide payment to the home skilled
 21 nursing facility consistent with the contract or the
 22 agreement described in subparagraph (A)(ii), as the
 23 case may be.

24 “(2) NO LESS FAVORABLE COVERAGE.—The coverage
 25 provided under paragraph (1) (including scope of services,
 26 cost-sharing, and other criteria of coverage) shall be no less
 27 favorable to the enrollee than the coverage that would be
 28 provided to the enrollee with respect to a skilled nursing fa-
 29 cility the post-hospital extended care services of which are
 30 otherwise covered under the Medicare+Choice plan.

31 “(3) RULE OF CONSTRUCTION.—Nothing in this sub-
 32 section shall be construed to do the following:

33 “(A) To require coverage through a skilled nursing
 34 facility that is not otherwise qualified to provide bene-
 35 fits under part A for medicare beneficiaries not enrolled
 36 in a Medicare+Choice plan.



1 “(B) To prevent a skilled nursing facility from re-

2 fusing to accept, or imposing conditions upon the ac-

3 ceptance of, an enrollee for the receipt of post-hospital

4 extended care services.

5 “(4) DEFINITIONS.—In this subsection:

6 “(A) HOME SKILLED NURSING FACILITY.—The

7 term ‘home skilled nursing facility’ means, with respect

8 to an enrollee who is entitled to receive post-hospital

9 extended care services under a Medicare+Choice plan,

10 any of the following skilled nursing facilities:

11 “(i) SNF RESIDENCE AT TIME OF ADMIS-

12 SION.—The skilled nursing facility in which the en-

13 rollee resided at the time of admission to the hos-

14 pital preceding the receipt of such post-hospital ex-

15 tended care services.

16 “(ii) SNF IN CONTINUING CARE RETIREMENT

17 COMMUNITY.—A skilled nursing facility that is pro-

18 viding such services through a continuing care re-

19 tirement community (as defined in subparagraph

20 (B)) which provided residence to the enrollee at the

21 time of such admission.

22 “(iii) SNF RESIDENCE OF SPOUSE AT TIME OF

23 DISCHARGE.—The skilled nursing facility in which

24 the spouse of the enrollee is residing at the time of

25 discharge from such hospital.

26 “(B) CONTINUING CARE RETIREMENT COMMUNITY

27 DEFINED.—The term ‘continuing care retirement com-

28 munity’ means, with respect to an enrollee in a

29 Medicare+Choice plan, an arrangement under which

30 housing and health-related services are provided (or ar-

31 ranged) through an organization for the enrollee under

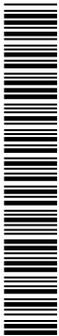
32 an agreement that is effective for the life of the en-

33 rollee or for a specified period.”.

34 (b) EFFECTIVE DATE.—The amendment made by sub-

35 section (a) applies with respect to contracts entered into or re-

36 newed on or after the date of enactment of this Act.



1 **SEC. 632. REVISED TERMS AND CONDITIONS FOR EX-**
 2 **TENSION OF MEDICARE COMMUNITY NURS-**
 3 **ING ORGANIZATION (CNO) DEMONSTRATION**
 4 **PROJECT.**

5 (a) IN GENERAL.—Section 532 of BBRA (113 Stat.
 6 1501A–388) is amended—

7 (1) in subsection (a), by striking the second sentence;

8 and

9 (2) by striking subsection (b) and inserting the fol-
 10 lowing:

11 “(b) TERMS AND CONDITIONS.—

12 “(1) JANUARY THROUGH SEPTEMBER 2000.—For the 9-
 13 month period beginning with January 2000, any such dem-
 14 onstration project shall be conducted under the same terms
 15 and conditions as applied to such demonstration during
 16 1999.

17 “(2) OCTOBER 2000 THROUGH DECEMBER 2001.—For
 18 the 15-month period beginning with October 2000, any
 19 such demonstration project shall be conducted under the
 20 same terms and conditions as applied to such demonstra-
 21 tion during 1999, except that the following modifications
 22 shall apply:

23 “(A) BASIC CAPITATION RATE.—The basic capita-
 24 tion rate paid for services covered under the project
 25 (other than case management services) per enrollee per
 26 month and furnished during—

27 “(i) the period beginning with October 1,
 28 2000, and ending with December 31, 2000, shall be
 29 determined by actuarially adjusting the actual capi-
 30 tation rate paid for such services in 1999 for infla-
 31 tion, utilization, and other changes to the CNO
 32 service package, and by reducing such adjusted
 33 capitation rate by 10 percent in the case of the
 34 demonstration sites located in Arizona, Minnesota,
 35 and Illinois, and 15 percent for the demonstration
 36 site located in New York; and



1 “(ii) 2001 shall be determined by actuarially
 2 adjusting the capitation rate determined under
 3 clause (i) for inflation, utilization, and other
 4 changes to the CNO service package.

5 “(B) TARGETED CASE MANAGEMENT FEE.—Effec-
 6 tive October 1, 2000—

7 “(i) the case management fee per enrollee per
 8 month for—

9 “(I) the period described in subparagraph
 10 (A)(i) shall be determined by actuarially ad-
 11 justing the case management fee for 1999 for
 12 inflation; and

13 “(II) 2001 shall be determined by actuari-
 14 ally adjusting the amount determined under
 15 subclause (I) for inflation; and

16 “(ii) such case management fee shall be paid
 17 only for enrollees who are classified as moderately
 18 frail or frail pursuant to criteria established by the
 19 Secretary.

20 “(C) GREATER UNIFORMITY IN CLINICAL FEA-
 21 TURES AMONG SITES.—Each project shall implement
 22 for each site—

23 “(i) protocols for periodic telephonic contact
 24 with enrollees based on—

25 “(I) the results of such standardized writ-
 26 ten health assessment; and

27 “(II) the application of appropriate care
 28 planning approaches;

29 “(ii) disease management programs for tar-
 30 geted diseases (such as congestive heart failure, ar-
 31 thritis, diabetes, and hypertension) that are highly
 32 prevalent in the enrolled populations;

33 “(iii) systems and protocols to track enrollees
 34 through hospitalizations, including pre-admission
 35 planning, concurrent management during inpatient
 36 hospital stays, and post-discharge assessment, plan-
 37 ning, and follow-up; and



1 “(iv) standardized patient educational mate-
2 rials for specified diseases and health conditions.

3 “(D) QUALITY IMPROVEMENT.—Each project shall
4 implement at each site once during the 15-month
5 period—

6 “(i) enrollee satisfaction surveys; and

7 “(ii) reporting on specified quality indicators
8 for the enrolled population.

9 “(c) EVALUATION.—

10 “(1) PRELIMINARY REPORT.—Not later than July 1,
11 2001, the Secretary of Health and Human Services shall
12 submit to the Committees on Ways and Means and Com-
13 merce of the House of Representatives and the Committee
14 on Finance of the Senate a preliminary report that—

15 “(A) evaluates such demonstration projects for the
16 period beginning July 1, 1997, and ending December
17 31, 1999, on a site-specific basis with respect to the
18 impact on per beneficiary spending, specific health uti-
19 lization measures, and enrollee satisfaction; and

20 “(B) includes a similar evaluation of such projects
21 for the portion of the extension period that occurs after
22 September 30, 2000.

23 “(2) FINAL REPORT.—The Secretary shall submit a
24 final report to such Committees on such demonstration
25 projects not later than July 1, 2002. Such report shall in-
26 clude the same elements as the preliminary report required
27 by paragraph (1), but for the period after December 31,
28 1999.

29 “(3) METHODOLOGY FOR SPENDING COMPARISONS.—Any
30 evaluation of the impact of the demonstration projects on
31 per beneficiary spending included in such reports shall in-
32 clude a comparison of—

33 “(A) data for all individuals who—

34 “(i) were enrolled in such demonstration
35 projects as of the first day of the period under eval-
36 uation; and



1 “(ii) were enrolled for a minimum of 6 months
2 thereafter; with

3 “(B) data for a matched sample of individuals who
4 are enrolled under part B of title XVIII of the Social
5 Security Act and are not enrolled in such a project, or
6 in a Medicare+Choice plan under part C of such title,
7 a plan offered by an eligible organization under section
8 1876 of such Act, or a health care prepayment plan
9 under section 1833(a)(1)(A) of such Act.”.

10 (b) EFFECTIVE DATE.—The amendments made by sub-
11 section (a) shall be effective as if included in the enactment of
12 section 532 of BBRA (113 Stat. 1501A–388).

13 **SEC. 633. EXTENSION OF MEDICARE MUNICIPAL**
14 **HEALTH SERVICES DEMONSTRATION**
15 **PROJECTS.**

16 Section 9215(a) of the Consolidated Omnibus Budget Rec-
17 onciliation Act of 1985, as amended by section 6135 of the
18 Omnibus Budget Reconciliation Act of 1989, section 13557 of
19 the Omnibus Budget Reconciliation Act of 1993, section 4017
20 of BBA, and section 512 of BBRA, is amended by striking
21 “December 31, 2002” and inserting “December 31, 2004”.

22 **TITLE VII—PACE PROGRAM**

23 **SEC. 701. EXTENSION OF TRANSITION FOR CURRENT**
24 **WAIVERS.**

25 Section 4803(d)(2) of BBA is amended—

26 (a) in subparagraph (A), by striking “24 months” and in-
27 serting “36 months”; and

28 (b) in subparagraph (B), by striking “3 years” and insert-
29 ing “4 years”.

30 **SEC. 702. CONTINUING OF CERTAIN OPERATING AR-**
31 **RANGEMENTS PERMITTED.**

32 (a) IN GENERAL.—Section 1894(f)(2) (42 U.S.C.
33 1395eee(f)(2)) is amended by adding at the end the following
34 new subparagraph:

35 “(C) CONTINUATION OF MODIFICATIONS OR WAIV-
36 ERS OF OPERATIONAL REQUIREMENTS UNDER DEM-
37 ONSTRATION STATUS.—If a PACE program operating



1 under demonstration authority has contractual or other
2 operating arrangements which are not otherwise recog-
3 nized in regulation and which were in effect on July 1,
4 2000, the Secretary (in close consultation with, and
5 with the concurrence of, the State administering agen-
6 cy) shall permit any such program to continue such ar-
7 rangements so long as such arrangements are found by
8 the Secretary and the State to be reasonably consistent
9 with the objectives of the PACE program.”.

10 (b) CONFORMING AMENDMENT.—Section 1934(f)(2) (42
11 U.S.C. 1396u–4(f)(2)) is amended by adding at the end the fol-
12 lowing new subparagraph:

13 “(C) CONTINUATION OF MODIFICATIONS OR WAIV-
14 ERS OF OPERATIONAL REQUIREMENTS UNDER DEM-
15 ONSTRATION STATUS.—If a PACE program operating
16 under demonstration authority has contractual or other
17 operating arrangements which are not otherwise recog-
18 nized in regulation and which were in effect on the date
19 of the enactment of this section, the Secretary (in close
20 consultation with, and with the concurrence of, the
21 State administering agency) shall permit any such pro-
22 gram to continue such arrangements so long as such
23 arrangements are found by the Secretary and the State
24 to be reasonably consistent with the objectives of the
25 PACE program.”.

26 (c) EFFECTIVE DATE.—The amendments made by this
27 section shall be effective as included in the enactment of BBA.

28 **SEC. 703. FLEXIBILITY IN EXERCISING WAIVER AUTHOR-**
29 **ITY.**

30 In applying sections 1894(f)(2)(B) and 1934(f)(2)(B) of
31 the Social Security Act (42 U.S.C. 1395eee(f)(2)(B), 1396u–
32 4(f)(2)(B)), the Secretary of Health and Human Services shall
33 exercise authority to modify or waive requirements in a manner
34 that responds promptly to the needs of PACE programs relat-
35 ing to areas of employment and the use of community-based
36 primary care physicians.

