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Balanced Budget Refinement Act of 1999,
as Incorporated into P.L. 106-113,
Consolidated Appropriations for FY 2000
Enacted November 29, 1999**

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Subtitle A – Adjustments to PPS Payments for Skilled Nursing Facilities

Temporary Increase in Payment for Certain High Cost Patients (Section 101)

Prior Law:

- The BBA required development and implementation of a per diem prospective payment system for skilled nursing facilities. Under the PPS, SNF payment rates encompass all costs of furnishing covered skilled nursing services (including routine, ancillary, and capital-related costs). The transition to the PPS began for cost reporting periods starting on or after July 1, 1998.

Provision:

- Increases payments for 15 patient group payment categories, known as RUGs (extensive services, special care, clinically complex, and 3 rehabilitation groups) by 20 percent for services furnished on or after April 1, 2000 and before the later of October 1, 2000 or implementation of payment refinements by HCFA. It also increases the federal portion of the rate by 4 percent increase for FY 2001 and 2002, and prohibits the increases from being built into the base federal rates.

Effective Date

- Services furnished on or after April 1, 2000.

Authorizing Facilities to Elect Immediate Transition to Federal Rate (Section 102)

Prior Law:

- The BBA provided for a transition to the PPS for SNFs that first received Medicare payment prior to October 1, 1995. In the first cost reporting period beginning after July 1, 1998, payment is 25 percent of the federal rate and 75 percent facility-specific. Payment in the second cost reporting period is a blend of 50 percent federal and 50 percent facility-specific. Payment in the third cost reporting period is a blend of 75 percent federal and 25 percent facility-specific. By the facilities' fourth cost reporting period, the facilities are to be paid the full federal rate. (Facilities that first received Medicare payment after October 1, 1995, (i.e., newer SNFs) began to be paid at the full federal rate as of July 1, 1998.)

Provision:

- This provision allows for SNFs to elect to bypass the transition to the PPS and instead to be paid at the full federal rate beginning with their next cost reporting period.

Effective Date

- Facilities can elect to be paid the full federal rate as of December 15, 1999, but the election is not effective for cost reporting periods beginning before January 1, 2000.

Part A Pass-Through Payment for Certain Ambulance Services, Prostheses, and Chemotherapy Drugs (Section 103)

Prior Law:

- The BBA excludes a short list of services from the prospective payment system and from consolidated billing (e.g. physicians' services, psychologist, CRNA, etc.).

Provision:

- This provision expands the list of services excluded by statute from the SNF PPS to include certain chemotherapy items and administration services, certain radioisotope services, certain prosthetic devices, and ambulance services furnished in conjunction with renal dialysis treatments. It requires that any increase in total payments that result from these exclusions be budget neutral beginning in FY 2001.

Effective Date

- Items and services furnished on or after April 1, 2000.

Provision for Part B Add-Ons for Facilities Participating in the NHCMQ Demonstration Project (Section 104)

Prior Law:

- The BBA provided for an add-on to the payment rates for Part B services furnished as part of a Part A covered stay for facilities that did not participate in the demonstration that preceded SNF PPS. The BBA did not provide for a similar add-on for facilities that participated in the demo.

Provision:

- This provision provides for an extra payment (add-on) for Part B services furnished as part of a Part A covered stay for SNFs that participated in the demonstration that tested the SNF PPS system.

Effective Date:

- As if included in the BBA.

Special Consideration for Facilities Serving Specialized Patient Populations (Section 105)

Prior Law:

- All SNFs are paid under the PPS; there are no special payment rules for SNFs serving primarily AIDS patients.

Provision:

- This provision allows SNFs that specialize in the treatment of AIDS patients, to be paid a 50-50 blend of their facility-specific and federal rates starting with the first cost reporting period beginning after enactment and ending on September 30, 2001. It

also requires a Secretarial Report to Congress by March 1, 2001 on the resource use of AIDS patients to determine whether adjustments in the SNF PPS payment categories (RUGs) are needed to account for the special needs of AIDS patients.

Effective Date:

- The first cost reporting period beginning after enactment.

MedPAC Study on Special Payment for Facilities Located in Hawaii and Alaska (Section 106)

Prior Law:

- Existing law provides for a cost-of-living adjustment for hospitals, but not SNFs, located in Alaska and Hawaii.

Provision:

- Requires MedPAC to study SNFs in Alaska and Hawaii to determine the need for a cost-of-living adjustment to the PPS rates to account for unique circumstances in those two states. The study is to be submitted no later than 18 months after enactment.

Effective Date

- Enactment

Study and Report Regarding State Licensure and Certification Standards and Respiratory Therapy Competency Examinations (Section 107)

Prior Law:

- Existing law does not provide for separate certification in respiratory therapy for health care providers who administer respiratory therapy in SNFs.

Provision:

- This provision requires the Secretary to conduct a study to (a) identify variations in State licensure and certification standards for health care providers administering respiratory therapy in SNFs; (b) examine State requirements relating to respiratory therapy competency examinations; and (c) determine whether regular respiratory therapy examinations or certifications should be required under the Medicare program. It also requires a report to Congress on the results of the study no later than 18 months after enactment.

Effective Date:

- Enactment.

Subtitle B – PPS Hospitals

Modification in Transition for Indirect Medical Education (IME) Percentage Adjustments (Section 111)

Prior Law:

- The BBA reduced the Medicare IME add-on payment to 6.0 percent in FY 2000, and to 5.5 percent beginning with FY 2001.

Provision:

- This provision increases payment to teaching hospitals for indirect medical education costs by adjusting the schedule for decreasing these payments. It sets IME payments at 6.5 percent for FY 2000, 6.25 percent for FY 2001 and 5.5 percent beginning with FY 2002.

Effective date:

- Discharges beginning with FY 2000.

Decrease in Reductions for Disproportionate Share Hospitals; Data Collection Requirement (Section 112)

Prior Law:

- The BBA reduced Medicare DSH payments by 1 percent in 1998, by 2 percent in 1999, by 3 percent in 2000, by 4 percent in 2001, and by 5 percent in 2002.

Provision:

- This provision would lessen reductions in DSH payments that are made to hospitals that care for large numbers of low income and uninsured patients. It reduces DSH payments by 3 percent in 2001 (instead of 4 percent) and 4 percent in 2002 (instead of 5 percent). It also requires hospitals to submit data on costs incurred by hospitals for providing uncompensated care, including bad debt and charity care.

Effective date:

- Discharges occurring during FY 2001. The submission of data is required for cost reporting periods beginning on or after October 1, 2001.

Subtitle C – PPS-exempt Hospitals

Wage Adjustment of Percentile Cap for PPS-Exempt Hospitals (Section 121)

Prior Law:

- The BBA established a cap for new PPS-exempt facilities' payments based on the 110th percentile of the national median of the target amount for hospitals in the same class (i.e., psychiatric hospitals, long-term care, etc.) for cost reporting periods ending

during FY 1996. This cap was wage adjusted. The BBA did not provide for a wage adjustment to the cap for facilities that received their first Medicare payment before October 1, 1997. The cap for these facilities was set at the 75th percentile of the national median of the target amount for hospitals in the same class.

Provision:

- This provision provides for a wage adjustment of the 75th percentile limit established by the BBA for PPS-exempt facilities that received their first Medicare payment before October 1, 1997.

Effective Date:

- For cost reporting periods beginning on or after October 1, 1999.

Enhanced Payments for Long Term Care and Psychiatric Hospitals Until Development of Prospective Payment Systems for Those Hospitals (Section 122)

Prior Law:

- The BBA put into place new, less generous, bonus and relief payments for PPS-exempt facilities. The bonus payment had been the lesser of half the amount by which operating costs are less than expected or 1 percent of the target amount.

Provision:

- This provision increases bonus payments for long-term care and psychiatric hospitals from 1.0 percent to 1.5 percent for cost reporting periods beginning on or after October 1, 2000 and before September 30, 2001; and 2.0 percent for cost reporting periods beginning on or after October 1, 2001 and before September 30, 2002.

Effective Date:

- Enactment

Per Discharge Prospective Payment System for Long-Term Care Hospitals (Section 123)

Prior Law:

- The BBA required the Secretary to submit by October 1, 1999 a report to Congress on the development of a PPS for long-term care hospitals.

Provision:

- Requires the Secretary to submit a report to Congress that describes a per discharge prospective payment system for long-term care hospitals by October 1, 2001. It also requires the Secretary to implement a per discharge PPS based on DRGs by October 1, 2002.

Effective Date:

- Report 10/01/01, PPS 10/01/02

Per Diem Prospective Payment System for Psychiatric Hospitals (Section 124)

Prior Law:

- No requirement for a PPS for psychiatric hospitals.

Provision:

- Requires the Secretary to submit by October 1, 2001 a Report to Congress on a per-diem PPS for psychiatric hospitals. It also requires the Secretary to implement by October 1, 2002 a per-diem PPS for psychiatric hospitals.

Effective Date:

- Report 10/01/01, PPS 10/01/02

Refinement of Prospective Payment System for Inpatient Rehabilitation Services (Section 125)

Prior Law:

- The BBA required the Secretary to implement a PPS for inpatient rehabilitation services by October 1, 2000.

Provision:

- Requires the Secretary to implement a per discharge PPS based on functional-related groups. Functional-related groups are to be based on impairment, age, comorbidities, and functional capability of patients and such other factors that the Secretary deems appropriate to improve the explanatory power of functional independence measure – function related groups. It does not preclude the Secretary from developing and implementing a transfer policy. It also requires the Secretary to submit, within 3 years of implementation of the PPS, a report to Congress on the impact on utilization and beneficiary access to services under the PPS for inpatient rehabilitation.

Effective Date:

- Enactment.

Subtitle D – Hospice Care

Temporary Increase in Payment for Hospice Care (Section 131)

Prior Law:

- Hospice payments are based on one of four prospectively determined daily rates that correspond to levels of care. Before BBA, the rates were updated annually by the hospital market basket. The BBA reduced the updates to market basket minus 1 percentage point for FY1999 through FY2002 and required the Secretary to collect hospice cost data.

Provision:

- Increases the payment update for FY 2001 by 0.5 percent and FY 2002 by 0.75 percent. The additional payments are not to be included in the updates after FY 2002.

Effective Date:

- Enactment.

Study and Report to Congress Regarding Modification of the Payment Rates for Hospice Care (Section 132)

Prior Law:

- The Secretary is required to collect data from hospices on the costs of care provided for each fiscal year beginning with FY1999.

Provision:

- Requires the GAO to study the feasibility and advisability of updating hospice payment rates and the cap amount determined with respect to a fiscal year for routine home care and other services included in hospice care. The study shall examine the cost factors used to determine hospice rates and caps, and evaluate whether the cost factors used to determine the rates should be modified, eliminated, or supplemented with additional cost.

Effective Date:

- A Report to Congress is due November 29, 2000 on the GAO study, including any recommendations for legislation that GAO determines appropriate.

Subtitle E – Other Provisions

MedPAC Study on Medicare Payment for Nonphysician Health Professional Clinical Training in Hospitals (Section 141)

Prior Law:

- The BBA required the Medicare Payment Advisory Commission to conduct a study on Medicare payment for training in nursing and other allied health professions.

Provision:

- Requires MedPAC to conduct a study of Medicare payment policy regarding professional clinical training of different classes of nonphysician health care professionals (such as nurses, nurse practitioners, physician assistants, allied health professionals, and psychologists).

Effective date:

- MedPAC must submit this report to Congress no later than 18 months after enactment.

Subtitle F – Transitional Provisions

Exception to the Case Mix Index (CMI) for One Year (Section 151)

Prior Law:

- No provision

Provision:

- Deems Northwest Mississippi to have satisfied the case mix index criteria for classification as a rural referral center for FY 2000.

Effective Date:

- For FY 2000

Reclassification of Certain Counties for Purposes of Reimbursement Under Medicare (Section 152)

Prior Law:

- No provision

Provision:

- Deems hospitals in Iredell County, North Carolina to be located in Charlotte-Gastonia-Rock Hill-North Carolina-South Carolina MSA. Deems hospitals in Orange County, New York to be included in New York, New York MSA. Deems hospitals in Lake County, Indiana and Lee County, Illinois to be located in Chicago, Illinois MSA. Deems hospitals in Hamilton-Middletown, Ohio to be located in Cincinnati, Ohio-Kentucky-Indiana MSA. Deems hospitals located in Brazoria County, Texas to be located in Houston, Texas MSA. Deems hospitals in Chittenden County, Vermont to be located in the Boston-Worcester-Lawrence-Lowell-Brockton, Massachusetts-New Hampshire MSA. Hospitals in these counties are deemed to be part of the specified MSAs for FY 2000 and FY 2001.

Effective Date:

- For discharges occurring during FY 2000.

Wage Index Correction (Section 153)

Prior Law:

- No Provision

Provision:

- Requires the Secretary to recalculate the Hattiesburg, Mississippi MSA for FY 2000 by including FY 1996 wage data from Wesley Medical Center.

Effective Date:

- For discharges occurring during FY 2000.

Calculation and Application of Wage Index Floor for a Certain Area (Section 154)

Prior Law:

- No provision

Provision:

- Requires the Secretary to recalculate the wage index for the Allentown-Bethlehem-Easton MSA for FY 2000 and 2001 by including the wage data from Lehigh Valley Hospital. For FY 2001, for calculating and applying the wage index, Lehigh Valley Hospital is treated as being classified in the Allentown-Bethlehem-Easton MSA.

Effective Date:

- For discharges occurring during FY 2000.

Special Rule for Certain Skilled Nursing Facilities (Section 155)

Prior Law:

- No provision

Provision:

- Establishes special payment rates for skilled nursing facilities in Baldwin or Mobile County, Alabama for FY 2000 and FY 2001.

Effective Date:

- For cost reporting periods beginning in FY 2000.

Subtitle A – Hospital Outpatient Services

Outlier Adjustment And Transitional Pass-Through For Certain Medical Devices, Drugs And Biologic Agents (Section 201(a), (b), (c), (d) and (i))

Prior Law:

- The BBA required the Secretary to develop and implement an outpatient prospective payment system in which payments are made based on a fee schedule established for each service or group of services. The Secretary was permitted to establish adjustments, in a budget neutral manner, as determined to be necessary to ensure equitable payments, such as outlier adjustments.

Provisions:

- Outlier Adjustments – In order to ensure appropriate payment for high-cost cases, this provision provides additional payments for “outlier” services that cost more than a given threshold (taking into account any transitional pass-through payments described

below). The threshold is to be established by the HHS Secretary. The additional payments are to cover the marginal cost of care beyond the threshold. These payments in total can be no more than 2.5 percent of total program payments for outpatient hospital services for each year before 2004 and no more than 3 percent in subsequent years. For services furnished before January 1, 2002, outlier payments may be based on costs for all services included in a bill for a patient submitted by an outpatient department, rather than for a specific outpatient service. In addition, the cost of services furnished to a patient may be based on an aggregate cost-to-charge ratio for the entire hospital, rather than cost-to-charge ratios for specific departments within the hospital.

- Transitional Pass-Through Payments - The provision also creates “transitional pass-through payments” for specific items in the outpatient setting in order to ensure beneficiary access to drugs, biologicals, and new technology. This means Medicare can, temporarily, pay above and beyond the prospective payment rate for orphan drugs, cancer therapy drugs, biologic agents, brachytherapy, radiopharmaceuticals, and new medical devices, drugs and biologic agents. New medical devices, drugs, and biologic agents shall receive a pass-through payment only if the cost is not insignificant in relation to the OPD fee schedule amount. For drugs and biologic agents, the pass-through payment will equal the difference between the otherwise applicable portion of the OPD PPS payment related to the drug or agent and 95 percent of the average wholesale price. For devices, the pass-through payment will equal the difference between that portion of the OPD PPS payment related to the device and the hospital’s cost for the device (determined based on adjusting charges). Pass-through payments are limited to a period of two to three years. Total additional payments cannot exceed 2.5 percent of total program payments for outpatient hospital services for each year before 2004 and no more than 2 percent in subsequent years. If the Secretary estimates, before the beginning of the year, that total pass-through payments for the year will exceed those caps, the Secretary shall reduce pro rata the amount of each pass-through payment to ensure the limit is not exceeded.
- Budget Neutrality - These outlier and pass-through payments must be made in a budget neutral manner so that they generate no increase or decrease in total payment for outpatient hospital services.
- No Impact on Copayments – The outlier and pass-through payments shall have no effect on beneficiary copayment amounts.
- Limitation on Judicial Review for New Adjustments – The following components of the outlier adjustments shall not be subject to administrative or judicial review: the threshold for determining whether a service shall receive an outlier payment; the marginal cost of care beyond the threshold; and the percentage used to limit aggregate outlier adjustments. The following components of the transitional pass-through payments shall not be subject to administrative or judicial review: the determination of insignificance of cost for new devices, drugs, and biologic agents; the duration of

additional payments; the portion of the OPD fee schedule amount associated with particular devices, drugs, or biologicals; and the application of any pro rata reduction to ensure that the aggregate limit is not exceeded.

Effective Date:

- Upon implementation of the prospective payment system.

Inclusion of Certain Implantable Items Under System (Section 201(e))

Previous Law:

- Previous law required implantable prosthetic devices and implantable durable medical equipment (DME) furnished in OPDs to be paid under the prosthetics and DME fee schedules. Implantable items associated with diagnostic tests were already paid under the payment system for outpatient department services.

Provision:

- Requires implantable prosthetic devices, implantable durable medical equipment, and any implantable items associated with diagnostic tests to be paid for under the outpatient prospective payment system when furnished in a hospital outpatient department. Such an implantable item must be classified to the group that includes the service to which it relates.

Effective Date:

- As if included in the BBA.

Authorizing Payment Weights Based on Mean Hospital Costs (Section 201(f))

Prior Law:

- The law required that the weights for the OPD PPS be based on median hospital costs.

Provision:

- This provision allows the HHS Secretary to base payment weights for the OPD PPS on mean hospital costs.

Effective Date:

- As if included in the BBA.

Limiting Variation of Costs of Services Classified With a Group (Section 201(g))

Prior Law:

- The law required the Secretary to establish groups of outpatient services so that services classified within each group are comparable clinically and with respect to the use of resources.

Provision:

- Stipulates that in classifying services to groups, the highest median cost for an item or service within a group can not exceed two times the lowest median cost for an item or service within the group. The Secretary may make exceptions in unusual cases, such as for low volume items and services, but may not make exceptions for orphan drugs.

Effective Date:

- As if included in the BBA.

Annual Review of OPD PPS Components (Section 201(h))

Prior Law:

- The law required the Secretary to periodically review and revise the groups, the relative payment weights, and the wage and other adjustments to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors.

Provision:

- Requires the Secretary to review components of the OPD PPS not less often than annually. The Secretary is also required to consult with an expert outside advisory panel, composed of representatives of providers, to review and advise the Secretary on the clinical integrity of the groups and weights. The panel may use data collected or developed by entities other than the Department of Health and Human Services.

Effective Date:

- Requires the Secretary to first conduct the annual review in 2001 for application in 2002.

Extension of Payment Provisions of Section 4522 of BBA until Implementation of PPS (Section 201(k))

Prior Law:

- Section 4522 of the Balanced Budget Act extended through calendar year 1999 the following two provisions that would otherwise have expired at the end of 1998: the 10 percent reduction in payments for hospital outpatient capital, and the 5.8 percent reduction for outpatient services paid on a cost basis.

Provision:

- This provision would extend the 10 percent reduction in payments for hospital outpatient capital and the 5.8 percent reduction for outpatient services paid on a cost basis beyond 1999 until such time as the outpatient prospective payment system is implemented.

Effective Date:

- As if included in the BBA.

Congressional Intention Regarding Base Amounts in Applying the HOPD PPS (Section 201(l))

Prior Law:

- The law required that the Secretary should determine the aggregate amount payable under the OPD PPS in 1999 (the base period) based on: (1) the total amount of Medicare payments that would have otherwise been paid for outpatient hospital services in 1999 in the absence of the PPS; and (2) the total amount of copayments that are estimated to be paid for outpatient hospital services in 1999 under the OPD PPS. This aggregate amount is then used to establish the conversion factor that is used to determine the OPD fee schedule amounts.

Provision:

- This provision authorizes the Secretary to determine the total amount of beneficiary copayments that were estimated to be paid for outpatient hospital services in 1999, without regard to the provision in prior law prescribing the manner in which this calculation was to be done. Instead, the provision requires only that the Secretary determine such amount in a budget neutral manner with respect to aggregate payments to hospitals.

Effective Date:

- As if included in the BBA.

Study of Delivery of Intravenous Immune Globulin (IVIG) Outside Hospitals and Physicians' Offices (Section 201(n))

Prior Law:

- No provision.

Provision:

- Requires the Secretary to study the extent to which intravenous immune globulin (IVIG) could be delivered and reimbursed by Medicare outside of a hospital or physician's office. The Secretary shall: consider sites of services that other payors use; determine whether covering these drugs in a patient's home raises safety concerns and whether it would reduce overall spending; and determine whether changing site of service would affect access to care. The Secretary shall make recommendations on the appropriate manner and settings under which Medicare should pay for IVIG outside a hospital or physician's office.

Effective Date:

- The study is due 18 months after enactment.

Establishing a Transitional Corridor for Application of OPD PPS (Section 202)

Prior Law:

- The law allowed the Secretary to establish adjustments to the OPD PPS, in a budget neutral manner, as determined to be necessary to ensure equitable payments.

Provision:

- Transitional Corridors - Establishes transitional corridors until January 1, 2004 for the OPD PPS to limit losses in payments under the OPD PPS. A formula is established so that hospitals receive additional Medicare payments if the amount they receive under the OPD PPS in relation to their costs is less than their payment to cost ratio in 1996. The 1996 payment to cost ratio is calculated as if the formula driven overpayment, which was eliminated in the Balanced Budget Act, effective on October 1, 1997, were eliminated in 1996. These transitional payments have no effect on beneficiary copayments and are not subject to budget neutrality.

In order to determine transitional payments, a comparison is made between a hospital's payments (including cost-sharing) under the prospective payment system in a given year (the PPS amount) and the hospital's costs in that year multiplied by the hospital's 1996 payment to cost ratio (the pre-BBA amount).

For OPD services furnished under the PPS before 2002, if a hospital's PPS amount is:

- between 90 percent and 100 percent of the pre-BBA amount, 80 percent of that loss will be made up by additional Medicare payments.
- between 80 percent and 90 percent of the pre-BBA amount, the hospital will receive additional payments equal to the amount by which 71 percent of the pre-BBA amount exceeds 70 percent of the PPS amount.
- between 70 percent and 80 percent of the pre-BBA amount, the hospital will receive additional payments equal to the amount by which 63 percent of the pre-BBA amount exceeds 60 percent of the PPS amount.
- less than 70 percent of the pre-BBA amount, the hospital will receive additional payments equal to 21 percent of the pre-BBA amount.

In 2002, if the hospital's PPS amount is:

- between 90 percent and 100 percent of the pre-BBA amount, 70 percent of that loss will be made up by additional Medicare payments.
- between 80 percent and 90 percent of the pre-BBA amount, the hospital will receive additional payments equal to the amount by which 61 percent of the pre-BBA amount exceeds 60 percent of the PPS amount.
- less than 80 percent of the pre-BBA amount, the hospital will receive additional payments equal to 13 percent of the pre-BBA amount.

In 2003, if the hospital's PPS amount is:

- between 90 percent and 100 percent of the pre-BBA amount, 60 percent of that loss will be made up by additional Medicare payments.

- less than 90 percent of the pre-BBA amount, the hospital will receive additional payments equal to 6 percent of the pre-BBA amount.
- Temporary Treatment for Small Rural Hospitals – If a hospital with not more than 100 beds is located in a rural area, Medicare payments shall be increased to that hospital to ensure that their PPS amount is no lower than their pre-BBA amount for each year before 2004.
- Permanent Treatment for Cancer Hospitals – In the case of cancer hospitals, Medicare payments shall be increased to ensure that their PPS amount in each year is no lower than their pre-BBA amount.
- Interim Payments – The Secretary shall make additional transitional payments to hospitals under this provision on an interim basis, subject to retrospective adjustments based on settled cost reports.

Effective Date:

- As if included in the BBA.

Study and Report to Congress Regarding the Special Treatment of Rural and Cancer Hospitals in Prospective Payment System for Hospital Outpatient Department Services (Section 203)

Prior Law:

- No provision

Provision:

- The Medicare Payment Advisory Commission (MedPAC) is required to conduct a study to determine the appropriateness (and appropriate method) of paying the following hospitals for OPD services under the OPD PPS: Medicare-dependent small rural hospitals, sole community hospitals, rural health clinics, rural referral centers, any other rural hospital with not more than 100 beds, any other rural hospital that the Secretary determines appropriate, and cancer hospitals. MedPAC is required to make recommendations for legislation that it determines is appropriate as a result of the study.

Effective Date:

- The report is due 2 years after enactment. The Secretary is required to comment on the report no later than 60 days after completion.

Limitation on Outpatient Hospital Copayment for A Procedure to the Hospital Deductible Amount (Section 204)

Prior Law:

- When the PPS is implemented, the law establishes beneficiary copayments at 20 percent of national median charges. These rates are frozen until the copayment represents 20 percent of the total fee schedule amount. Under previous law, there were no upper limits on copayment amounts.

Provision

- Caps beneficiary copayments for outpatient services under the prospective payment system to the dollar amount of the deductible for an inpatient hospital stay (under Part A) with Medicare making up the difference between the limited copayment amount and the otherwise applicable copayment amount.

Effective Date:

- Effective as if included in the BBA.

Subtitle B – Physician Services

Modification of Update Adjustment Factor Provisions to Reduce Oscillations and Require Estimate Revisions (Section 211)

Prior Law:

- The BBA established the Sustainable Growth Rate (SGR) to balance the need to control total Medicare spending with the need to ensure adequate payment for physicians' services. However, the formula resulted in wide, unintended fluctuations from year to year.

Provision:

- This provision stabilizes the formula for updating physician payment rates. It moves the SGR target for total physician spending, which is used to adjust inflation updates, to a calendar year basis, beginning with 2000. It requires, within 90 days from enactment, a *Federal Register* notice on factors relating to the transition of the SGR from a fiscal to a calendar year basis, including the SGR for 2000. It modifies the update adjustment factor to blend 75 percent of the difference between actual and target expenditures in the previous year, and 33 percent of the cumulative difference between actual and target expenditures. To promote budget neutrality, it provides special adjustments of -0.2 percent for 2001 through 2004 and +0.8 percent for 2005. It requires the SGR to be revised based on later data available by September 1st of the year of the revision. It includes a transition provision for years in which the SGR is revised. After the transition, each November 1st, the Secretary must publish the SGR for the following year and revise the SGR for the current year and two preceding years. The SGR for the third preceding year would be final.

- It requires a *Federal Register* notice by November 1 of each year, beginning with 2000, publishing the update, conversion factor, and allowed expenditures that will apply for the next year. It requires, by March 1 of each year beginning with 2000, that an estimate of the next year's sustainable growth rate and of the conversion factor and the data used in making the estimate be made available to the Medicare Payment Advisory Commission (MedPAC) and the public. It requires MedPAC to include in their June 1st annual report to Congress a review of the estimate of the conversion factor for the next year.
- It requires the Agency for Health Care Policy & Research to study: (1) ways to accurately estimate the impact on Medicare physician expenditures from: (a) improvements in medical capabilities; (b) advances in technology; (c) Medicare demographic changes; and (d) changes in geographical locations where beneficiaries receive services; (2) the rate of use of physician services in the original Medicare fee-for-service program among beneficiaries between ages 65 and 74, 75 and 84, 85 and over, and disabled beneficiaries under age 65; and (3) other factors that may reliably predict Medicare fee-for-service use of physician services. The Secretary must report to Congress within 3 years of enactment. MedPAC must report to Congress, within 6 months of the Secretary's report to Congress, including an analysis and evaluation of the Secretary's report and recommendations.

Effective Date:

- For determining the conversion factors for years beginning with 2001.

Use of Data Collected by Organizations and Entities in Determining Practice Expense Relative Values (Section 212)

Prior Law:

- Congress required that payment for physician practice expenses (overhead costs, etc.) be made based on the relative practice expense resources included in furnishing a service rather than on historical charges as in the past.

Provision:

- It requires a process to accept and use data collected or developed outside HHS to supplement HHS data in determining practice expense relative values. An interim final regulation must be published so such data can be used in computing practice expense relative value units for 2001. It requires that publication of the estimated and final updates for 2001 and 2002 include a description of the process for using external data in adjusting relative value units. It must also describe the extent to which such external data have been used, particularly where the data otherwise used are not based on a large enough sample to be statistically reliable.

Effective Date:

- Enactment, but applies to payments beginning with 2001. It requires an interim final regulation during 2000.

GAO Study on Resources Required to Provide Safe and Effective Outpatient Cancer Therapy (Section 213)

Prior Law:

- Medicare must pay for physician practice expenses based on the relative practice expense resources involved with furnishing the service.

Provision:

- It requires the GAO to conduct a nationwide study to determine the physician and non-physician clinical resources necessary to provide safe outpatient cancer therapy services and the appropriate Medicare payment rates. The GAO is required to: (1) determine the adequacy of practice expense relative value units associated with the use of those clinical resources; (2) determine the adequacy of work units in the practice expense formula; and (3) assess various standards to assure the provision of safe outpatient cancer therapy services. GAO is to report to Congress on these issues and include a cost estimate of their recommendations.

Effective Date:

- There is no statutory date for the report to Congress.

Subtitle C – Other Services

Revision of Provisions Relating To Therapy Services (Section 221)

Prior Law:

- Prior to BBA, there were two annual per beneficiary limits of \$900 each for physical therapy and occupational therapy furnished by independent practitioners of therapy. The BBA broadened the scope of these limits by establishing two annual payment limits for all outpatient Part B therapy services, except for therapy services furnished in hospital outpatient departments. The limits were established as follows: a \$1500 per beneficiary annual cap for all outpatient physical therapy and speech language pathology services and a \$1500 per beneficiary annual cap for all outpatient occupational therapy services.
- The BBA required the Secretary to report to Congress by January 1, 2001 recommending a revised policy for therapy services based on classification of individuals by diagnostic category and prior use of services, in place of the dollar limitations. The recommendations were to include how such a system of durational limits might be implemented in a budget-neutral manner.

Provision:

- 2-Year Moratorium on Caps - Suspends the annual payment limits for therapy services for 2 years -- 2000 and 2001.

- Focused Medical Reviews of Claims – Requires the Secretary, during the 2-year suspension, to conduct focused medical reviews of therapy claims, with an emphasis on claims for services in skilled nursing facilities.
- Revision of BBA Report – Requires the Secretary to submit a report, by January 1, 2001, including recommendations on: (a) the establishment of a mechanism for assuring appropriate utilization of outpatient therapy services; and (b) the establishment of an alternative payment policy for such services based on classification of individuals by diagnostic category, functional status, prior use of services, and other criteria determined appropriate by the Secretary. The report shall recommend how such a policy can be implemented in a budget-neutral manner.
- Study and Report on Utilization – Requires the Secretary to conduct a study, by June 30, 2001, which compares utilization patterns of therapy services provided on or after January 1, 2000 with utilization patterns for services provided in 1998 and 1999. The Secretary is required to review a statistically significant number of claims. The report must include recommendations for legislation that the Secretary determines to be appropriate.
- Referrals by Optometrists – Allows optometrists to refer patients for therapy services as well as establish and review the plan of care.

Effective Date:

- The following provisions are effective for services furnished on or after January 1, 2000: the 2-year moratorium on the caps, the focused medical review of claims and the provision allowing referrals by optometrists.
- The revision of the BBA report is effective as if included in the BBA.

Update In Renal Dialysis Composite Rate (Section 222)

Prior Law:

- Reimbursement for dialysis services for end stage renal disease patients is based on a fixed prospective payment amount set in statute by the Omnibus Budget Reconciliation Act of 1986 (OBRA 1986). OBRA 1990 added one dollar to the base rate that existed after 1986, making the base composite rate \$126 for hospital-based providers and \$122 for freestanding facilities. The rate does not increase each year.

Provision:

- Increases all composite rate payments in the year 2000 by 1.2 percent above 1999 payment rates. Increases year 2001 composite rate payments by 1.2 percent above 2000 rates.
- Sunsets OBRA 1986 language (as amended by OBRA 1989 and 1990) which sets current composite rate. OBRA 1986 composite rate setting language is no longer effective as of January 1, 2000.

- Requires MedPAC to study the difference in payment for home and facility hemodialysis and make recommendations regarding potential changes. Due 18 months after enactment.

Effective Date:

- Enactment.

Implementation of the Inherent Reasonableness (IR) Authority (Section 223)

Prior Law:

- The BBA gave the Secretary the authority to establish realistic and equitable payment amounts for Part B services (other than physicians' services) when the existing payment amounts are inherently unreasonable because they are either grossly excessive or grossly deficient [interim final rule was published 1/7/98]. In September 1998, the DMERCs notified suppliers of proposed IR reductions for six items. On August 13, 1999, HCFA published a Federal Register notice proposing IR reductions for six items.

Provision:

- The Secretary may not use or permit fiscal intermediaries or carriers to use the IR authority until after the GAO releases a report on IR requested on March 1, 1999 and the Secretary publishes a notice of final rulemaking. This final rule must take into account both the GAO report and the comments that were received in response to the interim final rule. In the final rule, HCFA must reevaluate the appropriateness of the criteria for determining whether payments are excessive or deficient that was used in the interim final rule and take appropriate steps to ensure the use of valid and reliable data when using the IR authority.

Effective Date:

- Enactment

Increased Reimbursement for Pap Smears (Section 224)

Prior Law:

- Medicare pays for the lab test component of Pap smears under the clinical laboratory fee schedule. There are currently no minimum payment amounts under such fee schedule.

Provision:

- Requires the Secretary to establish a national minimum payment amount for all diagnostic and screening Pap smear technologies approved by the Food and Drug Administration (FDA) as a primary screening method for detection of cervical cancer. The minimum payment amount shall be \$14.60 for tests furnished in 2000, and in subsequent years, the amount would be updated along with the rest of the clinical laboratory fee schedule.

- Expresses the sense of Congress that HCFA has been slow in providing incentives for use of new cervical cancer screening technologies, and should institute an appropriate payment increase for such technologies that have been approved by the FDA and that are significantly more effective than conventional Pap smears.

Effective Date:

- Test furnished on or after enactment.

Refinement of Ambulance Services Demonstration Project (Section 225)

Prior Law:

- The BBA mandated up to three demonstration projects under which local governments could contract with the Secretary to furnish ambulance services to beneficiaries in their jurisdiction on a capitated payment basis. In the first year, payment rates would equal 95 percent of the average per capita payment for ambulance services during the 3 most recent years for which data is available, with subsequent year increases based on the CPI-U.

Provision:

- Requires the Secretary to publish a request for proposals for the demonstration by July 1, 2000, and amends the demonstration payment formula by authorizing the Secretary to establish a budget-neutral first-year capitated payment rate based on the most current available data, with payment in subsequent years adjusted for inflation.

Effective Date:

- Effective as if included in the BBA.

Phase-In of PPS for Ambulatory Surgical Centers (Section 226)

Prior Law:

- Medicare payments for services provided in ambulatory surgical centers are paid based on a fee schedule established in 1982. HCFA has proposed revising, rebasing, and regrouping the payment rates using data from a 1994 cost survey. The revised rates will be put in place at the time that the outpatient prospective payment system is implemented.

Provision:

- If the new payment rates are implemented for ambulatory surgical centers prior to incorporating data from the 1999 cost survey, the Secretary would be required to phase in the new rates. In the first year, no more than one-third of the payment could be based on the new rates; thus, two-thirds or more would be based on the current rates. In the next year, no more than two-thirds could be based on the new rates; thus, one-third or more would be based on the current rates.

Effective Date:

- Enactment

Extension of Medicare Benefits for Immunosuppressive Drugs (Section 227)

Prior Law:

- Medicare currently covers drugs used to provide immunosuppressive therapy for thirty-six months following a Medicare covered organ transplant.

Provision:

- Increases the number of months of coverage of immunosuppressive drug therapy for post-transplant beneficiaries by 8 months, from 36 to 44 months, for the year 2000, for individuals who exhaust their 36 months of coverage during that year.
- For individuals who exhaust the 36-month period for immunosuppressive drugs in calendar year 2001, the statute provides for 8 months (or more) of additional coverage. The Secretary must specify what any increase in the number of additional months of benefits beyond 8 months will be by May 1, 2001.
- For beneficiaries who exhaust the 36-month period in 2002, 2003 and 2004, the number of additional months of benefits may be more or less than 8 months. The Secretary must specify what the number of additional months of benefits will be for each of these years by May 1 of the preceding year.
- The Secretary must compute the number of additional months of coverage for 2001 through 2004 (if any) using appropriate actuarial methods and make such computation so that, based on the best available data at the time the computation is made, the total expenditures for the additional months for FY 2000 through FY 2004 do not exceed \$150 million. The Secretary is directed to seek to provide for a level number of months of extension for FY 2001 through FY 2004. The Secretary is required to make an annual adjustment in the number of months of extension applicable to 2001 through 2004, to the extent necessary, based on differences between actual and estimated expenditures consistent with the \$150 million five-year figure.
- For the year 2000, for Medicare+Choice plans, the Secretary is required to treat the additional months of coverage in the same manner that a national coverage determination is treated.
- The Secretary must issue a report to Congress by March 1, 2003 including an analysis of the impact of the extension provision, and recommendations regarding an appropriate cost-effective method of providing coverage of immunosuppressive drugs under Medicare on a permanent basis.

Effective Date:

- January 1, 2000

Temporary Increase in Payment Rates for Durable Medical Equipment (DME) and Oxygen (Section 228)

Prior Law:

- The BBA set the updates for DME to zero percentage points for each of the years 1998 through 2002. It also sets the national payment limit for oxygen at the 1997 limit reduced by 25 percent for 1998, and further reduced by 5 percent, for a total reduction of 30 percent for 1999 and subsequent years.

Provision:

- The payment amount for the covered items shall increase by 0.3 percent in 2001 and by 0.6 percent in 2002. These increases would affect payments only in the year specified.

Effective Date:

- Items furnished during 2001 and 2002.

Studies and Reports (Section 229)

Prior Law:

- No provision

Provision:

- Requires the following studies:
 - MedPAC study on the cost-effectiveness of covering post-surgical recovery centers
 - AHCPR study comparing the differences in the quality of ultrasound and other imaging services provided by credentialed and non-credentialed individuals
 - MedPAC study of the regulatory burden placed on providers by the FFS Medicare system
 - GAO study of Department of Justice's use of the False Claims Act

Effective Date:

- Enactment

TITLE III – PROVISIONS RELATING TO PART A and B

Subtitle A – Home Health Services

Adjustment to Reflect Administrative Costs Not Included in the Interim Payment System; GAO Report on Costs of Compliance with OASIS Data Collection Requirements (Section 301)

Prior Law:

- Since July 19, 1999, home health agencies have been required to collect OASIS information on Medicare and Medicaid patients. To assist agencies with OASIS costs, Medicare raised the per visit limits for agencies. However, because of statutory constraints, no additional payment could be provided to agencies subject to the per beneficiary limit.

Provision:

- All home health agencies will be paid \$10 per Medicare beneficiary served during each agency's cost reporting period beginning in FY 2000 to help cover the cost of complying with the OASIS requirements. They will be paid about half of this amount by April 1, 2000 and the rest upon settlement of each agency's cost report.
- GAO will conduct a study of the costs incurred in complying with OASIS, and analyze the impact on patient privacy. The report must be submitted to Congress within 180 days from the date of enactment, and the HHS Secretary must comment on the report. The GAO will, no later than 180 days following receipt of this report, submit audit findings on the cost incurred by agencies in collection of OASIS data.

Effective Date:

- Beneficiaries served during the home health agency cost reporting period beginning in FY 2000.

Delay in the Application of 15 Percent Reduction in Payment Rates for Home Health Services Until One Year After Implementation of Prospective Payment System (Section 302)

Prior Law:

- The BBA required a 15 percent reduction in Medicare home health payments on October 1, 1999, with or without the implementation of the PPS. The Omnibus Consolidated and Emergency Supplemental Appropriations Act for FY 1999 delayed the reduction until October 1, 2000, with or without PPS.

Provision:

- This provision delays the 15 percent payment reduction until one year after implementation of the home health prospective payment system (PPS). The provision also eliminates the requirement for a 15 percent reduction if the PPS does not occur.

Six months following implementation of the PPS, the HHS Secretary is required to submit a report to Congress analyzing the need for the 15 percent reduction, or for any reduction in base payment amounts for home health services under the PPS.

Effective Date:

- Enactment.

Increase in the Per Beneficiary Limits (Section 303)

Prior Law:

- The BBA established a new payment limit under the interim payment system (IPS) for home health agencies, the aggregate per beneficiary limit. Agencies are subject to the lower of (1) the actual cost; (2) the per visit limit; or (3) the aggregate per beneficiary limit.

Provision:

- Home health agencies subject to the per beneficiary payment limit, but that fall below the national median, will receive a 2 percent increase in the per beneficiary limit for cost reporting periods starting during or after FY 2000.

Effective Date:

- Cost reporting periods beginning on or after October 1, 1999.

Clarification of Surety Bond Requirements (Section 304)

Prior Law:

- The BBA required home health agencies to obtain separate surety bonds of at least \$50,000 to participate in the Medicare and Medicaid programs.

Provision:

- Medicare home health agencies must have surety bonds for the lower of \$50,000 or, 10 percent of the aggregate amount of Medicare and Medicaid payments to the agency for that year. Agencies are required to have a surety bond for 4 years, or if there is a change in ownership or control of the agency for an additional period that the Secretary determines appropriate (not to exceed 4 years from the change). Home health agencies now can obtain a single bond for both Medicaid and Medicare business, so long as the bond guarantees return of overpayment under both programs.

Effective Date:

- Enactment.

Refinement of Home Health Agency Consolidated Billing (Section 305)

Prior Law:

- The BBA required that, under the PPS, payment for all items and services furnished to a beneficiary be made to the home health agency. This included payment for DME, which is separate from PPS payments.

Provision:

- Allows suppliers to bill Medicare directly for items provided to a beneficiary receiving home health services.

Effective Date:

- Enactment.

Technical Amendment Clarifying Applicable Market Basket Increase for PPS (Section 306)

Prior Law:

The BBA language implementing the market basket update read “2002 or 2003.”

Provision:

- This provision ensures that the inflation adjustment (market basket update) for home health will occur in both 2002 and 2003.

Effective Date:

- Enactment.

Study and Report to Congress Regarding the Exemption of Rural Agencies and Populations from Inclusion in the Home Health Prospective Payment System (Section 307)

Prior Law:

- The BBA requires prospective payment for all agencies, including rural agencies.

Provision:

- The Medicare Payment Advisory Commission is required to submit a report to Congress, including legislative recommendations, no later than 2 years from enactment on the feasibility and advisability of exempting rural home health agencies from the prospective payment system.

Effective Date:

- Enactment.

Subtitle B – Direct Graduate Medical Education

Use of National Average Payment Methodology in Computing Direct Graduate Medical Education Payments (Section 311)

Prior Law:

- Graduate medical education payments are based on hospital-specific per-resident amounts based on GME costs in 1984 and updated for inflation. There is wide variation in the per-resident payment amounts.

Provision:

- Per-resident payment amounts are increased for hospitals below 70 percent of a geographically adjusted national average, to 70 percent of that average. If a hospital's per-resident amount for a given cost reporting period exceeds 140 percent of a geographically adjusted national average, then the update for the next cost reporting period is zero for FY 2001 and FY 2002, and Consumer Price Index minus 2 percentage points (but not below zero) for FY 2003 through FY 2005. Hospitals with per-resident payment amounts between 70 percent and 140 percent of a geographically adjusted national average would continue to receive current payment amounts and scheduled updates.

Effective Date:

- For cost reporting periods beginning during FY 2001.

Initial Residency Period for Child Neurology Residency Training Programs (Section 312)

Prior Law:

- Pediatric neurology is a five-year residency program, but residents are only counted as a full resident for the three years of a pediatric residency or the four years of a neurology residency, whichever residency program they begin first.

Provision:

- This provision allows pediatric neurology residents to be counted as a full resident for five years.
- MedPAC is required to include, in its March 2001 Report to Congress, recommendations regarding the appropriateness of the initial residency period for other residency training programs in a specialty that requires preliminary years of study in another specialty.

Effective Date:

- July 1, 2000.

BBA Technical Corrections (Section 321)

Provision:

- Makes spelling and cross reference corrections in the BBA related to Medicare Part A and Part B, Medicare+Choice, and HIPAA.

Effective Date:

- Except as otherwise provided, the amendments made by this section shall take effect as if included in the enactment of BBA.

TITLE IV – RURAL PROVIDER PROVISIONS

Subtitle A – Rural Hospitals

Permitting Reclassification of Certain Urban Hospitals as Rural Hospitals (Section 401)

Prior Law:

- Payment for inpatient hospital services varies, among other things, based on whether a facility is in an urban or rural area, as determined by Metropolitan Statistical Areas (MSA).

Provision:

- The provision permits urban hospitals to be reclassified as rural hospitals if they are: (1) located in a rural census tract of an urban metropolitan statistical area (as determined by the most recent Goldsmith Modification), (2) located in any area designated by state law or regulation as rural; (3) located in an urban area but otherwise would qualify as a rural, regional or national referral center or a sole community hospital; or (4) other criteria specified by the HHS Secretary. HHS must act on applications for reclassification within 60 days.

Effective Date:

- January 1, 2000.

Update of Standards Applied for Geographic Reclassification for Certain Hospitals (Section 402)

Prior Law:

- Hospitals located in rural counties adjacent to one or more urban areas are treated as being located in the urban MSA to which the greatest number of workers in the county commute using standards published in 1980.

Provision:

- This provision allows more current Census data to be used in reclassification criteria for hospitals located between two Metropolitan Statistical Areas (MSAs). In FY 2001 and 2002 hospitals may choose to use either 1990 or 1980 census data. Starting in FY 2003, the most recently published Census data will be used.

Effective Date:

- For discharges occurring during cost reporting periods beginning on or after October 1, 1999.

Improvements in the Critical Access Hospital (CAH) Program (Section 403)

Prior Law:

- Critical Access Hospitals receive cost-based reimbursement and physicians bill carriers directly. A hospital could be designated as a Critical Access Hospital only if it was: (1) nonprofit or public; (2) located in a rural county more than a 35-mile drive (or 15-mile drive in certain other areas) and certified by the State as a necessary provider; (3) had 24-hour emergency care services; (4) had no more than 15 beds (25 if they have skilled nursing facility beds); and (5) had no more than a 96-hour length of stay per patient.

Provision:

- The provision makes several changes that expand the Critical Access Hospital program. It: (a) changes average length of stay requirements to an average of 96 hours; (b) extends eligibility to for-profit hospitals; (c) extends eligibility to hospitals that closed or downsized within the last 10 years; (d) allows billing for outpatient services based on an all-inclusive rate that covers both facility and professional services (subject to the physician fee schedule); and, (e) eliminates coinsurance and deductibles for outpatient clinical laboratory services, and establishes payment for these services based on the fee schedule.

Effective Date:

- The option to elect an all-inclusive rate method of bill submission applies to cost reporting periods beginning on or after October 1, 2000. Elimination of coinsurance and deductibles for outpatient clinical laboratory services is effective for services furnished on or after enactment. All other provisions are effective upon enactment.

Five Year Extension of Medicare Dependent Hospital (MDH) Program (Section 404)

Prior Law:

- The Balanced Budget Act of 1997 reinstated and extended the MDH classification, starting in October 1, 1997 through October 2001. The MDH program provides higher reimbursement for rural facilities with fewer than 100 beds serving large numbers of Medicare beneficiaries.

Provision:

- This provision extends the enhanced payment system for Medicare dependent hospitals for another five years.

Effective Date:

- Enactment.

Rebasing for Certain Sole Community Hospitals (SCH) (Section 405)

Prior Law:

- Sole community hospitals receive payment based on the greater of (1) a hospital-specific target amount based on its updated FY1982 costs; (2) a hospital-specific target amount based on its updated 1987 costs; or (3) the Federal national standardized amount.

Provision:

- This provision permits sole community hospitals to be paid a rebased target amount based on their FY1996 costs. A transition to the 1996 target amount is provided: FY 2001 – 25 percent rebased target amount, 75 percent previous target amount; FY 2002 – 50 percent rebased target amount, 50 percent previous target amount; FY 2003 – 75 percent rebased target amount, 25 percent previous target amount; and, FY 2004 – 100 percent rebased target amount.

Effective Date:

- For cost reporting periods beginning on or after October 1, 2000.

One-Year Sole Community Hospital Payment Increase (Section 406)

Prior Law:

- The payment increase for sole community hospitals in FY 2001 was set at the market basket minus 1.1 percent.

Provision:

- This provision gives sole community hospitals a one-year payment increase by providing an update of the full market basket percentage increase for FY 2001.

Effective Date:

- Enactment

Increased Flexibility in Providing Graduate Physician Training in Rural Areas (Section 407)

Prior Law:

- The BBA allows teaching hospitals to receive graduate medical education payments for no more residents than they had in 1996 (as of the last cost reporting period in that year).

Provision:

- This provision: (1) expands the number of residents Medicare will pay for in rural hospitals by 30 percent; (2) allows non-rural facilities that operate separately accredited rural training programs in rural areas, or that operate accredited training programs with integrated rural tracks, to also increase their resident limits, as determined by the Secretary; (3) allows hospitals to increase their residency caps by up to three if a primary care resident was on approved leave during the 1996 cost reporting period used to determine the cap; and (4) allows a resident who was at a Veterans' hospital and then transferred to a non-Veterans' hospital between January 1, 1997 and July 31, 1998, to be included in the residency cap at the non-Veteran's hospital.

Effective Date:

- All the provisions except the VA residency provision are effective April 1, 2000. The VA provision is effective as if included in the BBA.

Elimination of Certain Restrictions with Respect to Hospital Swing Bed Program (Section 408)

Prior Law:

- Rural hospitals with fewer than 100 beds can use some as "swing beds" for long-term care but must receive a certificate of need from the state to do so. Hospitals with more than 49 beds could be paid for providing extended care services for no more than 5 days care per patient.

Provision:

- This provision eliminates the requirement to obtain a state certificate of need to use acute care beds as "swing beds" for long-term care patients. It also eliminates constraints on the length of stay in swing beds for rural hospitals with 50-100 beds.

Effective Date:

- Effective at the end of the skilled nursing facility prospective payment system transition period. SNF PPS began for cost reporting periods beginning on or after July 1, 1997.

Grant Program for Rural Hospital Transition to Prospective Payment (Section 409)

Prior Law:

- The HHS Secretary can give grants to states under the Medicare Rural Hospital Flexibility Program for rural health care plans, rural health networks, designating Critical Access Hospitals, and emergency services.

Provision:

- This provision lets rural hospitals with less than 50 beds apply for grants of as much as \$50,000 to make data systems upgrades (both hardware and software) for new prospective payment systems.
- The Secretary is required to report to the House Ways and Means Committee and the Senate Finance Committee, at least annually on the grant program, with a final report no later than 180 days after the completion of all of the projects for which the grants are made.

Effective Date:

- Enactment.

GAO Study on Geographic Reclassification (Section 410)

Provision:

- This provision requires the General Accounting Office to study the effects of geographic reclassification of hospitals to determine the appropriateness for applying Medicare wage indices and whether the reclassifications result in more accurate payments for all hospitals. The study is to evaluate: (1) the effect of reclassification on rural hospitals that do not reclassify; (2) whether the current thresholds used in geographic reclassification reclassify hospitals to the appropriate labor markets; (3) the effect of eliminating geographic reclassification through use of occupational mix data; (4) group reclassification policy; (5) changes in the number of reclassifications and the compositions of the groups; (6) the effect of State-specific budget neutrality compared to national budget neutrality; and (7) whether sufficient controls exist over the intermediary evaluation of wage data reported by hospitals. The report is due to Congress no later than 18 months after date of enactment.

Effective Date:

- Enactment.

Subtitle B – Other Rural Provisions

MedPAC Study of Rural Providers (Section 411)

Prior Law:

- There are several categories of special payments and payment methodologies for rural hospitals, including designation as Critical Access Hospitals, Sole Community Hospitals, and Rural Referral Centers, all designed to promote access to quality care for rural beneficiaries.

Provision:

- This provision requires the Medicare Payment Advisory Commission (MedPAC) to evaluate the special payments and payment methodologies established for rural hospitals, including their impact on beneficiary access and quality of services. The report is due to Congress no later than 18 months after date of enactment.

Effective Date:

- Enactment.

Expansion of Access to Paramedic Intercept Services in Rural Areas (Section 412)

Prior Law:

- The BBA authorized direct payments to paramedics in rural areas for advanced life support services furnished under contract with a volunteer ambulance company that provides only basic life support services and that is prohibited by state law from billing for any services.

Provision:

- This provision requires areas designated as rural by any State law or regulation, or that are located in a rural census tract of a Metropolitan Statistical Area (as determined by the most recent Goldsmith Modification), to be treated as rural by Medicare in payment for paramedic intercept services.

Effective Date:

- January 1, 2000.

Promoting Prompt Implementation of Informatics, Telemedicine, and Education Demonstration Project (Section 413)

Prior Law:

- The demonstration was authorized in the BBA, with the goal of increasing access and compliance for chronic disease care and developing a model for cost-effective telemedicine delivery in both managed care and fee-for-service. It set payment for services at 50 percent of reasonable costs. It limited the amount of cost-share that a beneficiary could be required to pay.

Provision:

- This provision requires HHS to award a contract within three months of enactment for a four-year telemedicine demonstration project for beneficiaries with diabetes who reside in medically underserved rural and inner-city areas. The award must go to the applicant with the best technical proposal as of the date of enactment. The provision also clarifies that the underserved areas that qualify for the demonstration must be federally designated “medically underserved areas or health professional shortage areas” at the time of beneficiary enrollment in the demonstration. It establishes that the telemedicine provider must be a “telemedicine network.” It deletes a limit on payment at 50 percent of reasonable cost and instead allows payment be made for reasonable costs related to provision of these services. It requires the demonstration to bear all costs and bars cost-sharing by beneficiaries.

Effective Date:

- Enactment

TITLE V – MEDICARE+CHOICE & OTHER MANAGED CARE

Subtitle A – Provisions to Accommodate and Protect Medicare Beneficiaries

Changes in Medicare+Choice Enrollment Rules (Section 501)

Prior Law:

- Under prior law, when a Medicare+Choice plan terminated its contract or reduced its service area, enrollees’ “guaranteed issue” rights to Medigap policies did not apply until coverage terminated (generally January 1). In addition, enrollment in Medicare+Choice for institutionalized persons would have generally been limited beginning in 2002. And Medicare+Choice plans could only offer continuation of enrollment to enrollees who permanently left the plan’s service area and reside in designated “continuation areas” so long as the enrollees had access to Medicare’s basic benefits.

Provision:

- Section 501(a): Gives beneficiaries the option of access to an alternative Medicare+Choice plan and Medigap, either within 63 days of receiving notice from their plan that the plan is leaving the program, or within 63 days of when their coverage is terminated. Beneficiaries exercising the first option must disenroll from the Medicare+Choice plan before their coverage is terminated.
- Section 501(b): Institutionalized persons would be permitted to enroll in a Medicare+Choice plan or change from one plan to another at any time that a plan is accepting new enrollees.

- Section 501(c): Permits a Medicare+Choice plan that is reducing its service area to offer its enrollees, in all or part of the affected area, the option of staying in the plan so long as the enrollees agree to obtain all basic services (except for urgent or emergency services) exclusively through the plan's providers located in the plan's reduced service area. This is permitted only if no other Medicare+Choice plan is available at the time the plan elects to provide this option to its enrollees.

Effective Date:

- Section 501(a): Notices provided on or after enactment.
- Section 501(b): Enactment.
- Section 501(c): Applies to service area reductions before, on, or after enactment.

Change in Effective Date of Elections and Changes of Elections of Medicare+Choice Plans (Section 502)

Prior Law:

- Under prior law, a beneficiary's decision to enroll in a Medicare+Choice plan, change Medicare+Choice plans, or return to original Medicare from a Medicare+Choice plan was effective the first day of the first calendar month following the date on which the change was made.

Provision:

- A beneficiary's decision to change Medicare+Choice plan elections made after the 10th day of each month will not become effective until the first day of the second calendar month after the election is made.

Effective Date:

- Changes in elections of coverage made on or after January 1, 2000.

2-Year Extension of Medicare Cost Contracts (Section 503)

Prior Law:

- The Balanced Budget Act specified that cost-based contracts could not be extended or renewed after December 31, 2002.

Provision:

- Changes the date after which cost contracts cannot be renewed to December 31, 2004.

Subtitle B – Provisions to Facilitate Implementation of the M+C Program

Phase-in of New Risk Adjustment Methodology; Studies and Reports on Risk Adjustment (Section 511)

Prior Law:

- Medicare+Choice payments are adjusted using only demographic factors, including age, gender, Medicaid coverage, institutionalized status, and working status. The Balanced Budget Act required implementation of a risk adjustment payment methodology based on health status, effective January 1, 2000. The Secretary announced a five-year phase-in of risk adjustment. For the first four years risk adjustment would be based on a system using inpatient hospitalization data (PIP-DCG), blending the current demographic method with the new PIP-DCG method. In the fifth year, payments would be based on a comprehensive risk adjuster using data from multiple settings. The phase-in schedule was:

<u>Year</u>	<u>Old Demographic Method</u>	<u>New Method</u>
2000	90%	10% PIP-DCG
2001	70%	30% PIP-DCG
2002	45%	55% PIP-DCG
2003	20%	80% PIP-DCG
2004	----	100% ACC Method

Provision:

- Section 511(a): Changes the phase-in schedule for risk adjustment of Medicare+Choice payments. Provides that payments shall be based on 10% of the new risk adjustment methodology in 2000 and 2001 and no more than 20% in 2002.
- Section 511(b): Requires MedPAC to study and make recommendations to Congress by December 1, 2000 on the following aspects of the risk adjustment methodology:
- the ability of the average risk adjustment factor applied to a Medicare+Choice plan to explain variations in plans' average per capita Medicare costs;
- the year-to-year stability of the risk factors applied to each Medicare+Choice plan and the potential for substantial changes in payment for small plans;
- for new enrollees in a Medicare+Choice plan, the correspondence between the average risk factor calculated from fee-for-service data for these individuals before enrollment to the average risk factor calculated during their initial year of enrollment in a Medicare+Choice plan;
- for Medicare beneficiaries disenrolling from or switching Medicare+Choice plans, the correspondence between the average risk factor calculated from data prior to disenrollment to the period after disenrollment;
- the exclusion of discretionary hospitalizations from the risk adjustment methodology;
- any other changes or improvements that could be made to the risk adjustment methodology.

- Section 511 (c): Requires the Secretary of HHS to study and report to Congress by January 1, 2001 on reducing cost and burden on managed care organizations in complying with the reporting requirements on encounter data for implementation of risk adjustment. The study must address the following issues:
- limiting the number and types of sites of services for which encounter data must be reported;
- establishing alternative risk adjustment methods that would require submission of less data;
- the potential for Medicare+Choice organizations to misreport, overreport, or underreport prevalence of diagnoses in outpatient sites of care, the potential for increases in payments to Medicare+Choice organizations from changes in coding practices, and proposed methods for detecting and adjusting for variations in diagnosis coding;
- the impact of reporting requirements on the willingness of insurers to offer Medicare+Choice MSA plans and options for modifying the requirements; and
- differences in the ability of Medicare+Choice organizations to report encounter data and the potential for adverse competitive impacts on group and staff model health maintenance organizations or other integrated providers of care.

Effective Date:

- Enactment.

Encouraging Offering of Medicare+Choice Plans in Areas Without Plans (Section 512)

Prior Law:

- Bonus payments were not previously offered to Medicare+Choice plans that wanted to enter areas with no existing plans.

Provision:

- This provision increases Medicare+Choice payments in areas where enrollment in a Medicare managed care plan has not been offered since 1997 or for which all Medicare+Choice organizations serving the area filed notice by October 13, 1999 that they would no longer provide service in the area as of January 1, 2000. Payments are increased by an additional 5% for the first 12 months the plan is offered and by an additional 3% for the second 12 months the plan is offered. The bonus only applies to plans, which are first offered during the 2-year period beginning January 1, 2000, and to the first plan approved in any given area unless more than one plan is approved on the same date. These payment increases are temporary.

Effective Date:

- Enactment.

Modification Of The 5-Year Reentry Rule for Contract Terminations (Section 513)

Prior Law:

- Prior law generally prevented the Secretary from entering into a Medicare+Choice contract with a Medicare+Choice organization if, within the preceding 5 years, the organization had a Medicare+Choice contract that it did not renew. The ban could be waived under certain circumstances. HCFA interpreted the ban so that it did not apply to Medicare+Choice service area reductions, only to complete contract terminations. Further, in Operational Policy Letter #103, we stated that plans could ask for exceptions to the ban if they wanted to enter an area with two or fewer Medicare+Choice options.

Provision:

- This provision changes the ban from 5 years to 2 years. The provision also provides an exemption to the 2-year ban if, within 6 months of a Medicare+Choice organization giving notice that it was terminating its contract, a legislative or regulatory change were made that would increase payments for the payment area the plan terminated.

Effective Date:

- Effective for contract terminations before, on, or after enactment.

Continued Computation and Publication of Medicare Original Fee-For-Service Expenditures on a County-Specific Basis (Section 514)

Prior Law:

- Prior law required the Secretary to provide Medicare+Choice payment rates for each county annually. The last year for which adjusted annual per capita cost data were published was 1997.

Provision:

- Requires the Secretary to annually publish, beginning with 2001 and at the time Medicare+Choice rates are published, the following county-specific fee-for-service information for the second preceding year:
 - total monthly per capita expenditures, separately for Part A and Part B;
 - total monthly per capital expenditures, reduced by the estimate of expenditures not related to payment of claims (e.g., graduate medical education);
 - average risk factors based on diagnoses for inpatient services; and
 - average risk factors based on diagnoses for inpatient and other sites of service.

Effective Date:

- Enactment.

Flexibility to Tailor Benefits under Medicare+Choice Plans (Section 515)

Prior Law:

- The monthly basic and supplemental premiums and benefits offered under Medicare+Choice plans could not vary among individuals enrolled in the plan. However, HCFA had allowed Medicare+Choice plans to segment service areas so long as the plans charged uniform premiums and benefits within the segment.

Provision:

- Permits Medicare+Choice plans to vary premiums, benefits, and cost-sharing across individuals enrolled in the plan so long as these are uniform within each separate segment of a service area. The segment must consist of one or more payment areas (counties).

Effective Date:

- Applies to contract years beginning 2001.

Delay in Deadline for Submission of Adjusted Community Rates (Section 516)

Prior Law:

- Medicare+Choice plans were required to submit adjusted community rate (ACR) information by May 1 of the previous year.

Provision:

- Changes the date by which Medicare+Choice plans must submit ACR data to July 1.

Effective Date:

- Applies to information submitted by Medicare+Choice organizations for years beginning with 1999.

Reduction in Adjustment in National Per Capita Medicare+Choice Growth Percentage for 2002 (Section 517)

Prior Law:

- The Medicare+Choice update factor for 2002 was to be reduced by 0.5 percentage points.

Provision:

- Changes the reduction in the update for 2002 to 0.3 percentage points.

Deeming of Medicare+Choice Organization to Meet Requirements (Section 518)

Prior Law:

- Medicare+Choice organizations are deemed to meet standards if they are accredited by a private organization that applies and enforces standards (related to quality

assurance, confidentiality, and accuracy of enrollee records) that meet or exceed the standards set for Medicare+Choice plans.

Provision:

- Expands existing law on areas subject to deeming to include: anti-discrimination; access to services; advance directives; and provider participation. In addition, requires the Secretary to determine, within 210 days of receipt of an application from an accrediting organization, whether that organization meets HCFA's standards for deeming. Finally, HCFA could not require that an accreditation organization be able to certify plans for all categories of requirements.

Timing of Medicare+Choice Health Information Fairs (Section 519)

Prior Law:

- The annual nationwide coordinated information and publicity campaign for Medicare+Choice organizations was held in November.

Provision:

- Changes information and publicity campaign for Medicare+Choice organizations to the "fall season."

Effective Date:

- Applies to campaigns conducted beginning in 2000.

Quality Assurance Requirements for Preferred Provider Organization Plans (Section 520)

Prior Law:

- Preferred provider organizations were required to meet the quality requirements of all other coordinated care plans, including HMOs.

Provision:

- Requires preferred provider organizations to meet the same quality requirements as private fee-for-service plans and non-network MSAs.
- Within two years of enactment, requires MedPAC to study and report on appropriate quality improvement standards that should apply to each type of Medicare+Choice plan and to original Medicare. The study must examine the effects, costs, and feasibility of requiring entities and providers under fee-for-service Medicare to comply with quality standards and reporting requirements that are comparable to requirements for Medicare+Choice.

Effective Date:

- The reduction in quality requirements applies to contract years beginning on or after January 1, 2000.

Clarification of Non-Applicability of Certain Provisions of Discharge Planning Process to Medicare+Choice Plans (Section 521)

Prior Law:

- Prior law prohibited the discharge plan from specifying or limiting information given to patients upon discharge about qualified post-acute providers to ensure patients were not directed to a single post-acute facility.

Provision:

- This provision provides an exclusion for Medicare+Choice plans from this prohibition by specifying that hospitals are no longer required to inform Medicare+Choice enrollees, upon discharge from the hospital, of all available skilled nursing facilities and home health agencies. Hospitals may specify, or limit, the information provided to those facilities that contract with the enrollees' Medicare+Choice plan.

Effective Date:

- Enactment.

User Fee for Medicare+Choice Organizations Based on Number of Enrolled Beneficiaries (Section 522)

Prior Law:

- Prior law requires the Secretary to collect a user fee from each Medicare+Choice organization for use in carrying out Medicare+Choice education and enrollment activities. The activities are directed at all Medicare beneficiaries, including those in original fee-for-service Medicare. The user fee is equal to the organizations pro rata share of the aggregate amount of fees authorized to be collected from Medicare+Choice organizations. The Secretary is authorized to collect \$100 million in user fees annually.

Provision:

- Medicare+Choice user fees for education are available without further appropriation and will be based on the percentage of Medicare+Choice enrollees compared to all Medicare beneficiaries. For example, if Medicare+Choice plans enrolled 15% of the total Medicare population, plans would be responsible for 15% of the costs associated with the information campaign. A maximum of \$100 million (minus the user fee) is authorized to be appropriated each year for the education campaign.

Effective Date:

- Applies to fees charged on or after January 1, 2001.

Clarification Regarding the Ability of a Religious Fraternal Benefit Society to Operate Any Medicare+Choice Plan (Section 523)

Prior Law:

- Religious fraternal benefit societies were only allowed to operate (and limit enrollment to their membership) Medicare+Choice coordinated care plans.

Provision:

- Expands the number and type of plans that religious fraternal benefit societies may operate to include private fee-for-service plans and MSAs.

Effective Date:

- Enactment.

Rules Regarding Physician Referrals for Medicare+Choice Program (Section 524)

Prior Law:

- Prior law made it unlawful for physicians who bill Medicare to refer patients to certain entities if the physician has an ownership interest or a compensation arrangement with the entity to which the patient is referred. This includes Medicare+Choice plans. However, through our administrative authority, we provided an exception for Medicare+Choice plans from the physician self-referral ban.

Provision:

- Creates a specific statutory exemption for Medicare+Choice coordinated care plans to the physician self-referral law.

Effective Date:

- Enactment.

Subtitle C – Demonstration Projects and Special Medicare Populations

Extension of Social Health Maintenance Organization Demonstration (SHMO) Project Authority (Section 531)

Prior Law:

- The SHMO demonstration was to expire on December 31, 2000. The Balanced Budget Act mandated a report to Congress with a plan for integration and transition of the SHMOs into an option under Medicare+Choice by January 1, 1999 and a final report on the demonstration projects by March 31, 2001.

Provision:

- Extends the SHMO demonstration until 18 months after submission of an integration and transition plan report to Congress as required under the Balanced Budget Act.
- Extends the due date for the final report on the demonstration projects to 21 months after the date of the integration/transition report required by the BBA.
- Requires MedPAC to make recommendations six months after submission of the final report.
- Increases the aggregate limit on participants at all sites to not less than 324,000 individuals.

Effective Date:

- Enactment.

Extension of Medicare Community Nursing Organization (CNO) Demonstration Project (Section 532)

Prior Law:

- The CNO demonstration project began on January 1, 1994 to test, in four sites, a system of capitated payments for specified community nursing services covered by Medicare. Experimental and control groups were followed for health care utilization and costs. The experiment ended at the end of 1997. The Balanced Budget Act extended the CNO demonstration for an additional two years through 1999. A final report is in progress.

Provision:

- Extends the CNO demonstration project an additional two years and requires the Secretary to reduce payments so that the extension does not increase expenditures above the level that would have been made in the absence of the project. Requires the Secretary to report by July 1, 2001 on the results of the demonstration, including data through the end of 2000.

Effective Date:

- Enactment.

Medicare+Choice Competitive Bidding Demonstration Project (Section 533)

Prior Law:

- The Balanced Budget Act requires the Secretary to establish a demonstration project under which payments to Medicare+Choice organizations are determined through a competitive pricing methodology recommended by the Competitive Pricing Advisory Committee (CPAC). The make-up and responsibilities of CPAC were also set by the Balanced Budget Act.

Provision:

- Delays implementation of the competitive pricing demonstration until January 1, 2002, or if later, 6 months after CPAC has submitted a report to Congress on the inclusion of original Medicare in the demonstration design, whichever is later.
- The report must address the following topics;
 - changes that would be required to feasibly incorporate fee-for-service Medicare into the demonstration;
 - the quality and monitoring activities that should be required of plans in the demonstration, related costs of these projects, and the current ability of HCFA to collect and report comparable data for fee-for-service Medicare;
 - the viability of initiating a project site in a rural area and related recommendations; and
 - the benefit structure.
- Requires the Secretary, subject to CPAC's recommendations, to allow plans that bid below the government contribution rate to offer beneficiaries rebates on their Part B premiums.

Extension of Medicare Municipal Health Services Demonstration Project (MHSP) (Section 534)

Prior Law:

- The Medicare Municipal Health Services Demonstration Project demonstration was set to expire December 31, 2000.

Provision:

- Extends the MHSP demonstration project by two years, until December 31, 2002.

Effective Date:

- Enactment.

Medicare Coordinated Care Demonstration Projects (Section 535)

Prior Law:

- The Balanced Budget Act provided for a coordinated care demonstration project in a cancer center located in the District of Columbia, funded through District of Columbia appropriations.

Provision:

- Provides a direct appropriation of such funds as are necessary through the Medicare trust funds to cover the costs of this demonstration project, including costs for information infrastructure and recurring costs of case management services, flexible benefits, and program management.

Effective Date:

- Enactment.

Medigap Protections for PACE Program Enrollees (Section 536)

Prior Law:

- The BBA created certain Medigap “guaranteed issue” protections for Medicare+Choice plan enrollees. Included under these protections are: beneficiaries affected by plan terminations or service area reductions; beneficiaries who move out of a plan service area; beneficiaries who disenroll from a plan during a 12-month trial period; and other beneficiaries in certain situations.
- “Guaranteed issue” protections were not extended to enrollees in PACE programs.

Provision:

- Extends these protections to PACE program enrollees.

Effective Date:

- Applies to terminations or service area reductions made on or after enactment.

Subtitle D – M+C Nursing and Allied Health Professional Education Payments

Medicare+Choice Nursing and Allied Health Professional Education Payments (Section 541)

Prior Law:

- Medicare made reasonable cost payment to hospitals for hospital-operated nursing and allied health programs. These payments did not include payment for costs incurred with respect to beneficiaries enrolled in the Medicare+Choice program.

Provision:

- This provision provides an additional payment for hospitals that receive payment for approved educational activities for nurse and allied health professional training to reflect the costs of Medicare+Choice enrollees. The additional amount shall not exceed \$60 million in any year.

Effective Date:

- For portions of cost reporting periods beginning with 2000.

Subtitle E – Studies and Reports

Report on Accounting for VA and DoD Expenditures for Medicare Beneficiaries (Section 551)

Prior Law:

- N/A

Provision:

- Requires the Secretary to report to Congress on the use of services furnished by DoD and VA to Medicare beneficiaries, including both beneficiaries in fee-for-service Medicare and beneficiaries enrolled in Medicare+Choice, and include an analysis of how to adjust Medicare+Choice capitation rates.

Effective Date:

- Report to Congress due one year after enactment.

Medicare Payment Advisory Commission Studies and Reports (Section 552)

Prior Law:

- N/A

Provision:

- Requires MedPAC to study payment methodologies for frail elderly beneficiaries enrolled in a Medicare+Choice plan that: account for the chronic conditions among frail elderly; include medical diagnostic factors from all provider settings (including hospitals and nursing facilities); and include functional indicators of health status and other factors.
- Requires MedPAC to study and report on changes needed to make Medical Savings Accounts a viable option under the Medicare+Choice program.

Effective Date:

- Report to Congress due one year after enactment.

GAO Studies, Audits, and Reports (Section 553)

Prior Law:

- N/A

Provision:

- (553(a)) Requires GAO to study and report on the following issues related to Medigap Insurance:
 - the level of coverage provided by each type of policy;
 - current enrollment levels in each type of policy;
 - availability of each type of policy to beneficiaries over age 65 ½;
 - the number and type of policies offered in each state; and
 - the average out-of-pocket costs per beneficiary under each type of policy.
- (553(b)) Beginning in 2000, requires GAO to conduct an annual audit of the Medicare+Choice beneficiary education program and to report on the results of the audit, along with an evaluation of the effectiveness of the education program.

Effective Date:

- Section 553 (a) Report to Congress due July 31, 2001.
- Section 553(b) Reports to Congress due March 31, 2001, March 31, 2004, March 31, 2007, and March 31, 2010.

TITLE VI – MEDICAID

Increase in Disproportionate Share Hospital (DSH) Allotments for Certain States and the District of Columbia (Section 601)

Prior Law:

- The Balanced Budget Act capped the amount of federal matching funds available to States and the District of Columbia for DSH payments, listing specific dollar amounts for each State for federal FYs 1998 through 2002. The dollar amounts were based in part on each State's DSH spending in FY1995, as reported to HCFA as of January 1, 1998. The BBA also increased the federal matching rate for the District of Columbia from 50 percent to 70 percent.

Provision:

- This provision increases the amount of the federal portion of disproportionate share hospital (DSH) payments (provided for hospitals that care for substantial numbers of low-income and uninsured patients) in the District of Columbia, Minnesota, New Mexico and Wyoming for FY 2000, 2001, and 2002. The annual allotment for these years for the District of Columbia rises from \$23 million to \$32 million; Minnesota rises from \$16 million to \$33 million; New Mexico rises from \$5 million to \$9 million; and, Wyoming rises from \$0 to \$100,000. These increases will also result in higher DSH limits in succeeding years.

Effective Date:

- Applies to expenditures made on or after October 1, 1999.

Removal of Sunset on transitional administrative cost assistance (Section 602)

Prior Law:

- Welfare reform created the Temporary Assistance to Needy Families (TANF) program. Unlike the old Aid to Families with Dependent Children (AFDC) (welfare) program that it replaced, receipt of TANF cash assistance does not automatically mean an individual or family is eligible for Medicaid. States were therefore expected to incur new Medicaid administrative expenses for such things as computer reprogramming, new application forms and processes, worker retraining, public education and outreach. The \$500 million fund was established to help states cover these administrative costs.

Provision:

- This provision eliminates two restrictions on how states can gain access to a special \$500 million fund set up to help cover administrative costs related to welfare reform. It eliminates the October 1, 2000 “sunset” date, after which the funding would no longer have been available. It also eliminates the three-year (twelve-quarter) window that States have to spend the money after they first start to claim it.

Effective Date:

- Immediately

Modification of the Phase-Out of Payment for Federally-Qualified Health Center Services (FQHCs) and Rural Health Clinic Services (RHCs) Based on Reasonable Costs (Section 603)

Previous Law:

- Prior to the BBA, States were required to reimburse FQHCs and RHCs for 100 percent of “reasonable” costs for providing services to Medicaid patients. The BBA phased-out cost-based reimbursement to FQHCs and RHCs over a five-year period: 95 percent of costs in FY 2000, 90 percent of costs in FY 2001, 85 percent of costs in FY 2002, and 70 percent of costs in FY 2003. Cost-based reimbursement was to be eliminated after FY 2003.

Provision:

- This provision slows the phase-out of cost-based reimbursement for these facilities. Payments must be at least 95 percent of costs for FY 2001 and 2002, at least 90 percent of costs for FY 2003 and at least 85 percent of costs for FY 2004. Cost-based reimbursement is eliminated after FY 2004. It also directs the General Accounting Office to report to Congress on the effect of the phase-out of cost-based reimbursement on these facilities and the populations they serve and make recommendations on whether a new payment system is needed. The report is due one year after enactment. A related provision (Section 608(z)) removes a ban on waiving FQHC payment requirements in 1915b waivers (which allow States to limit beneficiaries’ choice of providers) as soon as the phase-out of cost-based reimbursement is complete.

Effective Date:

- This provision applies to expenditures made on or after the enactment of the BBA (August 5, 1998). However, since the payment rate for FY 2000 is the same in both the BBA language and this new provision, no retroactive payment adjustments should be required.

**Parity in Reimbursement for Certain Utilization and Quality Control Services;
Elimination of Duplicative Requirements for External Quality Review of Medicaid
Managed Care Organizations (Section 604)**

Prior Law:

- States received a 75 percent matching rate when they contracted with Medicare’s Peer Review Organizations (PROs) for external quality reviews of Medicaid managed care or medical and utilization reviews of fee-for-service care. States also received a 75 percent matching rate when they contracted with entities that meet the requirements for a PRO contract but do not have a PRO contract (PRO-like entities) for external quality review of Medicaid managed care. However, States received only a 50 percent match if they contracted with a PRO-like entity to do medical and utilization reviews of fee-for-service care. The BBA instituted new, more specific standards and requirements for States to contract with external entities to conduct quality reviews of all organizations that serve Medicaid managed care populations.

Provision:

- This provision gives States a higher, 75 percent, rate of federal matching funds for spending on contracts with PRO-like entities for fee-for-service review activities. It also eliminates references to older and now duplicative requirements for external quality review of Medicaid managed care, which were superseded by new requirements in the BBA.

Effective Date:

- The parity provisions apply to expenditures on or after the date of enactment. The elimination of the old external quality review requirements is effective once HCFA publishes final regulations for the new external quality review requirements.

**Inapplicability of Enhanced Match Under the State Children’s Health Insurance
Program to Medicaid DSH Payments (Section 605)**

Prior Law:

- The BBA created the SCHIP, giving States an enhanced federal matching rate for covering low-income uninsured children in a separate State-run insurance program, a Medicaid expansion, or a combination of both. When a State elects the SCHIP Medicaid expansion option, the costs for SCHIP Medicaid expansion children can be included when calculating Medicaid DSH payments.

Provision:

- Clarifies that the enhanced federal matching rate available under the State Children’s Health Insurance Program (SCHIP) does not apply to expenditures for disproportionate share hospital (DSH) payments in Medicaid.

Effective Date:

- Applies to expenditures made on or after October 1, 1999.

Optional Deferment of the Effective Date for Outpatient Drug Agreements (Section 606)

Prior Law:

- Drug manufacturers must enter into agreements with States to participate in the program. Agreements with manufacturers new to the program after March 1, 1991, could not go into effect until the first day of the first calendar quarter that began at least 60 days after the agreement was signed.

Provision:

- Gives States the option of covering drugs from manufacturers that are new to the Medicaid drug rebate program as soon as the manufacturer signs an agreement with the State to participate in the program. States must begin to cover drugs from manufacturers who have signed drug rebate agreements no later than the first day of the first quarter that begins 60 days or more after the agreement is signed.

Effective Date:

- Applies to expenditures made on or after October 1, 1999.

Making the Medicaid DSH Transition Rule Permanent (Section 607)

Prior Law:

- The Omnibus Budget Reconciliation Act of 1993 established caps on the amount of DSH payments States could make to each hospital. After a two-year transition, the cap was equal to 100 percent of the hospital's cost for treating uninsured patients, plus the difference between the hospital's cost for treating Medicaid patients and the amount the hospital receives from Medicaid for those patients. During the transition period, the cap was equal to 200 percent of those costs. The BBA extended the transition period for California to June 30, 2000, and lowered the cap from 200 percent to 175 percent of uncompensated care costs and Medicaid shortfalls.

Provision:

- Permanently authorizes the State of California to make disproportionate share hospital (DSH) payments to hospitals in amounts up to 175 percent of the hospital's uncompensated care costs and Medicaid shortfalls.

Effective Date:

- Effective as if enacted in BBA.

Medicaid Technical Corrections (Section 608)

Prior Law:

- The Secretary was prohibited from waiving Federally Qualified Health Center (FQHC) payment requirements in 1915b waivers (which allow States to limit beneficiaries' choice of providers).

Provision:

- Removes language banning waiver of FQHC payment rules in 1915b waivers as soon as the phase-out of cost-based reimbursement is complete in 2004. Corrects spelling, punctuation and cross-references throughout the title XIX Medicaid statute.

Effective Date

- All but 608(z) are effective immediately. Section 608(z) is effective October 1, 2004.

TITLE VII – STATE CHILDREN’S HEALTH INSURANCE PROGRAM (SCHIP)

Stabilizing the State Children’s Health Insurance Program Allotment Formula (Section 701)

Prior Law:

- Allotments for the first three years of the program were determined using each State’s proportion of the total number of low-income (under 200 percent of poverty) uninsured children, based on CPS data. After the first three years, the formula would include both the number of low-income and uninsured children starting in 2001, in order to account for the fact that the program should be decreasing the number of uninsured children.

Provision:

- This provision stabilizes the formula for determining how much federal funding each State may receive for SCHIP. It moves up, by one year to FY 2000, the beginning of the addition of the number of low-income children in each State to the formula used to calculate how much SCHIP funding each State can get. It stipulates that no State allotment can decrease by more than 10 percent from the State’s previous year’s allotment (10 percent annual floor) as a proportion of the total allotment to all states, nor more than 30 percent from the State’s FY 1999 allotment (30 percent cumulative floor). It stipulates that, as a proportion of the total allotments, no State’s allotment can increase by more than 45 percent from the State’s FY 1999 allotment (45 percent cumulative ceiling). It stipulates that the floors and ceilings described above must be implemented in a budget neutral manner. The allotments for States with the largest gains are reduced by the amount needed to pay for the increases to States that would have been reduced by more than the 10 percent annual floor or the 30 percent cumulative floor. If the floors and ceiling result in a surplus, the surplus must be distributed in a pro-rata manner to all States that have not exceeded the 45 percent cumulative ceiling. It changes the Current Population Survey (CPS) data and the

Census data used to count the number of low-income and low-income uninsured children from the three most recent fiscal years to the three most recent calendar years.

Effective Date:

- Effective for FY 2000 allotments and beyond.

Increased Allotments for Territories Under the State Children's Health Insurance Program (Section 702)

Prior Law:

- The authorizing legislation for SCHIP set aside 0.25 percent of the total allotment for the territories.

Provision:

- Increases the SCHIP allotments for the territories by \$34.2 million for FY 2000 and 2001, by \$25.2 million for FY 2002 through 2004, by \$32.4 million for FY 2005 and 2006, and by \$40 million for FY 2007. These increases are in addition to the 0.25 percent of the total SCHIP allotment that the territories receive under the normal allotment process.

Effective Date:

- Effective beginning FY 2000.

(Section 703) Improved Data Collection and Evaluations of the State Children's Health Insurance Program

Prior Law:

- Current law requires States to perform individual evaluations of their own programs. This provision is a new requirement that a Federal evaluation be performed for the entire program.

Provision:

- Gives \$10 million to the Department of Commerce to increase the sample size of the Current Population Survey (CPS) so that reliable estimates of the number of uninsured children by income, age and race can be determined on a State-by-State basis. Gives \$10 million to the HHS Secretary for a federal evaluation of the SCHIP program using a sample of 10 States. The evaluation must include surveys of the target population, evaluation of the effectiveness of different outreach strategies, the effectiveness of coordination between the SCHIP and Medicaid programs, the effects of cost-sharing requirements, and an evaluation of retention issues. The report is due to Congress on December 31, 2001. Directs the Inspector General to audit, and the GAO to report to Congress, every three years on State compliance with the requirement that SCHIP applicants that are found to be eligible for Medicaid be enrolled in Medicaid. Requires that all data relating to children in SCHIP and

Medicaid be coordinated with the data requirements in the Maternal and Child Health block grant. Directs the Secretary, through the Assistant Secretary for Planning and Evaluation, to establish a data clearinghouse on Federal health programs and children's health.

Effective Date:

- Enactment.

References to SCHIP and State Children's Health Insurance Program (Section 704)

Prior Law:

- The program was commonly referred to as the Children's Health Insurance Program.

Provision:

- Requires the Secretary and all other federal employees to use the phrase "State Children's Health Insurance Program" and the acronym "SCHIP" in all publications and other official communications when referring to the program.

Effective Date:

- Enactment.

SCHIP Technical Corrections (Section 705)

Provision:

- Makes spelling and cross reference corrections in the SCHIP statute (title XXI).

H.R. 3443 FOSTER CARE INDEPENDENCE ACT OF 1999
SUMMARY OF MAJOR HEALTH PROVISIONS
TITLE I – IMPROVED INDEPENDENT LIVING PROGRAM

Subtitles A – D

Improved Independent Living Program (Section 101), Increase in Amount of Assets Allowable for Children in Foster Care (Section 111), Preparation of Foster Parents to Provide for the Needs of Children in State Care (Section 112), State Option of Medicaid Coverage for Adolescents Leaving Foster Care (Section 121), and Increased Funding or Adoption Incentive Payments (Section 131)

Prior Law:

- States and localities received Federal funds for implementing Independent Living Programs (ILP) under title IV-E of the Social Security Act. The purpose was to assist children age 16 and older to gain the skills and education that they need to successfully transition from foster care to adulthood. There was no Medicaid eligibility group specifically targeted for such older foster care children, although such children could qualify for Medicaid if they met the criteria for eligibility under another category covered in their State.

Provisions:

- The “Foster Care Independence Act of 1999” doubles the annual funding authority for the Independent Living Program (ILP) from \$70 million to \$140 million, expands the purposes of the program, and updates the formula for distributing the funds among States. The bill provides States with the option to provide Medicaid to “independent foster care adolescents” who are age 18-21, who were in a foster care program for which the State was responsible, and who meet such eligibility criteria for income and resources as the State may, at its option, establish. These criteria may not be lower than those that generally apply for low-income families in that State. States may cover all such children or just the subset that, before their 18th birthday, received foster care assistance under title IV-E of the Social Security Act.

Effective Dates:

- October 1, 1999.

TITLE II - SSI FRAUD PREVENTION

Subtitle A – Fraud Prevention and Related Provision

State Data Exchanges (Section 209)

Prior Law:

- States and the Social Security Administration (SSA) exchange data to assist them in ascertaining the eligibility of beneficiaries in one program for another. State and SSA use and confidentiality standards are not necessarily the same.

Provision:

- Deems SSA standards to meet any standards of a State when the Commissioner of SSA requests information from that State for purposes of ascertaining an individual's eligibility for Social Security or Supplemental Security Income.

Effective Date:

- Enactment.

Computer Matches with Medicare and Medicaid Institutionalization Data (Section 212)

Prior Law:

- Supplemental Security Income benefits (SSI) are generally reduced or eliminated if the beneficiary is admitted to a medical institution and receives Medicaid coverage. An exception to the SSI reduction occurs if the person's stay is likely, as certified by a physician, not to exceed three months.

Provision:

- In lieu of the physician certification required under current law, the Commissioner of Social Security may instead conduct data matches with Medicare and Medicaid data maintained by the Secretary of HHS, under terms agreed upon by the Commissioner and the Secretary.

Effective Date:

- Enactment.

**THE TICKET TO WORK AND WORK INCENTIVES IMPROVEMENT ACT OF
1999
SUMMARY OF MAJOR HEALTH PROVISIONS**

TITLE II-EXPANDED AVAILABILITY OF HEALTH CARE SERVICES

Expanding State Options Under the Medicaid Program for Workers with Disabilities (Section 201)

Prior Law:

- Section 4733 of the Balanced Budget Act (BBA) gives States the option to allow certain people with disabilities, who would qualify for SSI except for earnings which exceed the allowable limit, to buy into Medicaid. Eligibility is limited to those qualifying in families with income of less than 250 percent of the official poverty line for the applicable family size.

Provision:

- Two Medicaid buy-ins are established through the creation of optional eligibility groups. The first, creating 1902 (a)(10)(A)(ii)(XV), allows States to offer a buy-in to working age individuals who would be eligible, except for earnings, for supplemental security income (SSI). States can set eligibility limits on assets and earned and unearned income.
- The second Medicaid buy in, 1902(a)(10)(A)(ii)(XVI), permits States to continue coverage for working individuals with disabilities whose medical conditions remain severe but who would otherwise lose eligibility due to medical improvement as determined at a regularly scheduled continuing disability review. Eligibility is limited to those who cease to be eligible for the first buy-in due to medical improvement.
- For both buy-ins, States which impose premiums may require premiums or cost-sharing set on a sliding scale based on income and charge 100% of the premium to individuals whose income exceeds 250% FPL but is below 450% FPL, provided that these premiums do not exceed 7.5 % of income. States must require payment of 100% of the premium for individuals whose adjusted gross income, as defined by the Internal Revenue Service, exceeds \$75,000 except that a State may subsidize the premiums with unmatched State funds.
- In order to receive Federal matching funds for these buy-ins, States must meet a maintenance of effort requirement for funds spent on State programs to enable people with disabilities to work. This maintenance of effort requirement specifically excludes money spent for medical assistance.
- A GAO report to Congress on the extent to which higher health care costs deter employment, and the effectiveness of the Medicaid buy-in provisions, is required no later than 3 years after the date of enactment of the Act.

Effective Date:

- October 1, 2000

Extending Medicare Coverage for OASDI Disability Benefit Recipients (Section 202)

Current Law:

- Title II beneficiaries who return to work and achieve earnings above substantial gainful activity (SGA), currently \$700 per month, receive 4 years of premium-free Medicare Part A.

Provision:

- The premium-free Medicare Part A benefits are extended to Title II beneficiaries who return to work for an additional 4 1/2 years, effectively extending Medicare coverage from 4 to 8 1/2 years.
- Not later than 5 years after the date of enactment of the Act, a GAO report is required which examines the effectiveness and cost of this extension of benefits for beneficiaries with different income levels as well as the use of Medicare versus private coverage.

Effective Date:

- October 1, 2000

Grants to Develop and Establish State Infrastructures to Support Working Individuals with Disabilities (Section 203)

Current Law:

None

Provision:

- A grant program is established to support the design, establishment, and operation of State infrastructures that provide items and services to people with disabilities and to conduct outreach campaigns regarding the existence of such infrastructures. States must offer personal assistance services (PAS) under their State Plan, to the extent necessary to enable individuals with disabilities to remain employed, in order to be eligible for the grant program. There is appropriated \$150 million/5 years with an index to the CPI-U for FY 2006-2011. Each State will receive at least \$500,000 for a fiscal year but not more than ten percent of the total expenditures by the State on the Medicaid buy-in for the working disabled (provided the State has exercised that option). States receiving funds under this section must report to the Secretary annually on the number of Title II and Title XVI beneficiaries that return to work.
- A recommendation to Congress is required not later than October 1, 2010 on continuation of the grant program after FY 2011.

Effective Date:

- Enactment. Appropriations begin FY 2001.

Demonstration of Coverage Under the Medicaid Program of Workers with Potentially Severe Disabilities (Section 204)

Current Law:

- None

Provision:

- The demonstration program allows participating States to provide Medicaid to workers with health conditions that have not yet rendered them blind or disabled, but that can be expected to cause the level of disability required to qualify for SSI/SSDI. The demonstration is intended help people remain employed by providing coverage to prevent deterioration in their health condition. States must apply to cover a specified maximum number of individuals with potentially severe medical conditions. The individuals must be 16-65 years old and working. The State defines, "potentially severe physical or mental impairment", enabling it to target specific disease categories. Also, States may operate demonstration projects on a sub-state basis. The demonstration program is funded at \$250 million over 6 years.
- States must fulfill a maintenance of effort requirement and provide for an independent evaluation in order to participate. Participating States are obligated to submit annual reports on the use of funds provided under the demonstration.
- A recommendation to Congress is required not later than October 1, 2004 on continuation of the demonstration after FY 2006.

Effective Date:

- Enactment. Appropriations begin FY 2001.

Election by Disabled Beneficiaries to Suspend Medigap Insurance When Covered Under a Group Health Plan (Section 205)

Current Law:

None

Provision:

- Each Medicare supplemental policy must provide for benefits and premiums to be suspended at the request of an individual who is entitled to Medicare on the basis of a disability and who becomes covered under an employer's group health plan. If the group health coverage is lost and if the policyholder provides notice of the loss within 90 days, the Medigap policy must be automatically reinstated, effective the date that the employer coverage ended.

Effective Date:

- Enactment.

Extension of Authority of State Medicaid Fraud Control Units (Section 407)

Current Law:

- State Medicaid Fraud Control Units (MFCUs) come under the purview of the Inspector General's office and are charged with investigating and prosecuting suspected fraud cases related to Title XIX of the Social Security Act. Currently, MFCUs are restricted to investigating only Medicaid fraud. If, during the course of their investigation, they run across evidence of fraud in other federal health programs, they must refer that portion of the case to the Inspector General of the relevant program.

Provision:

- This provision would allow MFCUs, upon approval of the relevant Inspector General, to investigate instances of fraud in other federal health programs as long as the overall case is primarily related to the Medicaid program. All funds recovered as a result of the investigation must be allocated to the federal health programs that were the basis for the activities resulting in the recovery.
- This provision also extends the authority of MFCUs to investigate and prosecute cases of resident abuse in non-Medicaid board and care facilities.

Effective Date:

- Enactment.