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MEDICARE, MEDICAID AND S–CHIP ADJUSTMENT ACT OF 1999

OCTOBER 26, 1999.—Ordered to be printed

Mr. ROTH, from the Committee on Finance, submitted the following

REPORT

[To accompany S. 1788]

[Including cost estimate of the Congressional Budget Office]

The Committee on Finance, to which was referred the bill (S. 1788) to amend titles XVIII, XIX, and XXI of the Social Security Act to make corrections and refinements in the Medicare, Medicaid, and S–CHIP programs, as revised and added by the Balanced Budget Act of 1997, having considered the same, reports favorably thereon as amended by the Committee, and recommends that the bill do pass.

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I. SUMMARY AND BACKGROUND

A. SUMMARY

The Medicare, Medicaid, and S–CHIP Adjustment Act of 1999, as reported by the Committee on Finance, provides for a series of short-term provider payment policy adjustments under the Medicare program and provides for a series of technical adjustments to The Medicaid program and the State Children's Health Insurance Program (S–CHIP).

B. BACKGROUND AND REASONS FOR LEGISLATION

The principal goal of the legislation is to address short-term and demonstrable problems in access to health care services by Medicare beneficiaries arising from significant provider payment policy changes made in the Balanced Budget Act of 1997. Issues arose in both the traditional fee-for-service program and in the Medicare+Choice program, which offers private health plan options to program beneficiaries. There was growing evidence that certain caps and other payment limitations and reforms adopted in BBA 97 needed to be adjusted to forestall the development of access problems for the 39 million beneficiaries covered by the Medicare program.

In addition, certain issues arose under Medicaid and S–CHIP of a more technical nature that the Committee felt should be addressed. These included stabilization of the S–CHIP allocation formula, adjustments to rules affecting disproportionate share hospital payments and a variety of data collection and coordination improvements. The Committee also sought to address a variety of

continuing, systemic problems in rural health care delivery and services through both Medicare and Medicaid provisions.

C. Legislative History

The Finance Committee conducted over 10 hearings from March, 1999 to July, 1999 on various Medicare and Medicaid topics, several of which touched on changes wrought in the programs by BBA 97. More specifically, on March 17, 1999 the Committee examined Medicare+Choice payment issues and a June 10, 1999 the Committee conducted a hearing that focused exclusively on issues under the fee-for-service program. Altogether, over 70 witnesses provided testimony this year in the Committee over needed changes in the Medicare and Medicaid programs, both short and long-term.

On October 21, 1999 the Finance Committee reported favorably by voice vote, the Medicare, Medicaid, and S–CHIP Adjustment Act of 1999.

II. EXPLANATION OF THE BILL

A. Section 1. Short Title

The short title is the "Medicare, Medicaid, and S–CHIP Adjustment Act of 1999".

B. Title I—Provisions Relating to Part A Only

1. Subtitle A—Skilled Nursing Facility Services

A. SECTION 101. INCREASE IN PAYMENT FOR CERTAIN HIGH COST PATIENTS

Current law

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

The BBA 97 instructs the Secretary how to (a) compute average per diem payment rates using Medicare-provided SNF costs in 1995 as the base year; (b) adjust the average rates for facility case-

mix and geographic differences; and update the per diem rates for years after 1995. This methodology aims at setting the prospective payment system per diem amounts to reflect overall Medicare payments for SNF care under the retrospect reimbursement payment system used prior to the prospective payment system in order to achieve budget neutrality for the new payment system when it is first implemented. the law specifies limited updates to payment under the RUG system in future years.

Explanation of provision

The bill would add 25% to the federal per diem payments for beneficiaries in the Extensive Services and Special Care RUGs (categories SE3, SE2, SE1, SSC, SSB, SSA as listed in HCFA's July 30, 1999 Federal Register) for the period April 1, 2000 to October 1, 2001. It would also add specified dollar amounts to RUG payments for five rehabilitation therapy RUGS (RMC, RUC, RMB, RHC, and RVC). These additional amounts would be paid from April 1, 2000 to October 1, 2001. It is the Committee's intention that the program's implementation begin on this date and that on this date each payment shall increase by the required amount so that the facilities will receive the additional payment authorized on April 1, 2000.

The Committee does not intend to limit the Secretary's ability to refine the current RUG rates, schedules to take effect October 1, 2000. Rather, the Committee anticipates that the Secretary would apply these add-on payments to comparable RUG categories under the refined system.

Reason for change

In a report prepared for the Health Care Financing Administration (HCFA), an independent review of the RUGs classifications demonstrated that the payment rates for the Extensive Services and Special Care RUGs did not6 meet the anticipated costs for the medically complex patients that fall within these categories. Data also has demonstrated the appropriateness of specific add-ons to the five rehab categories. The additional payments provide targeted relief in the interim, as the Secretary refines allocations among the RUGs in preparation for publication of the final rule.

Effective date

April 1, 2000.

B. SECTION 102. PROVISION FOR PART B ADD-ONS FOR FACILITIES PARTICIPATING IN THE NCHMQ DEMONSTRATION PROJECT

Current law

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

other SNFs because they are based on allowable costs in 1997 rather than 1995.

Explanation of provision

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

Reason for change

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

Effective date

As if included in the BBA.

C. SECTION 103. EXEMPTION OF FACILITIES FROM 3-YEAR TRANSITION PERIOD UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR SKILLED NURSING FACILITY SERVICES

Current law

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

Explanation of provision

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

Reason for change

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

Effective date

Upon enactment.

D. SECTION 104. STUDY AND REPORT REGARDING STATE LICENSURE AND CERTIFICATION STANDARDS AND RESPIRATORY THERAPY COMPETENCY EXAMINATIONS

Current law

No provision.

Explanation of provision

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

Reason for change

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

Effective date

Upon enactment.

E. SECTION 105. STUDY AND REPORT ON ALTERNATIVE PAYMENT METHODS FOR SKILLED NURSING FACILITIES SPECIALIZING IN CARE OF HIGH COST, CHRONICALLY ILL BENEFICIARIES

Current law

No provision.

Explanation of provision

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

Reason for change

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

Effective date

The Secretary would submit the report within one year from the date of enactment.

2. Subtitle B—Hospice Services

A. SECTION 121. PAYMENT FOR HOSPICE CARE

Current law

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

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

Explanation of provision

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

Reason for change

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

Effective date

Retroactive to October 1, 1999.

B. SECTION 122. STUDY AND REPORT TO CONGRESS REGARDING MODIFICATION OF THE PAYMENT RATES FOR HOSPICE CARE

Current law

No provision.

Explanation of provision

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

Reason for change

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

Effective date

Upon enactment.

Subtitle C—Other Part A Provisions

A. SECTION 141. STUDY AND REPORT REGARDING PROSPECTIVE PAYMENT SYSTEM FOR PSYCHIATRIC HOSPITALS

Current law

No provision.

Explanation of provision

The Secretary must report to Congress within two years of enactment of this act on the development of a prospective payment system for psychiatric hospitals. Special attention should be given to the unique circumstances affecting mental health facilities in rural areas.

Reason for change

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

Effective date

Upon enactment.

B. SECTION 142. REVISION OF PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT REHABILITATION SERVICES

Current law

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

Explanation of provision

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

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

Reason for change

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

The Committee believes that mandating a per-discharge system based on FIM–FRGs would not affect the Secretary's authority to implement a transfer or short stay outlier policy. Rather, the Committee expects that these policies are consistent with a FIM–FRG system. Moreover, the Committee intends that the Secretary retain her authority to utilize the MDS–PAC and other efforts to gather information about patients and care across post-acute care settings.

Effective date

Upon enactment.

C. SECTION 143. EXCEPTION TO CMI QUALIFIER FOR ONE YEAR

Current law

No provision.

Explanation of provision

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

Reason for change

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

Effectve date

The provisions are effective October 1, 1999.

D. SECTION 144. RECLASSIFICATION OF CERTAIN COUNTIES FOR PURPOSES OF REIMBURSEMENT UNDER THE MEDICARE PROGRAM

Current law

No provision.

Explanation of provision

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

Reason for change

Iredell County is still classified as "rural" for the purposes of Medicare reimbursement, even though Iredell County is almost completely surrounded by three "urban" Metropolitan Statistical Areas. Orange County hospitals compete directly for personnel with neighboring counties that are reimbursed on the higher New York City wage index. More specifically, these hospitals receive a reimbursement that is 26% less than neighboring counties solely based on the MSA to which it is classified.

Effective date

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

E. SECTION 145. WAGE INDEX CORRECTION

Current law

No provision.

Explanation of provision

The provision directs the Secretary to recalculate the Hattiesburg, Mississippi Metropolitan Statistical Area (MSA) wage index for FY 2000 using Wesley Medical Center's FY 1996 wage and hour data and to issue a wage index correction.

Reason for change

Due to the Health Care Financing Administration's error in not including Wesley Medical Center's FY 1996 wage and hour data to the FY 2000 Hattiesburg, Mississippi MSA wage index, Forrest General Hospital is facing severe and unexpected losses in Medicare payments this year. The hospital was unable to achieve an administrative correction in time to be included in HCFA's PPS final rule, published August 1, 1999. This provision grants the Secretary authority to make this change prior to publication of the PPS rule next year.

Effective date

October 1, 1999.

F. SECTION 146. CONSIDERATION OF AN APPLICATION BY A CERTAIN ENTITY FOR MEDICARE CERTIFICATION AS AN APPLICATION BY A NEW PROVIDER

Current law

No provision.

Explanation of provision

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

Reason for change

To correct unintended consequences stemming from a change in ownership.

Effective date

Upon enactment.

G. SECTION 147. STUDY ON REPORT ON COUNTY-WIDE GEOGRAPHIC RECLASSIFICATION

Current law

No provision.

Explanation of provision

The bill requires the Secretary, with input from the Geographic Reclassification Review Board, to study whether PPS rates are an adequate proxy for costs and whether the standard for countywide geographic reclassification needs to be updated or revised. A report on this issue shall be submitted to Congress one year after enactment.

Reason for change

The Committee is concerned that the standard for countywide geographic reclassification might need to be updated or revised and that the proxy factors used in these reclassification determinations might not adequately reflect appropriate costs of certain counties.

Effective date

Report to Congress is due one year after enactment.

C. TITLE II—PROVISIONS RELATING TO PART B ONLY

Subtitle A—Hospital Outpatient Department Services

A. SECTION 201. MULTIYEAR TRANSITION TO PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

Current law

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

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

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

Explanation of provision

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

The bill also exempts certain rural hospitals and cancer hospitals from the hospital outpatient prospective payment systems. The Committee notes that nothing in this section shall be construed as affecting the scheduled reduction in beneficiary coinsurance, as set forth in the BBA.

Reason for change

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

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

Effective date

Upon enactment.

B. SECTION 202. STUDY AND REPORT TO CONGRESS REGARDING THE INCLUSION OF RURAL AND CANCER HOSPITALS IN PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

Current law

No provision.

Explanation of provision

The bill would require the Medicare Payment Advisory Commission to prepare a report for Congress within 2 years of enactment regarding the feasibility and advisability of including cancer hospitals and rural hospitals in the outpatient prospective payment system. The bill also requires the Secretary to comment on the findings and conclusions of the Commission within sixty days.

Reason for change

Although the bill protects cancer and rural hospitals from the impact of the hospital outpatient prospective payment system on a

permanent basis, this provision requires the MedPAC to consider whether this protection is warranted over time and should be maintained. The bill also requires the Secretary to comment on this report.

Further, although the Committee intended to protect SCH and MDH providers from the severe reductions in Medicare revenue predicted to result from the proposed prospective payment system for outpatient departments, the Committee remains concerned that some small, low-volume hospitals not included in these classifications may face financial difficulty under the new system. Accordingly, the Committee directs MedPAC to also consider the impact of the proposed outpatient PPS on hospitals with less than 50 beds and less than 5,000 Medicare outpatient procedures per year.

Effective date

Upon enactment.

C. SECTION 203. TRANSITION PROVISIONS FOR DRUGS, BIOLOGICALS AND DEVICES IN THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENTS

Current law

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

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

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

Explanation of provision

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

The hospital outpatient PPS outlier policy is modeled after the inpatient PPS outlier policy. With regard to the inpatient PPS outlier policy, the Committee directs HCFA to comply with section 1886(d)(5)(A) of the Social Security Act for all prior fiscal years

with respect to cost reports which have been appealed or are subject to reopening. Section 1886(D)(5)(A) requires the Secretary to pay hospitals under Medicare an additional amount for their costlier, sicklier patients and directs that actual outlier payments are to be between 5 and 6 percent of total projected DRG payments for each fiscal year. HCFA paid outliers at less than the statutorily mandated 5% minimum for eight fiscal years and paid outliers at more than the 6% maximum for two years, with the underpayments totaling substantially more than the overpayments. The Committee is concerned that HCFA has failed to implement Congress' intent that not less than 5 percent but not more than 6 percent of total DRG payments in fact be paid as outlier payments.

The bill also provides for transitional payments to cover the add-on costs of certain services involving the use of medical devices, drugs and biologicals. For three years after implementation of the outpatient PPS, orphan drugs, drugs and biological used in cancer therapy, medical devices, drugs and biologicals which were not paid as hospital outpatient services in 1996 base year are eligible for these payments. It is the intent of the Committee that biophosphonates should be included in those cancer therapies covered under this provision. The transitional payments are made for a period of at least two years but not more than three years.

Prior to applying any limitations to the additional payment, the amount of the add-on must equal the amount for the new technology less the average cost included in the outpatient payment schedule for the existing technology. Specifically, for new drugs and biologicals, the amount of the additional payment is the amount by which 95 percent of the Average Wholesale Price (AWP) exceeds the portion of the applicable OPD fee schedule amount that the Secretary determines is associated with the drug or biological. For new medical devices, the add-on payment is that amount by which the hospital's charges for the device, adjusted to cost, exceed the OPD fee schedule amount associated with the device. New technology is defined in the bill to include devices, drugs, and biologicals for which Medicare payment was not being made as of December 31, 1996. The Committee also expects that the Secretary would also take the measures necessary to ensure that drugs, devices, and technology, including implantable radiological devices, that were paid as outpatient services in 1996 but for which sufficient costs and utilization data are not available will also be adequately paid under the new payment system.

In addition, the Committee understands that the Secretary is committed to creating separate payment categories for blood, blood products, and plasma-based and recombinant therapies. The Committee applauds these efforts but continues to be concerned that inadequate payment for these products and therapies could represent a barrier to patient access. Accordingly, the Committee expects the Secretary to carefully analyze potential patient access issues and create sufficient payment categories to adequately differentiate these products. Further, in classifying drugs and biologicals into payment categories, the Committee expects that consideration will be given to products that are therapeutically equivalent.

The total amount of additional payments in a year should not exceed a prescribed percentage of total projected payments under the

outpatient prospective payment system. The percentage is established at 2.5 percent for the first three years after implementation of the new outpatient payment system and up to 2.0 percent in subsequent years.

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

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

The Committee is supportive of the bipartisan effort to establish a five-year demonstration project to provide coverage of routine patient costs for Medicare beneficiaries who are enrolled in an approved cancer clinical trail. A majority of the members of the Senate Committee on Finance have cosponsored S. 784, the "Cancer Clinical Trials Coverage Act," sponsored by Senators John D. Rockefeller and Connie Mack. The demonstration project would provide coverage for items and services that would otherwise be covered under the Medicare program, are provided in connection with an approved clinical trail program. The demonstration program would not provide coverage for the provision of the investigational drug or device unless authorized by the Secretary of Health and Human Services or any item or service supplied without charge by the sponsor of the approved cancer clinical trail. The Committee believes this proposed demonstration project has great potential to improve the quality of life for Medicare beneficiaries with cancer as well as to advance our scientific knowledge of the treatment of cancer. The Committee believes this demonstration project is an important item to include in future legislation to modernize and strengthen the Medicare program.

With regard to Ambulatory Surgical Centers (ASCs), the Committee is concerned with HCFA's use of 1994 survey data. The Committee urges the secretary to update the survey data before implementation of the ASC prospective payment system, scheduled for July, 2000.

Reason for change

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

The legislation also creates an outlier payment for hospitals so they can offer the newest technology to patients without taking a

financial loss. In addition, there is an exemption from the prospective payment system (PPS) for certain medical devices, drugs and biologics so that both hospitals and suppliers are not losing money when providing the newest technology, orphan drugs, and cancer drugs to patients.

Effective date

Upon enactment.

2. Subtitle B. Physician's Services

A. SECTION 221. TECHNICAL AMENDMENT TO UPDATE ADJUSTMENT FACTOR AND PHYSICIAN SUSTAINABLE GROWTH RATE

Current law

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

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

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

Explanation of provision

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

factor and thereby make annual adjustments in the conversion factor less severe.

The subsection includes language requiring the Secretary to develop CY 1999 allowed expenditure targets based on current law so that a budget-neutral transition to the revised system can begin in CY 2000. The subsection also clarifies that the Secretary is to publish annual updates to the conversion factor on November 1st, while adding a new requirement that an early estimate of such conversion factor be made available by March 1st of each year. The committee believes that this directive can be accomplished by posting the information electronically, for example on the HCFA internet website. In addition, MedPAC is instructed to review this early estimate and comment on it in its annual report to Congress. The subsection also includes conforming technical amendments.

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

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

Reason for change

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

The Committee is concerned that the Health Care Financing Administration has not yet made substantive progress on the annual refinement of practice expenses required by the Balanced Budget Act. In particular, HCFA has not yet initiated a process of gathering additional data on expenses incurred by specialities underrepresented in the AMA data used to determine practice expenses by specialty. Further, a HCFA proposal to delete from practice expense allocations the costs of physician staff who assist in hospitals appear to violate the directive of the BBA that practice expense re-

imbursement recognize all costs incurred. The Committee concurs with the recommendation of MedPAC that HCFA should gather additional information on the use of physician staff in hospitals and make policy decisions only after examining all relevant information.

Effective date

Upon enactment.

D. TITLE III—PROVISIONS RELATING TO PARTS A AND B

1. Subtitle A—Home Health Services

A. SECTION 301. DELAY IN THE 15 PERCENT REDUCTION IN PAYMENTS UNDER THE PPS FOR HOME HEALTH SERVICE

Current law

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

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

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

Explanation of provision

This provision would repeal the scheduled 15% reduction in per beneficiary and per visit limits and would require that the 15% reduction be implemented simultaneously with the new prospective payment system.

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

Reason for change

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

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

Effective date

Upon enactment.

B. SECTION 302. INCREASE IN PER VISIT LIMIT

Current law

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

Explanation of provision

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

Reason for change

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

Effective date

October 1, 1999.

C. SECTION 303. INCREASE PER BENEFICIARY LIMITS FOR HOME HEALTH AGENCIES

Current law

Under the interim payment system that BBA implemented temporarily until the home health prospective payment system is implemented, home health agencies receive payments from Medicare that are the least of three amounts: (1) the agency's reasonable costs; (2) aggregate payments determined under limits per visit set at 105% of the national median cost per visit (the bill would increase it to 112%); or (3) aggregate payments under a formula based on average payments per beneficiary. About one-fifth of agencies receive payments under the per visit limit and the remainder receive payments under the per beneficiary formula. The per beneficiary aggregate limit does not restrict the amount a home health agency can spend on any individual, it is simply a technique for arriving at an aggregate budget amount for an agency's Medicare patients. For long-standing home health agencies, the per beneficiary limit is derived from the average payment the agency received for Medicare beneficiaries in fiscal year 1994 (with certain updates and adjustments); for newer agencies the per beneficiary limit is the median of the limits applied to other agencies. The average annual per beneficiary limit is approximately $3,800 but ranges up and down by about $1,200.

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

Explanation of provision

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

Reason for change

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

Effective date

Upon enactment.

D. SECTION 304. ELIMINATION OF 15-MINUTE BILLING REQUIREMENT

Current law

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

Explanation of provision

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

Reason for change

The 15-minute reporting requirement was established to collect data in the event that a coding system based on the amount of time a home health provider spent with a beneficiary was developed.

However, with the establishment and pending implementation of the proposed prospective payment system, there is no longer a need for the collection of this data.

Effective date

Upon enactment.

E. SECTION 305. REFINEMENT OF HOME HEALTH AGENCY CONSOLIDATED BILLING

Current law

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

Explanation of provision

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

Reason for change

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

Effective date

Upon enactment.

F. SECTION 306. STUDY AND REPORT TO CONGRESS REGARDING THE EXEMPTION OF RURAL AGENCIES AND POPULATIONS FROM INCLUSION IN THE HOME HEALTH PROSPECTIVE PAYMENT SYSTEM

Current law

No provision.

Explanation of provision

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

Reason for change

Concern has been cited that BBA changes in home health care services, and that the establishment of a prospective payment system, will create undue hardships on rural home health providers. This provision seeks to determine the effects of the prospective payment system on those providers and advise Congress on whether these providers or populations should be exempt from the home health prospective payment system.

Effective date

Upon enactment.

G. SECTION 307. EXTEND PERIODIC INTERIM PAYMENTS TO HOME HEALTH AGENCIES

Current law

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

Explanation of provision

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

Reason for change

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

Effective date

Upon enactment.

2. Subtitle B—Graduate Medical Education

A. SECTION 321. REVISION OF MULTI-YEAR REDUCTIONS OF INDIRECT GRADUATE MEDICAL EDUCATION PAYMENTS

Current law

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

Explanation of provision

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

Reason for change

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

The Committee recognizes the contributions of independent children's hospitals and academic medical centers in training this country's pediatricians and pediatric specialists and for their contributions to pediatric medical research. These institutions train nearly 30 percent of pediatric specialists and play a vital role in de-

livering health care in the communities in which they are located. These institutions, despite their contributions to medicine and society, receive very little Federal Graduate Medical Education (GME) financial support, because they have very few Medicare patients. The Committee believes the lack of Federal GME support should be addressed. Although the narrow scope of the Medicare, Medicaid, and S–CHIP Adjustment Act does not afford the opportunity, the Committee is committed to holding hearings and taking action to address this problem in the coming year and urges the earliest possible consideration of this issue in Congress. The Committee intends to move forward to assure that contributions from freestanding pediatric hospitals are equitably recognized and supported.

Further, the Committee is encouraged by HCFA's efforts to begin making GME payments to institutions involved in the training of cliental psychologists. The committee urges the Agency to implement this change as soon as possible.

Effective date

October 1, 1999.

B. SECTION 322. GRADUATE MEDICAL EDUCATION RESIDENT LIMITATION EXCEPTION

Current law

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

Explanation of provision

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

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

Reason for change

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

Effective date

As if included in the Balanced Budget Act of 1997.

E. TITLE IV—RURAL INITIATIVES

A. SECTION 401. SOLE COMMUNITY HOSPITALS AND MEDICARE DEPENDENT HOSPITALS

Current law

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

Explanation of provision

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

Reason for change

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

Effective date

Effective October 1, 1999.

B. SECTION 402. REVISION OF CRITERIA FOR DESIGNATION AS A CRITICAL ACCESS HOSPITAL

Current law

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

Explanation of provision

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

Reason for change

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

Effective date

Effective October 1, 1999.

C. SECTION 403. MEDICARE WAIVERS FOR PROVIDERS IN RURAL AREAS

Current law

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

Explanation of provision

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

Reason for change

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

Effective date

Upon enactment.

D. SECTION 404. EXTENDING MEDICARE DEPENDENT HOSPITALS

Current law

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

Explanation of provision

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

Reason for change

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

The Committee also wishes to express its intent to expand telemedicine services to all Medicare-covered services and all rural areas. The Health Care Financing Administration and the Department of Health and Human Services are directed to work together to produce timely analyses and cost estimates of proposals to meet the aforementioned objectives. It is also essential to sustain key projects where the federal government has made a substantial investment in infrastructure but has yet to authorize any substantial Medicare payments for the use of this equipment.

Effective date

As if included in the Balanced Budget Act of 1997.

E. SECTION 405. ASSISTING RURAL GRADUATE MEDICAL EDUCATION RESIDENCY PROGRAMS

Current law

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

Explanation of provision

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

Reason for change

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

Effective date

As if included in the Balanced Budget Act of 1997.

F. TITLE V—PROVISIONS RELATING TO PART C

1. Subtitle A—Provisions to Accommodate and Protect Medicare Beneficiaries

A. SECTION 501. PERMITTING ENROLLMENT IN ALTERNATIVE MEDICARE+CHOICE PLANS AND MEDIGAP COVERAGE IN CASE OF INVOLUNTARY TERMINATION OF MEDICARE ENROLLMENT

Current law

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

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

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

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

Explanation of provision

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

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

Reason for change

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

Effective date

Upon enactment.

B. SECTION 502. CHANGE IN EFFECTIVE DATE OF ELECTIONS

Current law

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

Explanation of provision

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

Reason for change

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

Effective date

Upon enactment.

C. SECTION 503. EXTENSION OF REASONABLE COST CONTRACTS

Current law

Prior to enactment of BBA 97, beneficiaries were able to enroll in risk-based health maintenance organizations (HMOs). They could also enroll in organizations with cost contracts. These entities were required to meet essentially the same conditions of participation as risk contractors. Under a cost contract, Medicare pays the actual cost the entity incurs in furnishing covered services.

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

Explanation of provision

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

Reason for change

There are a small number of pre-BBA "cost contracts" that are scheduled to expire in 2002. This provision would allow these plans another two years of operation. This provision would allow both the

beneficiaries and the plans additional time to transition to the Medicare+Choice program.

Effective date

Upon enactment

D. SECTION 504. REVISION OF NOTICE BY HOSPITALS REGARDING COVERAGE OF INPATIENT HOSPITAL SERVICES

Current law

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

Explanation of provision

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

Reason for change

This provision would have the traditional fee-for-service program operate under the same rules as the Medicare+Choice program in informing beneficiaries of their rights to appeal when being discharged from the hospital, creating a "level playing field" between the traditional program and the Medicare+Choice plans. This would also ensure that all beneficiaries are informed of their appeal rights. HCFA is more than willing to implement this change, but requires statutory authority to proceed.

Effective date

Upon enactment.

E. SECTION 505. EXTENDED MEDICARE+CHOICE DISENROLLMENT WINDOW FOR CERTAIN INVOLUNTARILY TERMINATED ENROLLEES

Current law

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

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

Explanation of provision

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

Reason for change

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

Effective date

Upon enactment.

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

A. SECTION 521. MODERATION OF MEDICARE+CHOICE RISK ADJUSTMENT IMPLEMENTATION

Present law

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

Explanation of provision

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

PROPOSED MODIFICATIONS TO THE RISK ADJUSTMENT OF MEDICARE+CHOICE PAYMENTS

Year	Current HCFA proposal (percent)	Proposed modification (percent)	Type of risk adjuster
2000	10	10	inpatient only
2001	30	10	inpatient only
2002	55	20	inpatient only
2003	80	30	inpatient only
2004	100	55	inpatient and outpatient [1]
2005	100	80	inpatient and outpatient [2]
2006	100	100	inpatient and outpatient [3]

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

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

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

In 2004, the Committee anticipates that HCFA will be prepared to implement a risk adjustment system based on data from both inpatient and ambulatory settings. The Committee intends to ease the transition to a risk adjustment method based on ambulatory data by phasing in the new method and phasing out the old method (based only on inpatient data). This process will take place between 2004 and 2006.

Reason for change

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

Effective date

Upon enactment.

B. SECTION 522. DELAY IN DEADLINE SUBMISSION OF ADJUSTED COMMUNITY RATES UNDER MEDICARE+CHOICE PROGRAM AND RELATED MODIFICATIONS

Current law

BBA 97 required Medicare+Choice plans to submit adjusted community rate (ACR) proposals by May 1 of the year prior to the actual contract year. Medicare+Choice organizations are required to submit ACR proposals to show that the benefit packages they plan to market neither exceed cost sharing for traditional Medicare plans or unfairly charge enrollees for additional benefits.

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

Explanation of provision

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

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

Reason for change

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

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

Effective date

Upon enactment.

C. SECTION 523. USER FEE FOR MEDICARE+CHOICE ORGANIZATIONS BASED ON THE NUMBER OF ENROLLED BENEFICIARIES

Current law

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

Explanation of provision

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

Reason for change

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

Effective date

October 1, 1999.

D. SECTION 524. CHANGE IN TIME PERIOD FOR EXCLUSION OF MEDICARE+CHOICE ORGANIZATIONS THAT HAVE HAD A CONTRACT TERMINATED

Current law

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

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

Explanation of provision

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

Reason for change

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

Effective date

Contract years beginning January 1, 1999.

E. SECTION 525. FLEXIBILITY TO TAILOR BENEFITS UNDER MEDICARE+CHOICE PLANS

Current law

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

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

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

Explanation of provision

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

Reason for change

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

The Committee is concerned about allegations that Medicare beneficiaries enrolled in the Medicare+Choice program are being denied access to chiropractic services, provided by a doctor of chiropractic. It was the clear intent of Congress, and especially this Committee, that beneficiaries enrolled in the Medicare+Choice program have access to the same covered medical services available to all beneficiaries under Part B.

Therefore, the Committee would like to clarify its intent that pursuant to the 1997 Balanced Budget Act, individuals enrolled in a Medicare+Choice plan under Medicare part C have access to covered chiropractic services, i.e., treatment by means of manual manipulation of the spine to correct a subluxation, as are available to beneficiaries under Medicare Part B.

Effective date

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

F. SECTION 526. IN APPLICABILITY OF QISMC TO PREFERRED PROVIDER ORGANIZATIONS

Current law

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

Explanation of provision

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

Reason for change

Preferred Provider Organizations (PPO) in many ways operate more like a fee-for-service plan than a health maintenance organization. Standards developed for HMOs appear to have discouraged

the entry of PPO plans into the Medicare-Choice system, because these standards are incompatible with the financing and delivery model of PPOs. This change would hold PPO plans to the same standards as the fee-for-service program, rather than those used for HMOs.

Effective date

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

G. SECTION 527. TIMING OF MEDICARE+CHOICE HEALTH INFORMATION FAIRS

Current law

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

Explanation of provision

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

Reason for change

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

Effective date

Upon enactment.

H. SECTION 528. RULES REGARDING PHYSICIAN REFERRALS FOR MEDICARE+CHOICE PROGRAM

Current law

The law establishes a ban on certain financial arrangements between a referring physician and an entity. Specifically, if a physician (or immediate family member) has an ownership or investment interest in or a compensation arrangement with an entity, the physician is prohibited from making a referral to the entity for services for which Medicare would otherwise pay. Current law provides an exception to both the ownership and compensation arrangement prohibitions for services provided by an organization with a contract under section 1876.

Explanation of provision

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

Reason for change

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

Effective date

Upon enactment.

I. SECTION 529. CLARIFICATION REGARDING THE ABILITY OF A RELIGIOUS FRATERNAL BENEFIT ORGANIZATION TO OPERATE A MEDICARE+CHOICE PRIVATE FEE-FOR-SERVICE PLAN

Current law

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

Explanation of provision

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

Reason for change

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

Effective date

Contract years beginning on or after enactment.

3. Subtitle C—Provisions Regarding Special Medicare Populations

A. SECTION 541. EXTENSION OF SOCIAL HEALTH MAINTENANCE ORGANIZATION DEMONSTRATION PROJECT AUTHORITY

Current law

The Deficit Reduction Act of 1984 required the Secretary of HHS to grant 3-year waivers for demonstrations of social health maintenance organizations (SHMOs) which provide integrated health and long-term care services on a prepaid capitation basis. The waivers have been extended on several occasions since then, and a second generation of projects was authorized by the Omnibus Budget Reconciliation Act of 1990.

The BBA 97 extended waivers for social health maintenance organizations through December 31, 2000, and expanded the number of persons who can be served per site from 12,000 to 36,000.

Explanation of provision

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

Reason for change

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

Effective date

Upon enactment.

B. SECTION 542. INAPPLICABILITY OF OASIS TO PACE

Current law

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

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

Explanation of provision

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

Reason for change

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

Effective date

Upon enactment.

C. SECTION 543. MEDIGAP PROTECTIONS FOR PACE PROGRAM ENROLLEES

Current law

The law guarantees issuance of specified Medigap policies (without an exclusion based on a pre-existing condition) for certain persons. Guaranteed issued protections extend to certain persons who elect to try one of the options available under the Medicare+Choice program. An individual is guaranteed issuance of the Medigap policy in which he or she was previously enrolled if the individual ter-

minated enrollment in a Medigap policy, enrolled in a Medicare+Choice organization, and then terminated such enrollment within 12 months. The guarantee only applies if the individual was never previously enrolled in a Medicare+Choice plan.

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

Explanation of provision

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

Reason for change

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

Effective date

Terminations or discontinuances on or after date of enactment.

D. SECTION 544. CONTINUATION OF THE FRAIL ELDERLY DEMONSTRATION PROJECT

Current law

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

Explanation of provision

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

Importantly the Committee does not intend for these provisions to apply to non-demonstration EverCare sits the operate based on a subcontract arrangement with a Medicare+Choice plan.

Reason for change

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

Effective date

Upon enactment.

4. Subtitle D—Studies and Reports To Assist in Making Future Improvement in the Medicare Program

A. SECTION 561. GAO STUDIES, AUDITS AND REPORTS

Current law

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

Explanation of provision

The bill would require GAO to conduct a study on Medigap policies. The report would include a study of: (1) the level of coverage provided by each type of Medigap policy; (2) the current enrollment levels in each type of policy; (3) the availability of each type of policy to persons over age 65½; (4) the number of states that offer each type of policy; and (5) the average out-of-pocket costs (including premiums) per beneficiary under each type of policy.

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

Reason for change

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

In the past, questions have been raised about the adequacy and effectiveness of the information HHS provides beneficiaries on their coverage options under both Medicare+Choice and the traditional fee-for-service plans. This provision asks GAO to audit this activity and report on the effectiveness of the program every 3 years. This information is provided to the Congress to help improve the information process.

Effective date

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

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

B. SECTION 562. MEDICARE PAYMENT ADVISORY COMMISSION STUDIES AND REPORTS

Current law

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

Explanation of provision

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

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

Reason for change

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

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

Effective dates

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

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

C. SECTION 563. COMPUTATION AND REPORT ON MEDICARE ORIGINAL FEE-FOR-SERVICE EXPENDITURE ON AN COUNTY-BY-COUNTY BASIS

Current law

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

The Secretary is not required to publish original fee-for-service expenditures on a county-by-county basis. These data comprise adjusted average per-capita cost (AAPCC) data. AAPCCs formed the basis of payments to managed care plans prior to enactment of BBA 97, and represented the costs of providing Medicare benefits to beneficiaries under the original fee-for-service program under parts A and B in each county nationwide. Because M+C payments are not longer directly tied to a payment areas's fee-for-service costs, APCCs have not been published.

Explanation of provision

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

Reason for change

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

Effective date

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

D. SECTION 564. STUDY AND REPORT ON THE EFFECTS COSTS, AND FEASIBILITY OF REQUIRING MEDICARE ORIGINAL FEE-FOR-SERVICE ENTITIES AND MEDICARE+CHOICE COORDINATED CARE PLANS TO COMPLY WITH UNIFORM QUALITY STANDARDS AND RELATED REPORTING REQUIREMENTS

Current law

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

Explanation of provision

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

Reasons for change

As quality has become more of an issue in the Medicare program, the primary emphasis has been on the HMOs. This study would provide analysis to help look beyond HMOs, to both the traditional fee-for-service program, as well as other types of plans that became possible as a result of the BBA, (e.g., preferred provider organizations, or point-of-service plans).

Effective date

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

E. SECTION 565. STUDY AND REPORT TO CONGRESS REGARDING DATA SUBMISSION USED TO ESTABLISH RISK ADJUSTMENT METHODOLOGY UNDER THE MEDICARE+CHOICE PROGRAM

Current law

No provision.

Explanation of provision

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

Reason for change

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

Given the amount of controversy surrounding the use of risk adjusters, it is important that the process be open and understood.

Effective date

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

G. TITLE VI. OTHER MEDICARE PROVISIONS

1. SECTION 601. MORATORIUM ON THERAPY SERVICES PAYMENT LIMITS

Current law

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

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

The Secretary is required to report to Congress by January 1, 2001, on recommendations for establishing a revised payment policy based on classification of individuals by diagnostic coverage groups.

Explanation of provision

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

Reason for change

The current $1,500 cap is an arbitrary amount. Moreover, the cap does not allow flexibility for the needs of a particular beneficiary. This proposal is intended to provide targeted relief until the Secretary reports on a more appropriate long-term policy with regard to outpatient therapy services.

Effective date

January 1, 2000.

2. SECTION 602. INCREASE IN PAYMENT AMOUNT FOR RENAL DIALYSIS SERVICES FURNISHED UNDER THE MEDICARE PROGRAM

Current law

Dialysis facilities providing care to beneficiaries with end-stage renal disease (ESRD) receive a fixed prospective payment amount for each dialysis treatment. This composite rate also includes payment for tests, services, drugs and supplies routinely required for dialysis treatment. The base composite rate for hospital-based providers is $126 and for free-standing facilities, it is $122. P.L. 101–508 required that the composite payment rate to dialysis facilities

be increased by $1 above the rate that was in effect as of September 30, 1990. The composite rate has not been changed since then.

Explanation of provision

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

Reason for change

The prospective payment, or composite rate, paid to dialysis facilities for each dialysis treatment they provide to Medicare beneficiaries has remained essentially unchanged since 1983. MedPAC reports that costs have risen in relation to the composite rate in recent years and has recommended that the rate be increased.

Effective date

Services furnished on or after October 1, 2000.

3. SECTION 603. PAP SMEARS

Current law

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

Explanation of provision

The bill directs the Secretary to establish a minimum payment amount of $14.60 for pap smear laboratory tests, including all cervical cancer screening technologies approved by the FDA, for a period of two years. During that time, the Committee expects to receive a report, mandated through the BBA, to establish a more appropriate long-term payment policy for clinical lab services.

Reason for change

Through the BBA, Congress emphasized the importance of preventive benefits, including pap smears, for Medicare beneficiaries. Yet, the current $7.15 reimbursement rate for pap smears is far below the national median cost of $14.60.

Effective date

January 1, 2000.

4. SECTION 604. DISPROPORTIONATE SHARE HOSPITALS

Current law

Medicare makes additional payments to hospitals that serve a disproportionate share of low income Medicare and Medicaid patients. BBA 97 reduced the disproportionate share hospital (DSH)

payment formula by 1% in FY 1998; 2% in FY 1999; 3% in FY 2000; 4% in FY 2001; 5% in FY 2002 and 0% in FY 2003 and in each subsequent year.

Explanation of provision

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

Reason for change

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

The Committee notes that in the final rule for FY 2000 changes to the hospital inpatient prospective payment system that were published in the Federal Register on July 30, 1999, the Secretary decided not to adopt refinements to the special exceptions process for capital payments. The Committee expects that appropriate changes in payment policy will be made in the fiscal year 2001 rule-making process to more adequately address problems arising from the transition to capital prospective payment for large capital projects of 450 beds or more begun during the transition by establishing a minimum payment floor equal to that provided to "old capital" without offsetting reductions; a graduated disproportionate share requirement; and, for public hospital projects, an extended placed-in-service date.

Effective date

Effective for payments made in FY 2000.

5. SECTION 605. CLARIFICATION OF THE INHERENT REASONABLENESS (IR) AUTHORITY

Current law

The BBA 97 provided the Secretary of HHS with enhanced authority to adjust Medicare Part B payment levels when those payments are not found to be "inherently reasonable." HCFA has proposed through its durable medical equipment regional carriers (DMERCs), applying the new inherent reasonableness authority to a variety of medical equipment items. HCFA promulgated its new IR authority via an interim final rule rather than a proposed rule with traditional notice and comment period.

Explanation of provision

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

Reasons for change

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

Effective

Upon enactment.

6. SECTION 606. TECHNICAL AMENDMENTS RELATING TO BBA PROVISIONS

A. Medicare Rural Hospital Flexibility Program

Current law

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

Explanation of provision

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

Reason for change

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

Effective date

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

B. Rural health clinic services

Current law

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

Explanation of provision

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

Reason for change

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

Effective date

As if included in the Balanced Budget Act of 1997.

C. PPS hospital payment update for temporary relief hospitals

Current law

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

Explanation of provision

This legislation would correct the reference.

Reason for change

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

Effective date

As if included in the Balanced Budget Act of 1997.

D. Maintaining savings from temporary reduction in capital payments for PPS hospitals

Current law

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

Explanation of provision

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

Reason for change

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

Effective date

As if included in the Balanced Budget Act of 1997.

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

Current law

The BBA 97 requires that the SNF prospective payment system be phased in over 3 years starting July 1, 1998, or the first date thereafter on which a SNF started a new annual cost reporting pe-

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

The current law requires that administrative and judicial review of facility specific rates not be permitted for SNFs with cost reporting periods starting before January 1, 1999.

Explanation of provision

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

Reason for change

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

Effective date

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

F. Transfer of criminal fines recovered in a Federal health care offense

Current law

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

Explanation of provision

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

Reason for change

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

Effective date

Effective as if included in the HIPPA.

G. Medicare Payments to newly established PPS exempt providers

Current law

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

Explanation of provision

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

Reason for change

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

Effective date

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

7. SECTION 607. EXCLUSION FROM PAYGO SCORECARD

Current law

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

Explanation of provision

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

Reason for change

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

Effective date

Upon enactment.

H. Title VII—Provisions Relating to Medicaid and Chip

1. SECTION 701. MEDICAID-RELATED BBA TECHNICALS

A. Cross Reference Corrections

Current law

No provision.

Explanation of provision

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

Reason for change

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

Effective date

Upon enactment.

B. Elimination of duplicative requirements for external quality review of Medicaid managed care organizations

Current law

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

Explanation of provision

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

Reason for change

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

Effective date

Effective when the Secretary of Health and Human Services certifies to Congress that it is fully implementing section 1932(c)(2) of the Social Security Act.

C. Making enhanced match under CHIP Program inapplicable to Medicaid DSH payments

Current law

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

Explanation of provision

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

Reason for change

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

Effective date

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

D. Making deferment of the effective date for outpatient drug agreements optional for States

Current law

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

Explanation of provision

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

Reason for change

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

Effective date

Upon enactment.

2. SECTION 702. INCREASE IN DISPROPORTIONATE SHARE HOSPITAL ALLOTMENT FOR CERTAIN STATES AND THE DISTRICT OF COLUMBIA

Current law

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

Explanation of provision

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

Reason for change

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

Effective date

Retroactive to October 1, 1999.

3. SECTION 703. MAKING MEDICAID DSH TRANSITION RULE PERMANENT

Current law

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

Explanation of provision

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

Reason for change

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

Effective date

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

4. SECTION 704. INCREASED ALLOTMENTS FOR TERRITORIES UNDER THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Current law

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

Explanation of provision

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

Reason for change

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

Effective date

Upon enactment.

5. SECTION 705. REMOVAL OF FISCAL YEAR LIMITATION ON CERTAIN TRANSITIONAL ADMINISTRATIVE COSTS ASSISTANCE

Current law

The Personal Welfare and Responsibility Act of 1996 replaced the Aid to Families with Dependent Children (AFDC) program and established the Temporary Assistance for Needy Families (TANF) program. Under the old program, people who qualified for AFDC were automatically eligible for Medicaid. Welfare reform de-linked Medicaid and TANF eligibility. Further, it provided states with a great deal more flexibility in designing welfare benefits and eligibility rules. Concerned that state Medicaid programs would face large new administrative costs for conducting Medicaid eligibility determinations that would otherwise not have occurred, Congress

established a fund of $500 million to assist with the transitional costs of the new dual eligibility activities. The funds are available at an increased federal matching rates for states that can demonstrate to the satisfaction of the Secretary that such additional administrative costs were attributable to welfare reform. The increased matching funds are available for the period beginning with fiscal year 1997 and ending with fiscal year 2000 and must relate to costs incurred during the first 12 quarters following the welfare reform effective date.

Explanation of provision

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

Reason for change

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

Effective date

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

6. SECTION 706. STABILIZATION OF CHIP ALLOTMENT FORMULA

Current law

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

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

Explanation of provision

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

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

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

Reason for change

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

Effective date

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

7. SECTION 707. CHIP DATA AND EVALUATION IMPROVEMENT ACT OF 1999

A. Funding for reliable annual State-by-State estimates on the number of children who do not have health insurance coverage

Current law

No provision.

Explanation of provision

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

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

Reason for change

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

Effective date

Upon enactment.

B. Funding for children's health care access and utilization State-by-State data

Current law

No provision.

Explanation of provision

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

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

Reason for change

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

Effective date

Upon enactment.

C. Federal evaluation of State children's health insurance programs

Current law

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

Explanation of provision

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

Reason for change

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

Effective date

Upon enactment.

D. Inspector general audit and GAO report on enrollees eligible for Medicaid

Current law

No provision.

Explanation of provision

The Committee provision requires that the Inspector General of the Department of Health and Human Services conduct an audit to determine how many Medicaid-eligible children are incorrectly enrolled in CHIP among a sample of States that provide child

health assistance through separate programs only (not via a Medicaid expansion). This audit will also assess progress in reducing the number of uninsured children relative to the goals stated in approved CHIP plans. The first such audit will be conducted in FY–2000, and will be repeated every third fiscal year thereafter. In addition, this provision requires GAO to monitor these audits and report their results to Congress within six months of audit completion (i.e., by March 1 of the fiscal year following each audit).

Reason for change

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

Effective date

Upon enactment.

E. Coordination of data collection with data requirements under the maternal and child health services block grant

Current law

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

Explanation of provision

The Committee provision would add to the existing reporting requirement under the MCH Block Grant authority inclusion of information (by racial and ethnic group) on the number of deliveries to pregnant women entitled to benefits under CHIP, and the number of infants under age one year entitled to CHIP benefits.

Reason for change

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

Effective date

Upon enactment.

F. Coordination of data surveys and reports

Current law

No provision.

Explanation of provision

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

Reason for change

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

Effective date

Upon enactment.

8. SECTION 708. GRANTS FOR FEDERALLY-QUALIFIED HEALTH CENTER SERVICES AND RURAL HEALTH CLINIC SERVICES UNDER THE MEDICAID PROGRAM

Current law

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

Explanation of provision

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

Reason for change

The provision is intended to encourage the maintenance of pre-Balanced Budget Act of 1997 reimbursement levels and make addi-

tional funds available to clinics for use in providing services to uninsured individuals.

It is the Committee's intent that the new grant program will contribute toward our shared goal of preserving the viability of community health centers and rural health clinics as important components of the health care safety net. Both the centers and clinics have a patient mix unlike that of other providers—with 35 percent of their patients on Medicaid—and as a result, are move vulnerable to Medicaid revenue losses than other providers. In the case of the health centers, which are statutorily mandated and funded by Congress to care for growing numbers of uninsured, more than 40-percent of their 11 million patients have no health insurance. If states do not respond to the new grant program, many health centers and clinics could find that their ability to care for low-income people in their communities will be compromised. The Committee intends to monitor this situation closely and, if evidence shows that the centers and clinics and the populations they serve are impacted negatively by state reimbursement policy decisions, the Committee will consider other legislative interventions.

Effect date

Upon enactment.

9. SECTION 709. ADDITIONAL TECHNICAL CORRECTIONS

Current law

No provision.

Explanation of provision

The provision would make technical corrections to Title XIX.

Reason for change

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

Effective date

Upon enactment.

III. BUDGET EFFECTS OF THE BILL

In compliance with paragraph 11(a) of rule XXVI of the Standing Rules of the Senate, and in accordance with section 403 of the Budget Act, the Committee advises that the Congressional Budget Office submitted the following statement on the Medicare, Medicaid, and S–CHIP Adjustment Act of 1999, as amended by the Committee.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washingon, DC, October 26, 1999.

Hon. WILLIAM V. ROTH, Jr. Chairman, Committee on Finance,
Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for the Medicare and Medicaid Balanced Budget Correction and Refinement Act of 1999.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Tom Bradley.

Sincerely,

DAN L. CRIPPEN, *Director.*

Enclosure.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

Summary

The Medicare, Medicaid, and S–CHIP Adjustment Act of 1999 would modify Medicare's payment rates for many services, including those furnished by skilled nursing facilities, home health agencies, hospitals, physicians, hospices, physical and speech therapists, occupational therapists, and managed care plans. The bill also would make changes to both Medicaid and the State Children's Health Insurance Program (S–CHIP). Those changes would include revised allotments to states and territories of funds distributed through S–CHIP and the Medicaid disproportionate share (DSH) program, and a new program of grants to states for services provided by federally qualified health centers and rural health clinics. In addition, the bill includes technical provisions that would have no effect on federal spending.

CBO estimates that the bill would increase federal direct spending by $1.1 billion in fiscal year 2000, by $11.9 billion over the 2000–2004 period, and by a total of $15.7 billion over the 2000–2009 period. Although the bill would increase direct spending, section 607 of the bill specifies that any net deficit increase resulting from enactment shall not be counted for purposes of enforcing the pay-as-you-go procedures established by the Balanced Budget and Emergency Deficit Control Act.

The bill contains no intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). CBO estimates that provisions of the bill affecting Medicaid would result in additional federal and state spending for health programs. The bill contains several private-sector mandates on insurers that provide medigap coverage. CBO estimates that the cost of those mandates would not exceed the threshold specified in UMRA ($100 million in 1996, annually adjusted for inflation).

Estimated cost to the Federal Government

The estimated budgetary impact of this bill is shown in the following table. The costs of this legislation fall within budget functions 550 (health) and 570 (Medicare).

	Outlays, by fiscal year, in billions of dollars—				
	2000	2001	2002	2003	2004
CHANGES IN DIRECT SPENDING					
Medicare:					
Skilled Nursing Facility Provisions	0.3	1.3	0.5	(2)	0
Hospital Outpatient Department Provisions	0.1	0.3	0.3	0.3	0.2
Physician Update	0	0.3	0.1	−0.1	−0.3
Home Health Provisions	0.1	1.8	−0.4	0.1	0
Graduate Medical Education Provisions	0.2	0.5	0.6	0.6	0.1
Rural Provisions	(2)	0.1	0.1	0.1	0.1
Managed Care Provisions	(2)	0.2	0.3	0.5	0.6
Other Provisions	0.2	0.4	0.2	0.1	0.1

	Outlays, by fiscal year, in billions of dollars—				
	2000	2001	2002	2003	2004
Interaction of Fee-for-Service Provisions and Medicare+Choice Payment Rates [1]	0	0.7	0.5	0.3	([2])
Subtotal, Gross Medicare Outlays	1.0	5.6	2.2	1.9	0.9
Part B Premium Receipts	0	−0.3	−0.3	−0.1	([2])
Subtotal, Net Medicare Outlays	1.0	5.3	2.0	1.8	0.9
Medicaid, S–CHIP, and other mandatory health programs	0.1	0.2	0.2	0.1	0.1
Total Changes	1.1	5.6	2.2	2.0	1.0

[1] The effect of changes in per-enrollee spending in the fee-for-service sector on payment rates for enrollees in Medicare+Choice plans.
[2] Costs or savings of less than $50 million.

Notes: S–CHIP is the State Children's Health Insurance Program. Components may not sum to totals because of rounding.

Basis of estimate

Medicare

Compared with spending projected under current law, the bill would increase Medicare outlays by $1.0 billion in fiscal year 2000 and by $11.0 billion over the 2000–2004 period. The following sections discuss changes in gross outlays directly attributable to provisions of the bill. In addition, the estimate includes two interactions: the effect of changes in per-enrollee spending in the fee-for-service sector on payment rates for enrollees in Medicare+Choice plans, and the effect of changes in Medicare Part B outlays on receipts from Part B premiums.

Payment rates for Medicare+Choice plans are based on spending in the fee-for-service sector, so provisions of the bill that increase fee-for-service spending would lead to higher payments to Medicare+Choice plans, beginning in 2001. No interaction with Medicare+Choice payments would occur in 2000 because the rates for 2000 have already been published and will not be adjusted unless services covered by the Medicare program change; the bill would not change covered services. CBO estimates the increase in spending attributable to the interaction between fee-for-service spending and Medicare+Choice payment rates would total $1.6 billion during the 2000–2004 period.

Part B premiums for 2000 have already been announced, and would not be changed by this bill. In subsequent years, however, about 25 percent of new part B outlays would be covered by premium payments by beneficiaries. CBO estimates that those premium payments would total $0.6 billion from 2000 through 2004.

Skilled Nursing Facilities. The bill would amend three policies enacted in the Balanced Budget Act of 1997 (BBA) regarding payment to skilled nursing facilities (SNFs). First, it would increase the federal rates paid for cases assigned to the extensive and special care categories by 25 percent and the federal rates paid for cases assigned to certain rehabilitation categories by a specified dollar amount. Those new rates would apply to services provided from April 1, 2000, through September 30, 2001. Second, it would enable SNFs that participated in the Nursing Home Case Mix and Quality Demonstration to receive an additional payment for Part B services in the facility-specific component of their payment rates. That policy would apply retroactively to services furnished since

the enactment of BBA. Third, for cost-reporting periods beginning after enactment, it would allow SNFs to elect to be paid exclusively under the federal rate, rather than a blend of federal and facility-specific rates. CBO estimates that those three provisions would increase Medicare expenditures by $0.3 billion in 2000 and by $2.1 billion over the 2000–2004 period.

Hospital Outpatient Department Service. The BBA established a prospective payment system (PPS) to replace cost-based reimbursement for most outpatient hospital services. The Secretary of Health and Human Services plans to implement the PPS in July 2000. Some hospitals will experience gains under the PPS—Medicare payments will exceed the cost of providing outpatient services—while other hospitals will experience losses. The bill would limit each hospital's loss during the first three years of the PPS, authorize the reclassification of certain urban hospitals as rural, exempt cancer hospitals and certain rural hospitals from the PPS, and establish outlier adjustment payments for high-cost cases and transitional payments for certain drugs, biologicals, and medical devices under the PPS. CBO estimates that those provisions would increase Medicare expenditures by $0.1 billion in 2000 and by $1.2 billion over the 2000–2004 period.

Physician Update. The BBA established payment formulas that tie the growth of per-enrollee expenditures for physician services to the growth of gross domestic product. Those formulas generate annual rate changes that oscillate widely around a smooth trend. CBO projects stable growth rates, however, because the timing of those oscillations is impossible to predict.

The bill would modify those payment formulas to reduce the oscillations around the smooth trend. CBO estimates the bill would not change spending in 2000 and would not change cumulative spending during the 2000–2004 period. Compared to current law, however, payments to physicians would be higher in 2001 and 2002 and lower in 2003 and 2004.

Home Health. The bill would amend several policies enacted in BBA regarding payment to home health agencies. It would eliminate the contingency reduction and gradually implement the 15-percent cut mandated in BBA by phasing in the reduction for implementing the PPS for home health services at a rate of 5 percent in the first year, 10 percent in the second year, and the full 15 percent in the third year. It would temporarily increase the per-visit limit to 112 percent of the median cost per visit for services furnished after October 1, 1999, and it would temporarily increase the per-beneficiary limits by 1 percent for services provided in cost-reporting periods beginning in 2000. Those increases in the per-visit and per-beneficiary limits would not be reflected in the payment rates set when the PPS is implemented. The bill would also postpone the elimination of periodic interim payments until the year after the PPS is implemented. Those policies would increase Medicare expenditures by $0.1 billion in 2000 and by $1.5 billion over the 2000–2004 period.

Graduate Medical Education. Medicare's PPS for hospital inpatient services adjusts payments for the higher patient care costs associated with medical education. The bill would freeze through 2003 the 1999 adjustment of 6.5 percent for every 0.1 change in the

ratio of residents to beds. The adjustment would then revert to the current-law adjustment of 5.5 percent. CBO estimates that this provision would increase outlays by $0.2 billion in 2000 and by $1.8 billion over the 2000–2004 period.

The bill also would allow exemptions from per-hospital caps on residency positions enacted by the BBA. One exemption would allow a hospital to increase its cap to absorb residents in a training program that had lost accreditation. Other provisions would allow certain hospitals to add three residency positions, as well as making other minor adjustments to the limits. Those provisions would increase spending by less than $50 million a year, with a cumulative increase in spending of $0.1 billion during the 2000–2004 period.

Rural Provisions. Payment rates in the prospective payment system for inpatient services furnished by acute care hospitals are updated annually by a market basket index (MBI) intended to reflect the prices of hospitals' input factors. The BBA mandated reductions from the MBI for payment updates in fiscal years 1998 through 2002. The bill would give hospitals classified as sole community hospitals and as Medicare-dependent small rural hospitals the full market basket increase in their prospective payment rates in fiscal years 2000 through 2002. CBO estimates that granting those hospitals the full MBI update would increase spending by $0.3 billion during the 2000–2004 period.

The BBA created a new classification of limited-service hospitals, called Critical Access Hospitals (CAHs), which are exempted from the PPS. Those hospitals are limited to providing inpatient hospital stays no longer than 96 hours (with case-by-case exceptions). The bill would allow longer inpatient stays in CAHs, provided that stays average 96 hours. CBO assumes that provision would make it more attractive for hospitals that meet the size and geographic eligibility requirements to obtain certification as a CAH, and would increase Medicare outlays by exempting more inpatient stays from the PPS. CBO estimates that this provision would increase Medicare outlays by less than $50 million in 2000 and by $0.1 billion over the 2000–2004 period.

The bill would extend for two years the Medicare-dependent small rural hospital program (which will expire at the end of 2000), and require the Secretary to create a waiver process to permit certain hospitals located in urban areas to be reclassified to obtain higher payment rates available to rural hospitals. We estimate that those provisions would increase spending by $0.1 billion during 2000 through 2004.

Managed Care. The bill would slow the implementation of adjustment of Medicare+Choice payment rates to more accurately reflect differences in cost per enrollee that are associated with health status. CBO estimates that this provision would not change spending in 2000, but would increase Medicare spending by $1.6 billion over the 2000–2004 period.

Other provisions would allow beneficiaries more time to enroll in Medicare+Choice or Medigap plans when plans withdraw from markets, allow cost contracts with health maintenance organizations to be renewed until December 31, 2004, make the administration of the Medicare+Choice program more flexible, and ease cer-

tain requirements that limit how potential providers design and market managed care products to offer to Medicare beneficiaries. In addition, the bill would modify and extend a number of demonstration projects. We estimate that those provisions would increase Medicare spending by $0.1 billion during 2000 through 2004.

Other Medicare Provisions. The bill includes numerous other modifications of Medicare law that are either technical in nature—that is, they have no effect on federal spending—or would result in relatively small changes in Medicare spending. The additional provisions that would affect Medicare spending are discussed below. In total, CBO estimates that these other provisions would increase Medicare outlays by about $1 billion over the 2000–2004 period.

Hospice Update. Effective for services furnished on or after October 1, 1999, the bill would increase the annual increase in payment rates for hospice services from MBI minus 1 percentage point to MBI minus one-half of a percentage point in 2000 through 2002. CBO estimates that would increase Medicare expenditures by less than $50 million in 2000 and by $0.2 billion over the 2000–2004 period.

Payments for Hospital Inpatient Services. The bill contains several provisions that would affect payments to hospitals for inpatient care, but would increase spending by less than $50 million during the 2000–2004 period. One provision would limit the reduction in disproportionate share payment rates to 3 percent in 2001, instead of the 4 percent reduction enacted in the BBA. Other provisions would codify the Administration's announced implementation of the PPS for inpatient care provided by rehabilitation hospitals, mandate that certain hospitals be reclassified as rural or urban for payment purposes, and require the Secretary to recalculate the area wage index for a Metropolitan Statistical Area using more recent data.

Outpatient Therapy Services. The BBA established annual limits on per-beneficiary payments for outpatient therapy services provided by independent therapists, comprehensive outpatient rehabilitation facilities (CORFs), SNFs and other nonhospital providers. The limits are a $1,500 combined annual cap on physical therapy and speech language pathology services, and a $1,500 annual cap on occupational therapy services. The bill would impose a two-year moratorium on the caps beginning in January 2000. We estimate that this provision would increase Medicare expenditures by $0.2 billion in 2000 and by $0.6 billion over the 2000–2004 period.

Renal Dialysis. The bill would increase Medicare's composite rate for renal dialysis by 2 percent beginning in October 2000. That provision would have no budgetary effect in 2000 and would increase Medicare expenditures by $0.3 billion over the 2000–2004 period.

Pap Smears. The bill would increase Medicare's payment rate for the clinical laboratory component of pap smear tests from January 2000 through December 2001. That provision would increase Medicare expenditures by less than $50 million over the 2000–2004 period.

Inherent Reasonableness Authority. The BBA granted the Secretary the authority to adjust Medicare Part B payment rates when they are not "inherently reasonable." The bill would suspend the

Secretary's authority to use the inherent reasonableness provision until three months after the release of a report by the Comptroller General on the impact of the inherent reasonableness provision. That provision would increase Medicare expenditures by less than $50 million over the 2000–2004 period.

Medicaid and S–CHIP

The bill would increase federal Medicaid spending by $91 million in 2000 and $441 million over the 2000–2004 period. Federal S–CHIP spending would increase by $49 million in 2000 and $248 million over the 2000–2004 period. In addition, the bill would create a new mandatory program that would provide grants to states to give to federally qualified health centers (FQHCs) and rural health clinics (RHCs). CB0 estimates that this new program would cost $75 million over the 2000–2004 period.

The bill contains numerous revisions to Medicaid and S–CHIP law that would result in no estimated impact on federal spending. The provisions that would affect federal spending are discussed below.

Welfare-related transitional assistance for administrative costs. Under current law, states can receive an enhanced match rate for certain administrative expenses related to enrollment of low-income families receiving assistance under the Temporary Assistance for Needy Families (TANF) program who are no longer automatically eligible for Medicaid because of welfare reform. Under current law, total federal spending under the enhanced match rate is limited to $500 million nationally and ends at the end of fiscal year 2000. in addition, the enhanced match rate applies only to spending in the first 12 quarters after each state began its TANF program. The bill would allow the enhanced match rate to continue after fiscal year 2000 and would eliminate the 12-quarters restriction.

CBO estimates that spending under the enhanced match will be $263 million through fiscal year 2000 under current law. Eliminating the restrictions on the availability of the enhanced match rate would increase federal spending by $60 million in 2000 and $220 million over the 2000–2004 period.

Increased DSH allotment for certain states and the District of Columbia. The federal share of Medicaid DSH payments for each state is capped at specified levels in current law through 2002. Individual state allotments are increased by inflation starting in fiscal year 2003. The bill would increase allotments for several states and the District of Columbia in fiscal years 2000, 2001, and 2002. The District of Columbia's allotment would increase from $23 million to $32 million, Minnesota's allotment would increase from $16 million to $33 million, New Mexico's allotment would increase from $5 million to $9 million, and Wyoming's allotment would increase from 0 to $0.1 million.

CBO assumes that those states would be able to spend the full amount of their allotment increases, and therefore estimates that federal spending would increase by $30 million a year through 2002. Because allotments after 2002 are increased by inflation using 2002 as a base year, federal spending would increase in 2003

and thereafter. We estimate that this provision would cost $152 million over the 2000–2004 period.

Optional deferment of the effective date for outpatient drug agreements. Under current law, when new manufacturers of outpatient prescription drugs enter into agreements under the Medicaid drug rebate program the agreement is not effective until the first day of the calendar quarter that begins more than 60 days after the date the agreement is entered into. Under the bill, states would have the option to consider the agreement effective on any date between the time the agreement is entered into and the date it would become effective under current law.

CBO estimates that this provision would have a negligible cost—less than $500,000 over the 2000–2004 period. Very few new manufacturers enter into rebate agreements with the Medicaid program each year. In most cases the agreements are entered into well before a drug manufactured by a new manufacturer is available for distribution on the market. In addition, states often require time after becoming aware of a new drug to update their systems to cover the drug and to notify pharmacies of the change. Nonetheless, it is possible that this change in law could result in very small additional costs to the federal government.

Medicaid interactions with Medicare Part B premium. Because Medicaid covers the cost of the Medicare Part B premium for individuals dually eligible for Medicaid and Medicare and for other low-income Medicare beneficiaries not poor enough to qualify for full Medicaid benefits, a change in the Medicare Part B premium affects federal Medicaid spending. CBO estimates that by increasing the amount of the Part B premium, the bill would increase federal Medicaid costs by about $50 million over the 2000–2004 period.

Increased allotments for Puerto Rico and the territories. Under current S–CHIP law, the territories are allotted 0.25 percent of the total amount made available to all states and territories each year. In the 1999 appropriations act (Public Law 105–277), the Congress provided an extra $32 million to the territories. The bill would provide the territories with an additional $34.2 million in 2000 and 2001, $25.2 million each year for 2002 through 2004, $32.4 million in each of 2005 and 2006, and $40 million for 2007. CBO assumes that the full amount of the allotment would be spent in each year under the bill, resulting in increased federal spending of about $150 million in the 2000–2004 period.

Improved data collection and evaluations of the S–CHIP program. The bill would appropriate funds for three different research activities related to the S–CHIP program. First, $10 million a year would be available for the Bureau of the Census to make adjustments to the Current Population survey to produce more reliable state-level data on the number of low-income children who do not have health insurance coverage. Second, $9 million a year would be available for the National Center for Health Statistics to collect data on children's health insurance through the State and Local Area Integrated Telephone Survey. Third, $10 million would be available beginning in 2000 for federal evaluation of S–CHIP programs in 10 state. CBO estimates that these provisions would cost $15 million in 2000 and $104 million over the 2000–2004 period.

In addition, the bill would instruct the Inspector General of the Department of Health and Human Service (HHS) to audit a sample of states every three years to determine the number of S–CHIP enrollees who are eligible for Medicaid and assess state progress in reducing the number of low-income children without health insurance coverage. The bill also would instruct the Secretary of HHS to establish a clearinghouse for the consolidation and coordination of all federal databases and reports regarding children's health. These two provisions would increase the authorizations of appropriations for HHS, but CBO has not yet estimated those amounts.

Grants to states for items and services provided by FQHCs and RHCs. The bill would create a mandatory grant program under which certain states would receive a share of $25 million a year for fiscal years 2001, 2002, and 2003 for distribution to FQHCs and RHCs. The FQHCs and RHCs could only use grant funds for providing Medicaid services to individuals not eligible for Medicaid. A state is not eligible to receive grant funds if it has reduced Medicaid reimbursement to FQHCs and RHCs under a state option established in the Balanced Budget Act of 1997. Under that option, states may phase-out cost-based reimbursement, a policy under which states pay facilities 100 percent of costs, beginning in fiscal year 2000. States that have already begun to implement the option may be eligible for the grant funds if they revert to paying facilities 100 percent of costs in fiscal year 2001.

CBO expects that states would spend the total amount of the grant funds by 2004, resulting in $75 million in increased direct spending over the 2000–2004 period. Most of the funds would be spent by states that would not otherwise have reduced reimbursement to FQHCs and RHCs under the Medicaid option. However, some states that would otherwise have reduced payments to FQHCs and RHCs would not reduce reimbursement under the bill in order to access grant funds during the period in which those funds are available. After the funds cease to be available, some of those states would opt to reduce reimbursement. As a result of the provision, CBO estimates that Medicaid outlays would be $1 million higher in fiscal year 2000 and $19 million higher over the 2000–2004 period.

Pay-as-you-go considerations

The Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays that would be subject to pay-as-you-go procedures are shown in the following table. For the purposes of enforcing pay-as-you-go procedures, only the effects in the budget year and the succeeding four years are counted.

	By fiscal year, in millions of dollars—									
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Changes in outlays	1,100	5,600	2,200	2,000	1,000	900	700	700	700	700
Changes in receipts	Not applicable									

Section 607 of the bill specifies that any net deficit increase resulting from enactment shall not be counted for purposes of enforcing the pay-as-you-go procedures.

Estimated impact on State, local, and tribal governments

The bill contains no intergovernmental mandates as defined in the UMRA. CBO estimates that provisions of the bill affecting Medicaid would result in additional federal and state spending for health programs.

By eliminating restrictions on the enhanced match for administrative costs under the TANF program, the bill would increase funds to states by $220 million over the 2000–2004 period. These funds would be available to states without any changes to their projected spending over that time.

Medicaid spending for DSH in each state is capped under current law through 2002, and any spending over those caps is paid for with state funds alone. Increasing these federal allotments for the District of Columbia, Minnesota, New Mexico, and Wyoming would result in additional funds to those states totaling $152 million over the 2000–2004 period. In order to receive the additional federal funds, CBO estimates that states would spend $75 million of their own Medicaid funds over that period. Similarly, increased allotments for Puerto Rico and the territories under the S–CHIP program would make an additional $150 million available to states in the form of federal matching funds over the 2000–2004 period. In order to receive the additional federal funds, Puerto Rico and the territories would spend about $80 million in their own funds over that period.

Just as federal expenditures for Medicaid would increase from changes to the Medicare Part B premium, state expenditures for Medicaid would also increase. CBO estimates that those state costs would total about $40 million over the 2000–2004 period.

Finally, states would receive $75 million in additional grants for items and services provided by federally qualified health centers and rural health clinics. States that have reduced reimbursement rates to FQHCs and RHCs would not be eligible for the grants. Consequently, the implementation of this program would be an incentive to maintain full reimbursement rates, which would result in additional Medicaid costs. CBO estimates that the state portion of those costs would total about $15 million over the 2000–2004 period.

Estimated impact on the private sector

The bill would impose several new mandates on insures who provide medigap coverage. Under current law, Medicare beneficiaries who lose supplemental coverage because of the termination or discontinuation of the employer-sponsored supplemental plan or the Medicare+Choice plan in which they are enrolled are entitled to purchase medigap coverage on favorable terms, if they apply within 63 days of the termination of enrollment. Under those circumstances, medigap insurers may not refuse to sell them a supplemental policy; charge them higher premiums based on their health status, claims experience, receipt of health care, or medical condition; or impose exclusion based on preexisting conditions.

The bill would allow beneficiaries to obtain medigap converge under the same favorable terms if the applied within 63 days of being notified of the pending termination or discontinuation of their plan, effectively giving them two windows of opportunity to

apply. It would also give protections to Medicare+Choice enrollees whose plan terminated and who subsequently chose to enroll in another Medicare+Choice plan. They would be able to obtain medigap coverage under the same terms if they disenrolled from the second plan within 12 months. Finally, the bill would grant enrollees in the Program of All-Inclusive Care for the Elderly the same medigap protections as Medicare+Choice enrollees.

Those provisions would enable more Medicare beneficiaries to obtain medigap coverage on a community-rated basis. Because of the restrictions on the premiums that they could charge, medigap insurers might incur costs that they could not immediately recover from premiums. However, the additional number of beneficiaries that the provisions would affect is likely to be small, so the costs imposed on insurers would be below the threshold specified in UMRA ($100 million in 1996, adjusted annually for inflation).

Estimate Prepared by: Federal costs: Charles Betley, Michael Birnbaum, Julia Christensen, Jeanne De Sa, Cyndi Dudzinski, and Dorothy Rosenbaum; Impact on State, local, and tribal governments: Leo Lex; Impact on the private sector: Linda Bilheimer.

Estimate Approved by: Peter H. Fontaine, Deputy Assistant Director for Budget Analysis

IV. VOTE OF THE COMMITTEE

In compliance with section 133 of the Legislative Reorganization Act of 1946, the Committee states that the Medicare, Medicaid, and S–CHIP Adjustment Act of 1999 was ordered reported favorably by voice vote.

V. REGULATORY IMPACT AND OTHER MATTERS

A. Regulatory Impact

In compliance with paragraph 11(b) of Rule XXVI of the Standing Rules of the Senate, the Committee states that the legislation will not significantly regulate any individuals or businesses relative to current law, will not impact on the personal privacy of individuals, and will result in no significant additional paperwork.

Titles I–VI. The regulatory impact of these titles will be limited largely to the need for the Health Care Financing Administration to develop program instructions and/or regulations to implement the provider and health plan payment policy changes in the legislation.

Title VII. The regulatory impact of these titles will be limited largely to the need for the Health Care Financing Administration to develop program instruction and/or regulations to implement the Medicaid and S–CHIP technical provisions.

There are no revenue offsets included in this legislation.

B. Unfunded Mandates Statement

This information is provided in accordance with section 423 of the Unfunded Mandates Reform Act of 1995 (P.L. 104–4). The Committee has reviewed the provisions of the bill as reported and has determined that no provisions in the bill contain private sector mandates.

C. COMPLEXITY ANALYSIS

Section 4022(b) of the Internal Revenue Service Reform and Restructuring Act of 1998 (the "IRS Reform Act") requires the Joint Committee on Taxation (in consultation with the Internal Revenue Service and the Department of Treasury) to provide a tax complexity analysis. Under the authority of the Joint Committee on Taxation, its staff has determined that the requisite tax complexity analysis is not required because the bill contains no provisions that amend the code.

VI. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In the opinion of the Committee, it is necessary, in order to expedite the business of the Senate, to dispense with the requirements of paragraph 12 of rule XXVI of the Standing Rules of the Senate, relating to the showing of changes in existing law made by the bill reported by the Committee.

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