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EXECUTIVE COMMITTEE MEETING

WEDNESDAY, NOVEMBER 17, 1993

U.S. Senate,

Committee on Finance,

Washington, DC.

The meeting was convened, pursuant to notice, at 11:36 a.m., Hon. Daniel Patrick Moynihan (chairman of the committee) presiding.

Also present: Senators Bradley, Rockefeller, Daschle, Conrad, Packwood, Danforth, Durenberger, and Grassley.

Also present: Dr. Paul Offner, Chief Health Counsel; Margaret Malone, Kathy King, Jane Horvath, and Sheila O'Dougherty, Professional Staff Members.

[The press release announcing the meeting follows:]

The Chairman. A very good morning.

We are in the Committee on Finance to consider a bill entitled the Social Security Act Amendments of 1993.

And these are, and as I believe and the committee understands, measures which were dropped from the bill the House had passed, but which were subject to objection on the Senate side according to our rules, specifically the Byrd rule about revenue. There are no revenue measures here -- no revenue impact here.

And our rule is designed to prevent substantive legislation being put on a recommendation bill where a limitation is made and so forth.

And it is a perfectly sensible rule, but one which would interfere with the desires of the House to have matters taken up, which we were in agreement on.

And so it was agreed in August that the House would put together a list of items. And we would bring it up in the Finance Committee and attempt to send it to the House where it would be promptly approved.

And so here we are. And there are more than a few of these items, but not so many that we cannot

run through them.

And I am going to ask Dr. Offner to do that. And I will ask if anyone has any comments that they would like to make to do so.

Senator Packwood.

Senator Packwood. I have no statement, Mr. Chairman.

The Chairman. That is in the spirit of the occasion.

Senator Rockefeller.

Senator Rockefeller. I have no statement.

The Chairman. No statement.

Does anyone have a statement?

Senator Rockefeller. I did want to congratulate particularly you and Senator Packwood on the work you did on the Suter matter which is taken care of in this, which deprived people of individual rights. And it is a small, but a very large item.

The Chairman. For those who care about it.

Senator Bradley.

Senator Bradley. Mr. Chairman, I have no statement, other than to say that I am glad that we are doing this and the sooner the better.

The Chairman. Senator Durenberger.

Senator Durenberger. Mr. Chairman, I am

probably as aware as anybody of all the work that went into producing the product, that we are probably going to take very little time in passing out of here.

I want to congratulate the staff and particularly those who worked through this whole process a couple of times already. And I am glad we are here today.

The Chairman. Senator Grassley, you are standing. You are not --

Senator Grassley. I am satisfied that we have a rolling form. I have an 11:45 appointment. I am going to vote aye. I assume you are going to have a voice vote.

The Chairman. I have it down.

Senator Grassley. All right.

The Chairman. Dr. Offner, would you proceed?

Dr. Offner. Mr. Chairman, why don't we start with income security if that is all right?

Ms. Malone. Mr. Chairman, you should have before you a document dated November 16th, entitled Markup Document for Income Security.

Although these income security amendments are generally of a minor and technical nature, there are several that are of particular interest to members

of the committee.

And I might just mention a few. One is the so-called Suter amendment which Senator Rockefeller just referred to.

The Chairman. Yes.

Ms. Malone. A second is a child support amendment, described on page 2, item 1, which requires State child support agencies to report the names of obligors who are at least 2 months delinquent in the payment of child support to consumer credit agencies.

Another is an amendment by Senator Dole which Senators Packwood and Chafee have cosponsored. And it is described on page 3, item 1, under the heading, Aid to Families with Dependent Children.

And that amendment gives States additional flexibility in establishing eligibility verification procedures for the AFDC and Medicaid programs.

And finally, I would note that the bill also includes the Chairman's Welfare Dependency Act which requires the Secretary of HHS to develop measures of welfare dependency and to prepare an annual report providing data on welfare dependency and recommendations to reduce dependency.

The Chairman. May I just note that nothing

would tell you more about the state of our welfare, the welfare dependency in this country at this stage in the twentieth century than the Federal Government bill measure?

They will not produce a series of annual statements, the way we measure bank deposits, the way we measure other deposits.

Senator Bradley. And will this amendment change that?

The Chairman. If they comply with it, yes.

Dr. Offner.

Dr. Offner. Our next presentation, Medicare Part A.

Ms. O'Dougherty. The document before you should be Title I Medicare Provisions, Subtitle A Provisions related to Part A.

A large number of the Part A provisions involve the changes to the rural hospital programs that were brought forth from H. R. 11.

Those are the essential access community hospital and the rural primary care programs. The authorization is continued at the current levels through 95.

The States have increased from seven to nine States. And then, there is various operating

procedures, provisions that are also under that.

The Rural Health Transition Grant Program, the appropriation has increased from $25 to $30 million from 1993 through 1997. So those two programs are a lot of the main provisions.

The Chairman. Now, did you say appropriation or authorization?

Ms. O'Dougherty. Authorization. I'm sorry.

Also included is the skilled nursing facility. Under the skilled nursing facility area is a requirement for the Secretary to begin collecting wage data specific to skilled nursing facilities. That is also included in here.

The other provisions fall under three categories: other provisions that are borrowed from H. R. 11, minor technical corrections or clarifications from the Health Care Financing Administration, and a new provision that expands the scope of expertise of the Payment Assessment Commission. So that is a summary of the Part A provisions.

Dr. Offner. Medicare Part B.

Ms. King. Mr. Chairman, under Medicare Part B, the provisions are those which were agreed to by both the House and the Senate in H. R. 11 and

subsequently vetoed by President Bush. And there are some technical corrections of the Omnibus Reconciliation Act of 1993.

The Chairman. We are still in Title I. What page do we turn to?

Ms. King. I am beginning on provisions relating to Part B, Section 111.

The Chairman. What page number?

Ms. King. I have page 5 on my sheet.

The Chairman. Page 5.

Ms. King. But I am not sure.

The Chairman. That is right, page 5.

Ms. King. All right. Sections 111, 112, 113, 114, 115, and 116 were all included in H. R. 11, vetoed by the President, as were Sections 121, 122, 123, 124, 125, 126, and 127.

And the provisions relating to durable medical equipment arose from a bill originally sponsored here in the Senate by Senator Pryor, and also other provisions sponsored by Senator Sassar.

The Chairman. Would you help me on this issue, Section 123 on page 11? Are there first amendment problems there?

Ms. King. Senator, none have been brought to our attention. And this is --

The Chairman. I am bringing them to your attention. I am asking you. I am not telling you. Why don't you explain that?

Ms. King. Senator, what this provision does is it prohibits durable medical equipment suppliers from making unsolicited telephone calls to beneficiaries without getting their written permission in advance.

And this provision is designed to keep suppliers from suggesting to Medicare beneficiaries that they need certain types of durable medical equipment which Medicare will pay for without consultation with a physician, without being ordered by a physician.

The Chairman. I just want my colleagues to notice, as we go by. I appeal to the legal instincts here. This is a problem. It constitutes a problem with the courts.

Senator Packwood. How does this relate to any of the laws that the State legislatures are passing on telephone solicitation?

The Chairman. I don't know.

Senator Packwood. I don't know either.

The Chairman. Can we get --

Ms. King. I'm sorry. I did not hear Senator

Packwood's question.

Senator Packwood. How does this differ from some of the prohibitions that the State legislatures are passing prohibiting certain kinds of telephone solicitation?

Ms. King. I'm sorry, Senator. I don't know the answer to that.

The Chairman. Well, I would just like to note for the record that we noticed that.

Ms. King. All right. Senator, I am now on Subpart 3, beginning on page 14, technical amendments relating to ambulatory surgical centers.

That is a provision that was in H. R. 11. Section 132 is a section that was not included in the Budget Act of 1993.

And it is a provision sponsored by Senator Rockefeller that has to do with the study of Medicare coverage for clinical trials of new cancer therapies.

The Chairman. Yes.

Ms. King. Section 133 is --

The Chairman. Senator Rockefeller, you noticed that.

Ms. King. Section 133 was dropped from the Over 93 Conference Agreement because it was a violation

of the Byrd rule, as were Sections 134, 135, 136, 137, and 138.

The Chairman. Can I make the unsolicited comment that there is too much statutory direction of cabinet officers saying you can study this and you can think about that? And that is what the proposal will do anyway.

Ms. O'Dougherty. Senator, I am now moving to Parts A and B, Section 151, Medicare secondary payor reforms.

These are provisions that were dropped from the Over 93 Conference Agreement because they were violations of the Byrd rule.

Section 152, Physician Ownership and Referral, is basically clarifications of some drafting uncertainties in the Reconciliation Act of 1993.

Sections 153 and 154, I believe, are part of Medicare Parts A and B issues that were also dropped from the Over 93 Conference Agreement.

Section 155 is something that was dropped from the Over 93 Conference Agreement, but has been substantially modified since that time to take into account the interest of all the affected parties.

And we believe that we have a consensus on this provision. It has to do with organ procurement.

The Chairman. I do not think I want to know more about organ procurement right now.

Senator Danforth.

Senator Danforth. Mr. Chairman, this question of organ procurement has been -- was, I would say, a tussle, involving the extent to which organs could be transported beyond their immediate locations.

It involved some tried and true relationships between communities with respect to the availability of organs. And it got to be sort of a regional struggle.

And thanks to a lot of staff work involving Susan Nestor and Kathy King and others, this has been worked out.

And my understanding is that this is now satisfactory to all parties and certainly satisfactory to all members of the Finance Committee.

It did involve, among other States, Missouri and Kansas, which, of course, included Senator Dole and myself. But Senator Dole and his staff and Phil Erk and my staff and I have all come to an agreement on this.

And as far as I know, this is satisfactory to everybody that is involved. And I want to express

my appreciation.

The Chairman. That is very generous of you, Senator Danforth.

Ms. King, you can accept that on behalf of your colleagues.

Ms. King. I should say that Susan Nestor was the primary negotiator on behalf of the Republicans. And she did bear most of the load on this.

Senator, we are moving to Sections 156 and 157 were also dropped. And 158 was also dropped from the Over 93 Conference Agreement.

And Section 159, Sheila.

Ms. O'Dougherty. Yes. Those are technical from HCFA that allows them to extend and make permanent the authority to grant the contract on a cost plus incentive basis.

Ms. King. And Section 160 is miscellaneous and technical corrections.

Moving to Subtitle D, Section 171, Medigap Insurance Policies, we have negotiated this very closely, and just reached an agreement that we believe is acceptable to all parties that involves some technical clarification.

And, Mr. Chairman, that is it for Medicare Parts A and B.

The Chairman. Thank you, Ms. King. Thank you, Ms. O'Dougherty.

Dr. Offner.

Dr. Offner. Finally, Medicaid.

Ms. Horvath. Mr. Chairman, I believe you have a document that is entitled Medicaid Explanation of Provisions.

The Chairman. I think it might have been better entitled Explanation of Medicaid Provisions.

Ms. Horvath. Explanation of Medicaid Provisions, yes. I realize that, too.

The Chairman. Let's speak of Medicaid.

[Laughter]

Ms. Horvath. The vast majority of these provisions were either in the Senate passed version of H. R. 11 or were in the House budget bill this year, and were dropped out because of lack of compliance with the Byrd rule.

There is a section at the end of the document which does make technical corrections to the Medicaid provisions of Over 93.

I will only call your attention to a few things that I think have been important to members of this committee in this package in Section 201 which is on the first page of your document, the Medicaid

managed care antifraud provisions which originated in the House, and then, also, Sections 202 through 205 which are waivers of the enrollment mix, the 75/25 rule for various Medicaid HMOs around the country.

And then, the Medicaid Audit and Disallowance Reform, Section 222 is a bill that was originally sponsored by many members of this committee, is finally in this package in final form.

The Chairman. What is that, Medicaid disallowances?

Ms. Horvath. Yes. Criteria for determining the amount of a Medicaid disallowance. It basically sets some standards for the Secretary, factors that the Secretary and then the departmental appeals board should consider when determining the amount of a Medicaid disallowance.

The Chairman. Yes.

Ms. Horvath. And then just finally, an issue that has been important to several members of this committee are the Over 90 Drug Rebate Program technicals are also in this package.

The Chairman. Thank you, Ms. Horvath.

Dr. Offner, I believe that is the situation.

I have observed that we have had a series of

Senators who have been in and out. And everyone is not here yet, but I am going to ask, unless someone wishes a roll call vote, if there is a motion to approve?

Senator Packwood. I would so move.

The Chairman. And is there a second?

Senator Rockefeller. Second.

The Chairman. There is a second from Senator Rockefeller.

Would those in favor say aye?

[Chorus of ayes.]

The Chairman. Those opposed?

[No response.]

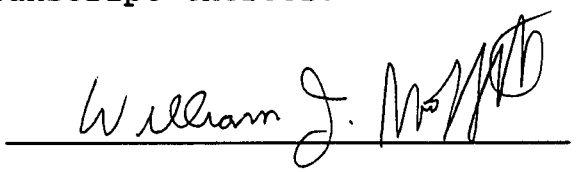
The Chairman. The ayes have it.

The meeting is concluded.

[Whereupon, at 11:56 a.m., the meeting was concluded.]

C E R T I F I C A T E

This is to certify that the foregoing proceedings of an Executive Committee Meeting held before the Committee on Finance, on November 17, 1993, were transcribed as herein appears and that this is the original transcript thereof.



WILLIAM J. MOFFITT

Official Court Reporter

My Commission expires April 14, 1994.

November 16, 1993

MARKUP DOCUMENT

INCOME SECURITY

I. Child Welfare, Foster Care, Adoption

1. Establishment of New Foster Care Review System. - Require the Secretary of HHS to issue regulations establishing a new quality review system that provides for withholding of Federal funds with respect to State child welfare and foster care programs that are not in substantial conformity with State plan requirements. Move current law conformity requirements from sec. 427 of the Social Security Act to sec. 422, making them part of the child welfare State plan requirements.

2. State Plan Requirement Regarding the Indian Child Welfare Act. - Require State child welfare program plans to include a description of the measures taken by the State to comply with the Indian Child Welfare Act.

3. Child Welfare Traineeships. - Establish Federal rules for awarding child welfare training grants that require (1) students who receive Federal stipends to serve in a public or private child welfare agency for a period equal to the period of training, or to repay the cost; and (2) institutions to enter into agreements with child welfare agencies for on-site training of stipend recipients.

4. Case Review System Requirements. - Initial dispositional hearings for children in foster care would continue to have to take place no later than 18 months after the original placement, but subsequent hearings would have to take place at least every 12 months thereafter (rather than "periodically," as in present law).

5. "Most Appropriate Setting" Requirement. - Current law requires each foster child to have a case plan designed to achieve placement in "the least restrictive (most family-like) setting available." This provision would be modified to require placement in "the least restrictive (most family-like) and most appropriate setting available."

6. Elimination of Foster Care Ceiling and Transfer Authority. - Repeal obsolete provisions in current law that expired September 30, 1992.

7. State Flexibility Demonstration Projects. - Authorize the Secretary of HHS to permit up to 10 States to conduct demonstration projects likely to promote the objectives of titles IV-B or IV-E. The Secretary could waive State compliance with requirements of these titles which, if applied, would prevent the State from carrying out the

demonstration, with certain specified exceptions.

8. Child Placed Out of State. - The case plan for a child placed in foster care in another State, or at a substantial distance from home, would have to include a declaration as to the reasons why the placement is in the best interests of the child. An agency caseworker would be required to visit a child placed out of State periodically, but at least every 12 months. The caseworker may be from either the State where the parents of the child are living, or the State where the child is placed.

9. Payment of State Claims for Foster Care and Adoption Assistance. - Codify regulations providing a timetable for the payment by the Federal government of State claims for foster care and adoption assistance.

10. Failure to Carry Out State Plan (Suter). - The Supreme Court decision in Suter v. Artist M. called into question whether individuals have the right to bring suit to enforce provisions in the Social Security Act that tell States how to administer their welfare, Medicaid, child welfare, and other Social Security Act state plan programs. Statutory language agreed to by the National Governors' Association and advocacy groups to restore the status quo, assuring that rights that existed prior to the Suter decision remain in place, would be added to title XI of the Social Security Act. The language is identical to language included as sec. 13234 of the House reconciliation bill and to language included in H. R. 11.

II. Child Support Enforcement

1. Reports to Credit Bureaus on Persons Delinquent in Child Support Payments. - Require State child support enforcement agencies to report periodically the names of obligors who are at least 2 months delinquent in the payment of support and the amount of the delinquency to consumer reporting agencies.

2. Technical Correction to OBRA '93 Regarding Calculation of Paternity Establishment Percentage. - Correct drafting of paternity establishment percentage as provided in Sec. 13721 of OBRA '93.

3. Share Use of Parent Locator Service with Department of Justice. - The Secretary of HHS is directed to enter into an agreement with the Attorney General under which the services of the Parent Locator Service are made available to the Office of Juvenile Justice and Delinquency Prevention upon its request for the purpose of locating a parent or child.

III. Supplemental Security Income

1. Definition of Disability for Children under Age 18 Applied to All Individuals under Age 18. - Apply the SSI childhood definition of disability to all SSI applicants who are under age 18, including those who are married or head of household.

2. Commission on Childhood Disability. - The Secretary of HHS is directed to appoint a Commission on the Evaluation of Disability in Children to conduct a study, in consultation with the National Academy of Sciences, on the effects of the current SSI definition of disability as it applies to children under the age of 18 and their receipt of services, including the advantages and disadvantages of using an alternative definition.

3. Modification of "Pass Through" Requirement. - The Social Security Act includes rules that States must follow in passing through to recipients the amount of Federal SSI benefit increases. These rules would be modified to require, upon request of a State, the disregard of retroactive payments made pursuant to the Supreme Court decision in Sullivan v. Zebley.

IV. Aid to Families with Dependent Children

1. Simplification of Income and Eligibility Verification System. - Allow one adult member of a family or household to sign a declaration, under penalty of perjury, on behalf of other adults in the household as to their citizen or alien status (rather than requiring each adult to sign). In addition, in the case of a newborn child, an adult could sign a declaration no later than the date of the next redetermination of the eligibility of the family or household (rather than delaying eligibility until a declaration is signed). Applies to the AFDC, Medicaid, unemployment insurance, and food stamp programs.

2. Measurement and Reporting of Welfare Receipt. - Require the Secretary of HHS, in consultation with the Secretary of Agriculture, to develop (1) indicators of the rate at which, and (to the extent feasible) the degree to which, families depend on income from welfare programs; and the duration of welfare receipt; and (2) predictors of welfare receipt. The Secretary would be required to prepare an annual report, including such recommendations for legislation as the Secretary determines necessary or desirable to reduce welfare receipt.

3. New Hope Demonstration Project. - The Secretary of HHS would be authorized to approve the New Hope demonstration project (operated by a private nonprofit corporation in Milwaukee, Wisc.) which offers low income residents employment, wage supplements, child care, health care, and counseling and training for job retention or advancement.

4. Delay in AFDC-UP Mandate for Outlying Jurisdictions. - Delay the requirement for implementation of the AFDC - Unemployed Parent program in Puerto Rico, Guam, the Virgin Islands, and American Samoa until such time as the limitations on Federal matching payments to these jurisdictions for purposes of making AFDC maintenance payments are repealed.

5. Extension of New York State Child Assistance Program. - Extend the Child Assistance (CAP) demonstration program for an additional 5 years, to April 1, 1999.

6. State Option to Use Retrospective Budgeting Without Monthly Reporting. - States would decide, with respect to categories of families, whether or not to use monthly reporting, retrospective budgeting, or a combination of the two. Thus, unlike under present law, States could use retrospective budgeting for a category of families that is not required to report monthly.

V. JOBS Program

1. JOBS Funding for Indian Tribes. - The current law formula for funding each Indian JOBS program is based on the number of adult members of the Indian tribe that receive AFDC. This formula excludes those Indians who live on the Indian reservation but belong to another tribe. The amendment provides that all Indians who live on the reservation, regardless of whether they are members of the tribe, are to be counted in determining the tribe's allocation of funds.

2. Delay Report on Performance Standards in the JOBS Program. - The date by which the Secretary of HHS must submit recommendations to the Congress for JOBS performance standards would be delayed for one year, to October 1994. The Secretary would be required to develop criteria for performance standards, rather than performance standards.

VI. Unemployment Compensation

1. Extend Reporting Date for Advisory Council on Unemployment Compensation. - The Emergency Unemployment Compensation Act of 1991 authorized a quadrennial advisory

council on unemployment compensation to examine the purpose, goals, and function of the unemployment compensation system, and to make recommendations for improvement. The first report is due by February 1, 1994. The amendment would delay the Council's first report for one year, to February 1, 1995.

2. Unemployment Trust Fund Transfers. - Strike language inadvertently included in the Unemployment Compensation Amendments of 1992 (P. L. 102-318), that relates to the transfer of funds from the State administration account to the extended unemployment compensation account, within the Federal Unemployment Trust Fund.

VII. Other Provisions

1. Extension of Demonstration to Expand Job Opportunities. - The amendment continues authority (through fiscal year 1995) for a demonstration project established by the Family Support Act of 1988 to create employment opportunities for certain low income individuals.

2. Extension of Authorization for Early Childhood Development Projects. - The amendment continues (through fiscal year 1998) the authority to test and evaluate the effect of early childhood development programs on families receiving AFDC and participating in the JOBS program (originally authorized in the Family Support Act of 1988).

3. Reallocation of Funds under the Title XX Program for Empowerment Zones and Enterprise Communities. - Funds that are received by a zone or community but are not used would be reallocated to the States for use under the title XX social services block grant program.

4. Technical Corrections Related to the Human Resource and Family Policy Provisions of the Omnibus Budget Reconciliation Act of 1990.

5. Technical Corrections Related to the Human Resource and Income Security Provisions of the Omnibus Budget Reconciliation Act of 1989.

6. Elimination of Obsolete Provisions Relating to Treatment of the Earned Income Tax Credit.

7. Redesignation of Certain Provisions.

TITLE I - MEDICARE PROVISIONS

Subtitle A - Provisions Relating to Part A

Section 101. Provisions Relating to Adjustments to Standardized Amounts for Wages and Wage-Related Costs

(a) Wage Index and Medicare Geographic Classification Review Board (MGCRB) -- The Secretary would be authorized, but not required, to take occupational mix into account in the development of MGCRB guidelines for reclassification to the extent the Secretary determines is appropriate. Clarifies that if labor markets are no longer based on Metropolitan Statistical Areas, the method of calculating the wage index for reclassification would not apply and the MGCRB guidelines may be revised.

(b) Labor and Non-Labor Portions of Standardized Amounts -- The Secretary would set the labor and non-labor portion of each standardized amount equal to the national average beginning in fiscal year 1995.

Effective Date

Effective upon the date of enactment.

Section 102. Essential Access Community Hospital (EACH) Amendments

(a) Authorization for appropriations would be continued at current levels ($10 million a year for grants to States and $15 million a year for grants to hospitals) through fiscal year 1995. The length of stay requirement for State designation of rural primary care hospitals would be modified to provide that no patient may be admitted unless the attending physician certifies that the patient may reasonably be expected to be discharged or transferred within 72 hours, and that the facility may not provide surgery or other services requiring general anesthesia (other than procedures approved for performance on an ambulatory basis) unless the attending physician certifies that the risk of transfer to another facility for the services outweighs the benefits. The Secretary would be authorized to terminate the designation of a rural primary care hospital whose average length of stay (not counting longer stays during periods of inclement weather or other emergencies) exceeds 72 hours. The General Accounting Office would report to the Congress, within 2 years after enactment, on the application and impact of the changes in length-of-stay requirements.

(b) The number of States eligible for grants under the EACH program would be increased from seven to nine. The Committee anticipates that the Secretary will designate additional States

on the basis of applications received in response to the initial solicitation and the evaluation performed by the Department in response to those applications.

(c) The Secretary would be authorized to designate an urban hospital as an essential access community hospital if the hospital otherwise meets the criteria for designation. However, urban hospitals would not be eligible for a change in Medicare payment as a result of the designation.

(d) A State receiving a grant under the EACH program could designate a facility in an adjoining State as an essential access community hospital or a rural primary care hospital if the facility is otherwise eligible for designation. The Secretary would be authorized to designate a facility as an essential access community hospital or a rural primary care hospital if the facility is not in a State receiving an EACH program grant and if the facility is a member of a rural health network of a State receiving a grant.

(e) The requirements for written policies and procedures and the supervision of those procedures in rural primary care hospitals would be amended to clarify that the requirements are similar to those for hospitals. Specifically, rural primary care hospitals would be required to appoint a physician, as defined in section 1861(r)(1) of the Social Security Act, to supervise the implementation of the policies.

(f) A rural primary care hospital that had a swing-bed agreement at the time of designation would be authorized to provide swing-bed services up to the hospital's licensed acute care bed capacity at the time of conversion, minus the number of inpatient beds retained by the rural primary care hospital. The Committee recognizes that the statutory criteria regarding designation of a rural primary care hospital are based on the expectation that the RPCH will have a limited number of inpatient beds, and expects that in cases where the RPCH has a substantially greater number of patients, the Secretary may impose additional standards with respect to staffing or other requirements comparable to those applicable to skilled nursing facilities.

(g) The applicability of the inpatient hospital deductible and coinsurance to stays in rural primary care hospitals would be clarified.

(h) The Secretary would be required to implement a prospective payment system for outpatient RPCH services by January 1, 1996. The election of payment alternatives would continue until the Secretary implemented the new system. Payment for outpatient rural primary care hospital services would be made without regard to lesser-of-cost-or-charges limits. Minor

drafting errors would be corrected.

Effective Date

Effective upon the date of enactment.

Section 103. Provisions Related to Rural Health Transition Grant Program

Appropriations for the rural health transition grant program would be authorized at $30 million a year for fiscal years 1993 through 1997. Rural Primary Care Hospitals would be eligible to receive grants.

Effective Date

Effective upon the date of enactment.

Section 104. Psychology Services in Hospitals

In a State in which such supervision is authorized by State law, the care of hospital inpatients receiving qualified psychologist services could be supervised by a clinical psychologist with respect to such services to the extent permitted by State law.

Effective Date

Effective upon the date of enactment.

Section 105. Medicare-Dependent, Small Rural Hospital and Sole Community Hospitals.

(a) Medicare Dependent, Small Rural Hospitals -- A technical correction to clarify that payment amounts are determined by using a 36 month cost reporting period. The target amount definitions needed to make the calculations for Medicare Dependent Hospitals would be extended to September 30, 1994.

(b) Sole Community Hospitals -- A technical correction to clarify that the update factor for these hospitals would be based on cost reporting periods for fiscal year 1994.

Effective Date

Effective upon the date of enactment.

Section 106. Skilled Nursing Facilities

(a) Wage Index -- The Secretary would be required to begin collecting the data necessary to compute a wage index based on wages specific to skilled nursing facilities within one year of enactment. The Prospective Payment Assessment Commission would be required to study and report by March 1, 1994 on the impact of applying routine per-diem cost limits on a regional basis.

(b) A technical correction to utilization review and minor conforming amendments to correspond to Medicaid Nursing Home Reform.

Effective Date

Effective upon the date of enactment.

Section 107. Notification of Availability of Hospice Benefit

Hospital conditions of participation with respect to discharge planning would be modified to require an evaluation of a patient's likely need for appropriate post-hospital services, including hospice services, and the availability of those services.

Effective Date

The provision would apply to services furnished on or after the first day of the first month beginning more than one year after the date of enactment.

Section 108. Clarifying Expertise of Individuals to Serve on Prospective Payment Assessment Commission

Expertise of individuals to serve on the Prospective Payment Commission would be clarified to provide for expertise in health facility management, reimbursement of health facilities or other providers of services which reflect the scope of the Commission's responsibilities.

Effective Date

Effective upon the date of enactment.

Section 109. Authority for Budget Neutral Adjustments for Changes in Payment Amounts for Transfer Cases.

The Secretary currently defines transfers and determines payment amounts for transfer cases in the Prospective Payment

System. The Secretary would be authorized to make future revisions to transfer payment policy in a budget neutral manner.

Effective Date

Effective upon the date of enactment.

Section 110. Clarification of DRG Payment Window; Miscellaneous and Technical corrections

A Diagnosis Related Group (DRG) window provision of 24 hours would apply to hospitals that are not paid on the basis of DRGs. Other minor technical corrections would be made to Part A.

Effective Date

Effective upon the date of enactment.

PROVISIONS RELATING TO PART B

Sec 111. Development of Resource-Based Methodology for Practice Expenses

The Secretary would be required to develop a methodology for implementing in 1997 a resource-based system for determining practice expense relative value units for each physicians' service. In developing the methodology, the Secretary would consider the staff, equipment and supplies used in the provision of various medical and surgical services in various settings. The Secretary would be required to report to Congress on the methodology by June 30, 1995. The existing payment methodology would be repealed when the new payment methodology takes effect--for services provided in years beginning with 1997.

Effective date

Effective upon enactment.

Sec. 112 Geographic Adjustment Refinements

(a) Use of More Recent Data.--The Secretary would review and revise the geographic practice cost index (GPCI) by not later than January 1, 1995 using the most recent data on practice expenses, malpractice expenses and physicians' work effort. The Secretary would consult with appropriate representatives of physicians in reviewing geographic adjustment factors and

indices. The Secretary is required to study and report to the Congress on the construction of the index by April 1, 1994.

The Secretary would conduct a study and, within one year of enactment, report to the Congress on: (1) the data necessary to review and revise the GPCI indices, including the shares allocated to physicians' work effort, practice expenses (other than malpractice expenses) and malpractice expenses; the weights assigned to the input components of such shares; and the index values assigned to such components; (2) any limitations on the availability of data necessary to review and revise the indices at least every 3 years; (3) ways to address such limitations, with attention to the development of alternative data sources for input components for which current index values are based on data collected less frequently than every three years; and (4) the costs of developing more accurate and timely data sources.

Effective Date

Effective upon the date of enactment.

Sec. 113 Extra-Billing Limits

(a) Limitations on Beneficiary Liability--Non-participating physicians and nonparticipating suppliers would be prohibited from billing or collecting from any person an actual charge in excess of the Medicare limiting charge. No person would be liable for payment of any amount billed in excess of the limiting charge. Physicians, suppliers and other persons who bill or collect amounts exceeding the limiting charge would be required to: (1) refund the full amount collected in excess of the limiting charge; (2) reduce the outstanding balance owed for other items and services furnished to the individual by the amount of the charge exceeding the limiting charge and refund any amount in excess of the outstanding balance; or (3) in the case of where the excess charges have not been collected by the physician, reduce the actual charge billed for the service to the amount approved by Medicare.

Carriers would be required to notify a physician, supplier or other person within 30 days if the physician has billed in excess of the limiting charge. The physician, supplier or other person would be required to refund or credit excess charges within 30 days after the date the physician, supplier, or other person is notified by the carrier of the violation.

A physician, supplier or other person who (1) knowingly and willfully bills or collects amounts in excess of the limiting charge on a repeated basis; or (2) fails to comply with the refund requirements would be subject to sanctions in accordance with Section 1842(j) of the Social Security Act.

(b) Clarification of Mandatory Assignment Rules for Certain Practitioners--Specifies that physicians' assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers and clinical psychologists could only bill for services on an assignment-related basis and that no person is liable for amounts billed in violation of the assignment-related basis. The Secretary could impose sanctions under Section 1842(j) of the Social Security Act on a practitioner who knowingly and willfully bills in violation of this requirement.

(c) Information Regarding Limiting Charges--

(1) Carriers would be required to provide limiting charge information on the Explanation of Medicare Benefits form after the submission of an unassigned claim which exceeds the limiting charge, and to include on such forms information relating to the beneficiary's right to a refund of any excess amounts collected.

(2) Carriers would be required to screen 100 percent of unassigned claims submitted by non-participating physicians, suppliers or other persons prior to making payment to determine whether the amount billed exceeds the limiting charge.

(d) The Secretary would report to the Congress annually on the extent to which annual charges exceeded limiting charges, the number and types of services involved, and the average amount of excess charges.

(e) The provision makes miscellaneous and technical corrections.

Effective Date

Except as otherwise provided, subsections (a) and (e) would be effective on enactment, except that subsection (a) does not apply to services of a non-participating supplier or other person furnished before January 1, 1994; subsections (b) and (c)(2) would apply to services furnished, or contracts, on or after January 1, 1994; and subsection (c)(1) would apply to forms provided on or after July 1, 1994. Subsection (d) applies to reports for years beginning with 1994.

Sec. 114 Development of RB RVS for Pediatric Services

The Secretary would fully develop and refine by October 1, 1994 the relative values for the full range of pediatric services. The Secretary would conduct a study of the relative values for pediatric and other services to determine whether

there are significant variations in the resources used in providing similar services to different populations. In conducting the study, the Secretary would consult with appropriate organizations representing pediatricians and other physicians, and submit a report to the Congress by July 1, 1995.

Effective Date

Effective upon the date of enactment.

Sec. 115 Claims Relating to Physician Services

The Secretary would be prohibited from imposing any fees related to the filing of claims for physicians' services, for claims errors or denials, for administrative appeals, for obtaining unique identifier numbers, or for responding to inquiries concerning the status of pending claims.

The Secretary would be permitted to recognize substitute billing arrangements between two physicians. In order to be recognized, such substitute billing arrangements would be required either to be informal, reciprocal, coverage agreements or per diem or other fee-for-time agreements. The duration of such agreements would be limited to 60 continuous days, and claims for services provided pursuant to such agreements would be required to include the unique identifying number of both physicians. These requirements would be effective for services provided under such arrangements in the first month beginning more than 60 days after the enactment of this Act.

Effective Date

Effective upon the date of enactment.

Sec. 116 Miscellaneous Technical Corrections

(a) Overvalued Procedures--Some procedures would be deleted from the list of exempted services and errors in the names of other services would be corrected. The procedures that would be deleted from the list of exempted services are: lobectomy; enterectomy; colectomy; cholecystectomy; and sacral laminectomy.

(b) Radiology Services--The conversion factors below the maximum reduction amount would not be permitted to be increased. The provision makes other technical changes to OBRA 90.

(c) Anesthesia Services--The conversion factors below the maximum reduction amount would not be permitted to increase. The provision makes other technical changes to OBRA 90.

(d) Assistants at Surgery--The application of the extra-billing limits to physicians serving as assistants at surgery would be clarified.

(e) Technical Components of Diagnostic Services--The limits on payment for the technical component of diagnostic services would not apply to services whose payments were reduced under the OBRA 89 overvalued procedure list.

(f) Statewide Fee Schedules--The OBRA 90 requirement for agreement from members of Congress would be eliminated, and Nebraska and Oklahoma would be statewide localities beginning in 1991.

(g) Study of Aggregation Rule for Claims of Similar Physician Services--The date that the study must be submitted to the Congress would be changed from December 31, 1992 to December 31, 1993.

A number of technical and drafting errors contained in OBRA 90 would be made through minor and conforming amendments.

Effective Date

Effective as if included in OBRA 90.

Part 2 Durable Medical Equipment

Sec 121. Certification of Suppliers

(a)

(1)Certification of Suppliers--Suppliers of medical equipment and supplies (durable medical equipment, prosthetic devices, orthotics and prosthetics, surgical dressings and such other items as the Secretary may determine and home dialysis supplies and equipment and immunosuppressive drugs) will not be reimbursed for these items unless they have a Medicare supplier number. A supplier may not obtain a supplier number unless the supplier meets uniform national standards prescribed by the Secretary. By January 1, 1996, the Secretary would revise the standards.

The standards would require suppliers to (1) comply with all applicable State and Federal licensure and regulatory requirements; (2) maintain a physical facility and inventory on an appropriate site; (3) have proof of appropriate liability insurance; (4) meet other requirements established by the Secretary. In addition, the requirement for suppliers to obtain a supplier number does not apply to medical equipment and supplies furnished as incident to a physician's service. The

Secretary is prohibited from delegating the responsibility to determine whether the supplier meets the standards necessary to obtain a supplier number.

The Secretary would be prohibited from issuing more than one billing number to any supplier, unless the issuance of more than one number is appropriate to identify subsidiary or regional entities under the supplier's ownership or control.

(2) Standardized Certificates of Medical Necessity--Not later than October 1, 1994, the Secretary would develop one or more standardized certificates of medical necessity for medical equipment and supplies if a certificate of medical necessity is required by the Secretary.

The OBRA 90 provision prohibiting suppliers of medical equipment and supplies from distributing completed or partially completed certificates of medical necessity would be modified. Effective May 1, 1994, suppliers may distribute to physicians or beneficiaries a certificate of medical necessity which contains no more than the following information: (1) an identification of the supplier and the beneficiary to whom such equipment or supplies are furnished; (2) a description of the equipment and supplies; (3) any product code identifying the medical equipment or supplies; (4) any other administrative information (other than information relating to the beneficiary's medical condition) identified by the Secretary. If a supplier distributes a certificate containing any of this information, the supplier must also list on the certificate of medical necessity the fee schedule payment amount and the supplier's charge prior to distribution to the physician for completion. Suppliers who violate the provisions would be subject to a civil money penalty in an amount not to exceed $1,000 for each certificate of medical necessity so distributed.

(3) Uniform National Coverage and Utilization Review Requirements--Not later than January 1, 1996, the Secretary would, in consultation with representatives of DME suppliers, beneficiaries, and medical specialty organizations, develop and establish uniform national coverage and utilization review criteria for 100 items of medical equipment and supplies. The criteria would be part of the instructions available to suppliers, and no further publication, including *Federal Register* publication, would be required.

The Secretary would select an item for development of national coverage and utilization review criteria if: (1) the item is frequently rented or purchased by beneficiaries; (2) the item is frequently subject to a determination that it is not medically necessary; or (3) a wide variation in the coverage or utilization review criteria applied to the item exists among carriers (as of the date of enactment). The Secretary would be

required annually to review and determine whether items not on the list should be subject to uniform national coverage and utilization review criteria and to subject them to these criteria if necessary.

(b) Use of covered items by disabled beneficiaries--The Secretary would study and report to the Congress not later than one year following enactment on the effects of the methodology for determining payments for durable medical equipment items and supplies on the ability of persons entitled to disability benefits to obtain equipment, including customized items.

(c) Variations in Quality of Equipment--The Secretary would study and report to the Congress not later than one year after enactment describing prosthetic devices or orthotics and prosthetics that do not require individualized or custom fitting and adjustment. The Secretary would make recommendations regarding an appropriate method for determining the amount of payment for such items that do not require individualized or custom fitting and adjustment.

Effective Date

Effective upon enactment, except as otherwise indicated.

Sec. 122 Prohibition Against Carrier Forum Shopping

The Secretary would be authorized to designate in a regulation one carrier for one or more entire regions to process all claims within the region for covered durable medical equipment, prosthetic devices, and orthotics and prosthetics. Unless permitted by the Secretary, suppliers would be prohibited from submitting claims to any carrier other than the carrier having jurisdiction over the geographic area that includes the permanent residence of the patient to whom the item is furnished.

Effective Date

Effective for items and services furnished on or after May 1, 1994.

Sec. 123 Restrictions on Certain Marketing and Sales Activity

Suppliers would be prohibited from making unsolicited telephone contacts with Medicare beneficiaries, unless the individual gives written permission to the supplier, or the supplier has furnished the individual with a covered item within the preceding 15 months. Medicare would not pay for items provided subsequent to a prohibited telephone contact. The Secretary would be required to exclude from programs under the

Social Security Act suppliers who knowingly make prohibited telephone contacts to such an extent that the supplier's conduct establishes a pattern of contacts in violation of the prohibition. Beneficiaries would not be liable for the cost of items provided as a result of prohibited telephone contacts, and the supplier would be required to refund any amounts collected on a timely basis or be subject to certain sanctions.

Effective Date

Effective 60 days after enactment.

Sec. 124 Anti-kickback Clarification

The exemption from anti-kickback penalties for employees in bona-fide employment relationships with providers of Medicare-covered services and supplies would not include the tasks of transmitting assignment rights of Medicare beneficiaries to suppliers of covered items, or performing warehousing or stock inventory functions.

Effective Date

Effective 60 days after enactment.

Sec. 125 Limitations on Beneficiary Liability for Non-covered Services

Medicare beneficiaries would not be financially liable for covered items furnished by a supplier on an unassigned basis if: (1) the supplier does not meet Medicare standards for suppliers of medical equipment and supplies; (2) Medicare has denied payment for the item in advance; or (3) the carrier has determined that the item is not medically necessary.

Effective Date

Effective for services provided on or after October 1, 1994.

Sec. 126 Adjustments for Inherent Reasonableness

The Secretary would determine whether the payment amounts for decubitus care mattresses, transcutaneous electrical nerve stimulators (TENS), and any other items considered appropriate by the Secretary are inherently reasonable and would adjust payments for these items if the amounts are not inherently reasonable. Adjustments for these items would be based on the prices and costs applicable at the time the item is furnished.

Effective Date

Effective on the date of enactment.

Sec. 127 Miscellaneous and Technical Corrections

(a) Updates to Payment Amounts--The OBRA 90 error would be corrected by specifying that the 1991 and 1992 update is the CPI-U minus one percentage point.

(b) Potentially Overused Items and Advance Determinations of Coverage--The Secretary would be able to develop a list of potentially overused items for which advance determinations of coverage may be made if the Secretary determines, based on prior payment experience, that these items are frequently subject to unnecessary utilization throughout a carrier's entire service area or portion of such area. The Secretary could also develop a list of suppliers for which advance determinations of coverage may be made because the Secretary has found that a substantial number of claims have been denied on the basis that they are not medically necessary; or the Secretary has identified a pattern of overutilization resulting from the business practices of the supplier.

A carrier would be required to determine in advance of delivery of an item whether payment for the item may not be made because the item not covered, is included on the list of potentially overused items developed by the Secretary or the item is furnished by a supplier included on the list of potentially abusive suppliers developed by the Secretary.

(c) Study in Variations in Durable Medical Equipment Supplier Costs--The Secretary would be required to collect data on supplier costs for DME and analyze them to determine costs attributable to service and product components and the extent to which they vary by type of equipment and geographic region. The HCFA administrator would be required to submit a report and recommendations for a geographic cost adjustment index for DME supplies and an analysis of the impact of such an index on Medicare payments.

(d) Oxygen Retesting--The OBRA 90 language regarding the arterial blood gas values would be amended to require retesting when a beneficiary's initial value is at or above 56.

In addition, the proposal includes certain technical corrections to Sections 4152 and 4153 of OBRA 90.

Effective Date

Effective as if included in OBRA 90.

Part 3-Other Items and Services

Sec. 131 Technical Amendments Relating to Ambulatory Surgical Centers

(a) Payment Amounts--The update for ambulatory surgery services would be established, beginning with fiscal year 1995, at the CPI-U, as estimated by the Secretary, for the twelve-month period ending with the midpoint of the year involved. The Secretary would be required to conduct a survey, based on a representative sample of procedures and facilities, taken not later than January 1, 1995 and updated every five years thereafter, of the actual audited costs of ambulatory surgery facilities. The survey results would be used in establishing payment rates. The Secretary would be required to consult with appropriate trade and professional organizations in updating the list of procedures that can be performed in ambulatory surgery centers.

(b) Adjustments to Payment Amounts for New Technology Intraocular Lenses--The Secretary would be required, within one year after the date of enactment, to develop and implement a process for reviewing reimbursement for new technology intraocular lenses (IOLs). In order to be considered a new technology IOL, the device would have to be approved by the FDA. The Secretary would also be required to consider specific circumstances in determining whether to adjust the payment amount for new technology IOLs. The provision also would specify the administrative procedures for reviewing and approving new technology IOLs.

(c) Technical Corrections--The provision makes technical and miscellaneous corrections to OBRA 90 regarding ambulatory surgery centers.

Effective Date

Subsection (a) would be effective upon enactment. Any adjustments of payment amounts under Subsection (b) would become effective not later than 30 days after the date on which the notice of adjustment is published. Subsection (c) would be effective as if included in OBRA 90.

Sec. 132 Study of Medicare Coverage of Patient Care Costs Associated with Clinical Trials of New Cancer Therapies

The Secretary would study the costs of patient care for Medicare beneficiaries enrolled in clinical trials of new cancer therapies (where the protocol for the trial has been approved by

the National Cancer Institute or meets similar scientific and ethical standards, including approval by an Institutional Review Board) and report to Congress within two years.

Effective Date

Effective upon enactment.

Sec. 133 Study of Annual Cap on Medicare Payments for Outpatient Physical and Occupational Therapy

The Secretary would study the appropriateness of continuing the annual limitation on the amount of payment for outpatient services of independently practicing physical and occupational therapists and report to Congress by January 1, 1995.

Effective Date

Effective upon enactment.

Sec. 134 Part B Premium Payments for Late Enrollment

The Secretary would be authorized to enter into agreements with States for purposes of allowing States to make premium payments for penalties associated with late enrollment under Part B. States would be permitted to make quarterly payments on a lump-sum basis.

Effective Date

Effective upon enactment.

Section 135 Treatment of Inpatients and Provision of Diagnostic X-Ray Services by Rural Health Clinics and Federally Qualified Health Centers

The provision clarifies that rural health clinics (RHCs) and federally qualified health centers (FQHCs) are not limited to providing services solely to outpatients. Physician services provided to Medicare patients of a RHC or a FQHC would be covered (and paid for through the all-inclusive rate) when such patients are inpatients in a covered medical facility. In addition, diagnostic X-ray services would be covered as qualified RHC and FQHC services.

Effective Date

Applies to services furnished on or after January 1, 1994.

Section 136 Application of Mammography Certification Requirements

Any mammography facility providing covered screening or diagnostic mammograms to Medicare beneficiaries would be required to hold a certificate (or provisional certificate) issued in accordance with the provisions of the Public Health Service Act.

Effective Date

Applies to mammography furnished by a facility on and after the first date that the certificate requirements of section 354(b) of the Public Health Service Act apply to such mammography conducted by such facilities.

Sec. 137 Coverage of Speech-Language Pathologists and Audiologists

The term "speech pathologist" would be changed to "speech-language pathologist" where it appears, except that this amendment would not change the definition of services covered in any setting. A statutory definition of speech-language pathologists and audiologists would be established, consistent with current coverage guidelines.

Effective Date

Effective on January 1, 1994.

Sec. 138 Other Technical Amendments Relating to Part B of the Medicare Program

(a) Revision of Information on Part B Claims--The claim form would be required to include the unique physician identification number (UPIN), and the requirement that claims indicate whether the referring physician is an investor in the entity would be repealed.

(b) Consultation for Social Workers--Clinical social workers would be required to consult with a patient's attending physician in the same manner as clinical psychologists.

(c) Reports on Hospital Outpatient Payment--The requirement for the preparation of reports contained in Section 6137 of OBRA 89 and Section 1135(d)(6) of the Social Security Act would be repealed.

(d) Radiology and Diagnostic Services Provided in Hospital Outpatient Departments--Outpatient payment limits would apply to diagnostic services. The physician component of the limit would be based on the resource based relative value scale.

(e) Payments to Nurse Practitioners in Rural Areas--The services of nurse practitioners and clinical nurse specialists would be added to the list of services excluded from the definition of inpatient hospital services.

(f) Other Technical and Conforming Amendments--The special enrollment period would be modified to allow individuals who have employer group health coverage to enroll in Part B at any time they are enrolled in the group health plan, rather than after they leave the plan. If an individual enrolls in Part B while enrolled in the group health plan or in the first month after leaving the plan, Medicare coverage would begin on the first day of the month in which the individual enrolled (or, at the option of the individual) on the first day of any of the following three months).

Various technical and conforming amendments to Sections 4154 through 4164 of OBRA 90 would be made.

Effective Date

Except as otherwise provided, effective as if included in OBRA 90.

Subtitle C Provisions Relating to Parts A and B

Sec. 151 Medicare Secondary Payer Reforms

(a)(1) The Administrator of HCFA would be required to mail questionnaires to individuals, before such individuals become entitled to benefits under part A or enroll in part B, to determine whether the individual is covered under a primary plan. In addition, the provision would clarify that payments would not be denied for covered services solely on the grounds that a beneficiary's questionnaire fails to note the existence of other health plan coverage.

(2) Providers and suppliers would be required to complete information on claim forms regarding potential coverage under other plans.

Civil monetary penalties would be established for an entity that knowingly, willfully and repeatedly fails to complete a claim form with accurate information.

(b)(1) Contractors would be required to submit a report to the Secretary annually regarding steps taken to recover mistaken payments.

(2) The Secretary would be required to evaluate the performance of contractors in identifying cases in which Medicare

is secondary payer.

(3) The provision would clarify the Secretary's authority to charge interest if payment is not received within 60 days after notice is given.

Effective date

The requirements under subsection (a) regarding improved identification of Medicare secondary payer situations would be effective upon the date of enactment, with the exception of subparagraph (2)(A), affecting screening requirements for providers and suppliers, which would apply to items and services furnished on or after January 1, 1994. The requirements specified under (b)(1) and (b)(2) would apply to contracts with fiscal intermediaries and carriers for years beginning in 1994. Paragraph (b)(3) affecting the deadline for reimbursement by primary plans would apply to payments for items and services furnished on or after the date of enactment.

Section 152. Physician Ownership and Referral

The provision would clarify reporting requirements by specifying that physicians would be required to report investment and compensation arrangements (in addition to ownership) of designated health services. The provision would also clarify the list of designated health services subject to self-referral prohibitions by deleting the term "other diagnostic services" following radiology services and substituting "magnetic resonance imaging, computerized axial tomography scans and ultrasound services." The provision would clarify the application of effective dates with respect to some exceptions.

Effective date

The provisions regarding reporting requirements and the list of designated health services would apply to referrals made on or after January 1, 1995. The provision clarifying effective dates would apply as if included in the enactment of OBRA 93.

Section 153. Definition of FMGEMS Examination for Payment of Direct Graduate Medical Education

This provision allows the Secretary to recognize the successor test to the Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS).

Sec. 154 Qualified Medicare Beneficiary Outreach

The Secretary would be required to establish and implement a method for obtaining information from individuals when they become entitled to benefits under part A or enroll in part B that may be used to determine eligibility for benefits under the QMB program.

Effective Date

Effective upon the date of enactment.

Sec. 155 Hospital Agreements with Organ Procurement Organizations

Hospitals and rural primary care hospitals would be required to enter into an agreement with the organ procurement organization (OPO) designated by the Secretary for the geographic area in which the hospital or rural primary care hospital is located unless the hospital or rural primary care hospital has obtained a waiver from the Secretary. The Secretary would be required to grant a waiver if the Secretary determines: (1) that the waiver is expected to increase organ donation; and (2) that the waiver will assure equitable treatment of patients referred for transplants within the service area served by such hospital's designated OPO and within the service area served by the OPO with which the hospital or rural primary care hospital enters into an agreement under the waiver.

In making a decision whether to grant a waiver, the Secretary would be authorized to consider such factors as (1) cost effectiveness; (2) improvements in quality; (3) whether there has been any change in a hospital's designated OPO due to a change made on or after December 28, 1992 in the definitions for metropolitan statistical areas (as established by the Office on Management and Budget); and (4) the length and continuity of a hospital's relationship with an OPO other than the hospital's designated OPO, except that the factors the Secretary may consider in determining whether to grant a waiver are not to be construed to permit the Secretary to grant a waiver that is not expected to increase organ donation or assure equitable treatment to both OPOs affected by a waiver.

Hospitals or rural primary care hospitals seeking a waiver would be required to submit an application to the Secretary containing information the Secretary deems appropriate. The Secretary would be required to publish a public notice of any waiver application within 30 days of receiving an application and would be required to offer interested parties the opportunity to submit written comments during a 60-day period following publication of the notice.

Hospitals and rural primary care hospitals that currently have agreements with organ procurement organizations other than

the OPO designated by the Secretary for that geographic area and which desire to continue such agreements must submit a waiver application to the Secretary by January 1, 1995. Hospitals and rural primary care hospitals may continue such agreements pending the Secretary's decision on the waiver.

The Office of Technology Assessment (OTA) would be required, pursuant to the approval of its Technology Assessment Board, to study the efficacy and fairness of requiring a hospital or rural primary care hospital to enter into an agreement with the OPO designated by the Secretary for the service area in which the hospital or rural primary care hospital is located and the impact of this requirement on the efficacy and fairness of organ procurement and distribution. The OTA would be required to submit its report to Congress not later than two years following enactment of this act. The report is to include findings and the implications of these findings on policies affecting organ procurement and distribution.

Effective date

Applies to hospitals and primary care hospitals participating in Medicare and Medicaid beginning January 1, 1995.

Sec. 156 Peer Review Organizations

The requirement that PROs precertify selected surgical procedures would be repealed. Clarifies the notification of state licensing boards by PROs.

Effective Date

Effective upon the date of enactment.

Sec. 157 Health Maintenance Organizations

The Secretary would be required to revise the payment methodology for HMOs for contract years beginning with 1994 to take into account variation in costs associated with beneficiaries for whom Medicare is the secondary payer. The Secretary would be further required to submit a proposal to Congress by October 1, 1994 that provides for revisions to the payment methodology for contract years beginning with 1996. In proposing the revisions, the Secretary would be required to consider (1) the difference in costs associated with beneficiaries with different health status and (2) the effects of using alternative geographic classifications. The Comptroller General would be required to report to the Congress on the proposed revisions no later than three months after the Secretary's proposal was submitted.

Effective Date

Effective upon the date of enactment.

Sec. 158 Home Health Agencies

(a) Wage Index -- The most recent hospital wage data are to be used in constructing the home health wage index for cost reporting periods beginning July 1, 1996.

(b) Waiver of Liability Extension -- The limits on liability for claims disallowed by a lack of medical necessity are extended through December 31, 1995 to be comparable to Skilled Nursing Facilities (SNFs) and Hospice Services.

Sec. 159 Permanent Extension of Authority to Contract with Fiscal Intermediaries and Carriers on Other than a Cost Basis

Limited authority provided in section 2326 of the Deficit Reduction Act of 1984 for the Secretary to enter into agreements with fiscal intermediaries and carriers on other than a cost basis would be made permanent.

Sec. 160 Miscellaneous and Technical Corrections

(a) Survey and Certification Requirements--The provision would clarify that user fees imposed under the Clinical Laboratory Improvement Act are not subject to the general ban on user fees.

Minor and technical errors relating to a home dialysis demonstration program authorized under OBRA 90 and Medicare secondary payer requirements in OBRA 90 would be corrected. In addition, the provision would correct minor and technical errors in Sections 4201 through 4207 of OBRA 90.

(b) Other Technical Amendments--A number of minor technical amendments relating to Parts A and B of the Medicare program would be made.

(c) Technical Correction To Revisions of Coverage for Immunosuppressive Drug Therapy--The provision would modify the phase-in schedule enacted in OBRA 93 for beneficiaries who receive immunosuppressive drugs following an organ transplant. Individuals who receive a transplant prior to 1994 would be eligible for immunosuppressive drug coverage within 12 months following the date of the transplant. Individuals who receive a transplant during 1994 would be eligible for such drug coverage for 487 days after the date of the transplant.

Effective Date

Effective on the date of enactment.

Subtitle D--Medicare Supplemental Insurance Policies

Sec. 171 Standards for Medicare Supplemental Insurance Policies

Preventing Duplication--This provision would continue the current law prohibition on the sale of duplicative health insurance policies subject to the conditions described in the following paragraph. The provision would clarify that it is unlawful to sell or issue to an individual entitled to benefits under Part A or enrolled under Part B: (i) a health insurance policy with knowledge that such policy duplicates health benefits to which such an individual is otherwise entitled under Medicare or Medicaid; (ii) a Medigap policy with knowledge that the individual is entitled to benefits under another Medigap policy; or, (iii) a health insurance policy, other than a Medigap policy, with knowledge that such policy duplicates health benefits to which the individual is otherwise entitled.

Penalties would not apply, however, to the sale or issuance of a policy or plan that duplicates health benefits under Medicare or Medicaid or a policy or plan that duplicates health benefits to which the individual is otherwise entitled if, under the policy or plan, all benefits are fully payable directly to or on behalf of the individual without regard to other health benefit coverage of the individual. In addition, for the penalty to be waived in the case of the sale or issuance of a policy or plan that duplicates benefits under Medicare or Medicaid, the application for the policy must include a statement, prominently displayed, disclosing the extent to which benefits payable under the policy or plan duplicate Medicare benefits.

Policies that would be subject to the disclosure requirement include, but are not limited to: specific disease policies, hospital confinement indemnity policies, long term care policies, policies that provide fixed indemnity benefits for nursing home care, nursing services in the home or for home care, and policies that provide fixed indemnity benefits for any medical or surgical service or treatment.

The new provisions pertaining to non-duplication would not alter the current law prohibition on the sale of a Medigap policy to a Medicaid beneficiary, except for policies containing prescription drug coverage to Qualified Medicare Beneficiaries, and there is no prohibition on sale of policies to low-income Medicare beneficiaries for whom Medicaid pays only Part B

premiums.

Loss Ratios and Refund of Premiums--The provision would clarify that the OBRA 90 loss ratio standard would apply to policies sold or renewed after the effective date of the provision. With respect to a refund or credit for policies issued prior to the effective date of the provision, the calculation would be based on aggregate benefits provided and premiums collected for all policies issued by an insurer in a state and based only on aggregate benefits provided and premiums collected under the policies after the effective date. Other minor and technical drafting errors would be corrected.

Pre-existing Condition Limitations--The provision would clarify the intent of OBRA '90 that, in the case of individuals enrolled in part B prior to age 65, Medigap insurers are required to offer coverage, regardless of medical history, for a six-month period when the individual reaches age 65. The provision would also clarify that insurers are prohibited from discriminating in the price of policies for such an individual, based upon the medical or health status of the policyholder.

Other Miscellaneous and Technical Corrections--The provision would clarify that certain language should be deleted from section 12(C) of the National Association of Insurance Commissioners Model Regulations pertaining to sales commissions. The effective dates for various provisions would be modified. Other minor and technical drafting errors would be corrected.

Effective Date

Effective upon the date of enactment.

Medicaid Explanation of Provisions

Sec. 201 Medicaid Managed Care Antifraud Provisions

a) Prohibiting Affiliations with Individuals Debarred by Federal Agencies -- Prohibits Medicaid managed care entities from having as a director, officer, partner, or person with beneficial ownership greater than five percent of the organization's equity if the person has been debarred or suspended from government contracting pursuant to the Federal Acquisition Regulations, or if the person is an affiliate of such debarred person. Prohibits Medicaid managed care entities from having business affiliations (employment, consulting, or other agreement) for the provision of goods and services that are significant and material to the managed care organization if the person has been debarred or suspended from government contracting pursuant to the Federal Acquisition Regulations.

b) Requirement for State Conflict of Interest Safeguards in Medicaid Risk Contracting -- Requires a state to certify to the Secretary that it has safeguards against conflict of interest between state employees responsible for Medicaid managed care contracting and such contractors.

c) Disclosure of Financial Information -- Requires Medicaid managed care contractors to report financial information specified by the Secretary and the states related to fiscal solvency. A managed care contractor must also agree to make available certain specified information to enrollees upon request.

d) Prohibiting Marketing Fraud -- Requires the Secretary to promulgate regulations on marketing for enrollment and re-enrollment purposes to provide adequate client information.

e) Requiring Adequate Provision Against the Risk of Insolvency -- Requires the Secretary promulgate regulations concerning solvency standards for Medicaid managed care contractors.

f) Requiring Report on Net Earnings and Additional Benefits -- Medicaid managed care providers will be required to provide an audited financial statement and a report on any benefits provided to Medicaid clients in excess of what was required under the Medicaid contract. These will be annual requirements and the required information will be provided to the State and the Secretary for each contract year.

Effective Date

a) Effective for Medicaid managed care contracts entered into or renewed on or after January 1, 1994.

b) Effective July 1, 1994, whether or not there are

Medicaid Explanation of Provisions

Sec. 201 Medicaid Managed Care Antifraud Provisions

a) Prohibiting Affiliations with Individuals Debarred by Federal Agencies -- Prohibits Medicaid managed care entities from having as a director, officer, partner, or person with beneficial ownership greater than five percent of the organization's equity if the person has been debarred or suspended from government contracting pursuant to the Federal Acquisition Regulations, or if the person is an affiliate of such debarred person. Prohibits Medicaid managed care entities from having business affiliations (employment, consulting, or other agreement) for the provision of goods and services that are significant and material to the managed care organization if the person has been debarred or suspended from government contracting pursuant to the Federal Acquisition Regulations.

b) Requirement for State Conflict of Interest Safeguards in Medicaid Risk Contracting -- Requires a state to certify to the Secretary that it has safeguards against conflict of interest between state employees responsible for Medicaid managed care contracting and such contractors.

c) Disclosure of Financial Information -- Requires Medicaid managed care contractors to report financial information specified by the Secretary and the states related to fiscal solvency. A managed care contractor must also agree to make available certain specified information to enrollees upon request.

d) Prohibiting Marketing Fraud -- Requires the Secretary to promulgate regulations on marketing for enrollment and re-enrollment purposes to provide adequate client information.

e) Requiring Adequate Provision Against the Risk of Insolvency -- Requires the Secretary promulgate regulations concerning solvency standards for Medicaid managed care contractors.

f) Requiring Report on Net Earnings and Additional Benefits -- Medicaid managed care providers will be required to provide an audited financial statement and a report on any benefits provided to Medicaid clients in excess of what was required under the Medicaid contract. These will be annual requirements and the required information will be provided to the State and the Secretary for each contract year.

Effective Date

a) Effective for Medicaid managed care contracts entered into or renewed on or after January 1, 1994.

b) Effective July 1, 1994, whether or not there are

regulations.

c) Effective for contract years beginning on or after April 1, 1994, whether or not there are regulations promulgated by such date for information required to be reported before that date.

d) Effective for contract years beginning on or after April 1, 1994.

e) Effective for contract years beginning on or after January 1, 1995.

f) Effective for contract years beginning on or after January 1, 1994.

Sec. 202-204 Medicaid Managed Care Waiver Extensions

Extends waivers of the enrollment mix requirement for certain managed care organizations in the District of Columbia, Tennessee, and Wisconsin through December 1995.

Effective Date

Effective upon enactment, except for Chartered Health Plan of the District of Columbia, whose waiver extension is effective retroactively back to October 1992.

Sec. 205 Extension of Minnesota Prepaid Medicaid Demonstration Project

Extends the demonstration period through 1998 and provides authority and conditions for the imposition of premium charges for participants.

Effective Date

Effective upon enactment.

Sec. 211 Prior Institutionalization Requirement for Home and Community Based Waiver Programs

Eliminates the prior institutionalization requirement for habilitation services provided under a home and community based waiver program.

Effective Date

Effective for services provided on or after January 1, 1994.

Sec. 212 Third Party Liability

Relieves states of the obligation to pursue payment from third parties for the costs of Medicaid case management services

when it is not cost-effective in the aggregate to do so.

Effective Date

Effective January 1, 1994.

Sec. 213 Changes to Certain Waiver Formula

Makes technical changes to the 1915(d) waiver formula.

Effective Date

Effective as if included in OBRA 87.

Sec. 221 Presumptive Eligibility

Modifies current law to permit state eligibility workers to make presumptive eligibility determinations for pregnant women under certain conditions if the state uses all other presumptive providers specified in statute.

Effective Date

Effective January 1, 1994.

Sec. 222 Medicaid Disallowances

Allows states to make a showing of certain factors that the Secretary and the Departmental Appeals Board shall consider in determining the amount of a Medicaid disallowance.

Effective Date

Effective for disallowances made on or after enactment.

Sec. 223 Medicaid Intermediate Sanctions for Kick Violations

a) Penalty for Kickbacks -- In addition to criminal penalties for kickback violations under Title XI, provides for intermediate sanctions (civil monetary penalties) for violation of the antikickback rules by state health care program providers.

b) Authorization to Impose Civil Monetary Penalties -- Allows the Secretary of HHS to impose civil monetary penalties if the Attorney General does not initiate action in federal District Court within one year of the date on which the Secretary presents to the Attorney General for consideration, a case concerning a state health care program provider.

Effective Date

a) Effective upon enactment.

b) Effective for cases presented to the Attorney General on

or after enactment.

Sec. 224 Medicaid Tax and Donation Provision

Makes technical change to 1991 law to prohibit double taxation of Health Maintenance Organizations.

Effective Date

Effective Janaury 1, 1994 except where state law changes are required.

Sec. 225 Application of Mammography Certification Rules

Requires a Medicaid facility to be certified (provisionally or otherwise) under Sec. 354 of the Public Health Service Act in order to receive payment for mammography screening.

Effective Date

Effective concurrent with Sec. 354 except in the case of states requiring state enabling legislation in which case the provision is effective the first day of the first calendar quarter beginning after the close of the first regular session of the state legislature that begins after the date of enactment.

Sec. 226 Nursing Home Reform Changes

a) Nurse Aide Training in Nursing Facilities Subject to an Extended Facility Survey -- Modifies the conditions under which a nursing facility would be prohibited from conducting nurse aide training when it is subject to an extended survey of compliance with Medicaid conditions of participation.

b) Requirements for Drug Regimen Review Consultants -- Allows the Secretary to consider the availability of qualified consultants in determining whether a nursing facility has met requirements for review of resident drug therapies.

c) Residents' Personal Funds -- Raises the minimum amount of funds which a nursing facility must place in a separate, interest bearing account from $50 to $100.

d) Due Process Protections for Nurse Aides -- Prohibits including any undocumented allegations against a nurse aide in a state registry that pertain to resident abuse or neglect, or misappropriation of resident property.

e) Written Notice of Allegations -- Clarifies that a state must make written notification to a nurse aide of allegations of abuse or misappropriation of property, including a written notice of an opportunity for a hearing to rebut allegations and requires that the state make a written finding concerning the

allegation(s).

Effective Date

a) Effective as if included in OBRA 87.

b) Effective as if included in OBRA 87.

c) Effective January 1, 1994.

d) Effective January 1, 1994.

Sec. 227 Maternal and Child Health Block Grant

Sets the MCHBG authorization level at $705 million.

Effective Date

Effective upon enactment.

Sec. 242 Corrections to OBRA 90 Drug Rebate Program

Makes various technical corrections and clarifications to the Medicaid drug rebate provisions of OBRA 90.

Effective Date

Effective as if included in OBRA 90.

Secs. 241, 243-264 Corrections to OBRA 90

Makes various technical corrections and clarifications to OBRA 90 provisions.

Effective Date

Effective as if included in OBRA 90

Secs. 271-273 Corrections to OBRA 93

Makes technical corrections to OBRA 93 provisions concerning personal care services and emergency services to aliens.

Effective Date

Effective as if included in OBRA 93.

Sec. 274 Corrections to Eligibility Provisions of OBRA 93

Makes technical corrections to the asset transfer and trusts provisions of OBRA 93, by including a delayed effective date for states requiring enabling legislation to implement the new rules on asset transfers (to parallel similar provision for

implementation of trust rules) and clarifying that when assets are returned to an individual, the period of ineligibility is proportional to the amount of assets that were not returned.

Effective Date

Effective as if included in OBRA 93

Sec. 275 Corrections Relating to Medicaid Estate Recoveries

Makes technical corrections to the estate recovery provisions.

Effective Date

Effective as if included in OBRA 93

Secs. 276-277 Corrections Relating to Third Party Liability and Medical Child Support

Makes technical changes to both provisions and clarifies that a state must assure the Secretary that it has laws requiring insurers to recognize the rights of assignment of both the state Medicaid agency and the rights of assignment of any other state Medicaid agency.

Effective Date

Effective as if included in OBRA 93.

Sec. 278 Physician Referral

Makes a technical correction to Sec. 13624 concerning physician referrals.

Effective Date

Effective as if included in OBRA 93.

Sec. 279 Vaccine Purchase Provisions

a) Interim Replacement Program -- Conforms provision to current practice by clarifying that vaccine shipping costs for the Medicaid replacement program are not included in the vaccine price under the price cap.

b) Vaccine Purchase -- Clarifies that excise taxes are not included under the price cap.

Effective Date

Both a) and b) are effective as if included in OBRA 93.

Sec. 280 OBRA 1990 Demonstration Project

Makes technical correction to OBRA 90 Medicaid demonstration project.

Effective Date

Effective as if included in OBRA 90.