CONFERENCE AGREEMENT ON MEDICARE PROVISIONS INCORPORATED BY REFERENCE INTO H.R. 3194, THE "DISTRICT OF COLUMBIA APPROPRIATIONS ACT," WHICH WERE INTRODUCED AS H.R. 3426, THE "MEDICARE, MEDICAID, AND SCHIP BALANCED BUDGET REFINEMENT ACT OF 1999”

November 17, 1999

TITLE I–PROVISIONS RELATING TO PART A

Subtitle A–Adjustments to PPS Payments for Skilled Nursing Facilities (SNFs)

Sec. 101. Temporary Increase in Payment for Certain High Cost Patients

Current Law

The SNF prospective payment system (PPS) includes 44 hierarchical resource utilization groups (RUGs). The RUGs are utilized to formulate the per diem payments to SNFs on behalf of Medicare patients. The RUG payments represent the average cost for patients in each RUG category. During a phase-in starting in 1998, the per diem payment is based partially on the facility's specific costs and partially on a federal per diem rate.

H.R. 3075, as Passed

Increases temporarily the federal per diem payment by 10% for 12 RUGs in the "Extensive Services," "Special Care," and "Clinically Complex" categories. Increased payments would be made from April 1, 2000 through September 30, 2000.

S.1788, as Reported

Increases temporarily the federal per diem payment by 25% for "Extensive Services" and "Special Care" categories and adds specified dollar amounts to per diem rates for five RUGs for rehabilitation therapies. Increased payments would be made from April 1, 2000 through September 30, 2001.

Agreement

The agreement includes the Senate provision with amendments. For SNF services furnished on or after April 1, 2000, and before the later of October 1, 2000, or implementation by the Secretary of Health and Human Services (hereafter referred to as "Secretary") of a refined RUG system, per diem payments are increased by 20% for 15 RUGs falling under categories for Extensive Services, Special Care, Clinically Complex, High Rehabilitation, and Medium Rehabilitation. It is the intent of the parties to the agreement that the implementation begin on April 1, 2000, and that on this date, each payment shall increase by the required amount so that the facilities will receive payment authorized on April 1, 2000. In FY 2001 and 2002 the federal per diem payment to a facility is increased by 4% in each year, calculated exclusive of the 20% RUG rate increase.

Sec. 102. Authorizing Facilities to Elect Immediate Transition to Federal Rate

Current Law

Payments to SNFs under the federal per diem RUG system are phased in over a period of time. Starting in 1998, a SNF receives per diem rates that are a blend of 75% of the facility-specific rate and 25% of the federal per diem rate. The proportions shift annually by 25 percentage points until the federal rate equals the full payment.

H.R. 3075, as Passed

Permits SNFs to choose to receive payments based wholly on the federal per diem rate if that would be more advantageous to the facility; effective for elections made more than 60 days after enactment.

S.1788, as Reported

Permits SNFs to choose to receive payments based wholly on the federal per diem rate if that would be more advantageous to the facility; effective upon enactment.

Agreement

The agreement includes the House provision with modification. SNFs may elect immediate transition to the federal rate on or after December 15, 1999 for cost reporting periods beginning on or after January 1, 2000. There is no election for cost reporting periods beginning before January 1, 2000. SNFs may elect immediate transition up to 30 days after the start of their cost reporting period.

Sec. 103. Part A Pass-Through Payments for Certain Ambulance Services, Prostheses, and Chemotherapy Drugs

Current Law

SNF PPS payments are inclusive of ancillary services and drugs (except for renal dialysis services) needed by patients in specified RUGs.

H.R. 3075, as Passed

Excludes certain items, starting April 1, 2000, from RUG payments. Provides separate payment for ambulance services for beneficiaries needing renal dialysis in a facility outside of the SNF, specific chemotherapy items and services, radioisotope services, and customized prosthetic devices delivered to the beneficiary during an inpatient SNF stay. Beginning with FY 2001, requires Secretary to reduce base RUG rates to account for exclusion of these items to ensure budget neutrality.

S.1788, as Reported

No provision.

Agreement

The agreement includes the House provision. The parties to the agreement include this provision in recognition that skilled nursing facilities (SNFs) from time to time experience high-cost, low probability events that could have devastating financial impacts because their costs far exceed the payment they receive under the prospective payment system (PPS). This provision is an attempt to exclude from the PPS certain services and costly items that are provided infrequently in SNFs. For example, in the case of chemotherapy drugs, Health Care Financing Administration (HCFA) physicians excluded specific chemotherapy drugs from the PPS because these drugs are not typically administered in a SNF, or are exceptionally expensive, or are given as infusions, thus requiring special staff expertise to administer. Some chemotherapy drugs, which are relatively inexpensive and are administered routinely in SNFs, were excluded from this provision.

While this provision exempts ambulance services for end-stage renal disease (ESRD) patients, the parties to the agreement note that, in many cases, regularly scheduled trips may be made in vehicles that are less costly than an Advanced or Basic Life Support ambulance, and the parties to the agreement urge that SNFs use these cost-saving services appropriately.

The parties to the agreement recognize that excluding services or items from the PPS by specifying codes in legislation may not be the most appropriate way to protect SNFs from extraordinary events. Additionally, some items may have been inadvertently excluded from the list. New, extremely costly items may come into use or codes may change over time. Therefore, the parties to the agreement expect the Secretary to use her authority to review periodically and modify, as needed, the list of excluded services and items to reflect changes in codes and developments in medical technology. The parties to the agreement also request the General Accounting Office (GAO) to review the codes of the excluded items and make recommendations on whether the criteria for their exclusion are appropriate by July 1, 2000.

Section 1888(e)(5)(A) of the Social Security Act directed the Secretary to establish a SNF market basket index (MBI) that "reflects the changes over time in the prices of an appropriate mix" of goods and services. The parties to the agreement believe that the Secretary should ensure that the current SNF MBI, as developed by the Secretary and based on Fiscal Year 1992 costs, fulfills this mandate. The parties to the agreement recognize that the Secretary revised and rebased the 1992 costs when developing the MBI; however, the Secretary should ensure that these types of modifications adequately reflect the costs of the efficient delivery of medically necessary new medications developed since 1992. Innovative medical research techniques, combined with significant technological advances, have led to the development of numerous new medications over the past seven years. The Secretary should ensure that these types of changes are represented in the current SNF MBI.

Accordingly, Congress expects the Secretary to: (1) evaluate the appropriateness of the SNF MBI with respect to medications used in the SNF population based on data from the first fiscal year after full implementation of the SNF PPS when they become available; (2) consider modification of the current SNF MBI as appropriate; and (3) ensure that the MBI continues to be

responsive to new medications used by the SNF population.

Sec. 104. Provision for Part B Add-ons for Facilities Participating in the Nursing Home Case Mix and Quality (NHCMQ) Demonstration Project

Current Law

SNFs that had participated in the NHCMQ demonstration that preceded completion and implementation of the RUG/PPS do not have the cost of Part B services to their Medicare patients accounted for under the facility-specific component of the PPS during the transition period as do other SNFs.

H.R. 3075, as Passed

Includes the cost of Part B services in the computation of the facility-specific component of the per diem payment during the transition to the federal per diem PPS for SNFs that had participated in the NHCMQ demonstration, including updates of the SNF market basket increase minus 1 percentage point, except for an increase in FY 2001 of the SNF market basket plus 0.8 percentage points. The provision becomes effective retroactively to implementation of the Balanced Budget Act of 1997 (BBA 97).

S.1788, as Reported

Similar to the House provision, with updates of the market basket increase minus 1 percentage point for cost reporting periods after 1997 and with allowances for exceptions payments.

Agreement

The agreement includes the House provision with a modification to keep the FY 2001 update at market basket minus 1 percentage point.

Sec. 105. Special Consideration for Facilities Serving Specialized Patient Populations

Current Law

No provision.

H.R. 3075, as Passed

Provides temporarily for special per diem payments to be based 50% on the facility-specific rate and 50% on the federal rate for hospital-based SNFs: (1) that were certified for Medicare before July 1, 1992; (2) in 1998 served patients who were immuno-compromised secondary to an infectious disease; and (3) for which such patients accounted for more than 60% of the facility's total patient days in 1998. The special rates apply for the first cost reporting

period starting after enactment and end on September 30, 2001. Requires the Secretary to assess and report within 1 year of enactment on the resource use of such patients and recommend whether permanent adjustments should be made to the RUGs in which they are classified.

S.1788, as Reported

Requires the Secretary to study and report to Congress within 1 year of enactment on alternative payment methods for SNFs specializing in caring for extremely high cost, chronically ill populations.

Agreement

The agreement includes the House provision.

Sec. 106. MedPAC Study on Special Payment for Facilities Located in Hawaii and Alaska

Current Law

No provision.

H.R. 3075, as Passed

Requires the Medicare Payment Advisory Commission (MedPAC) to study and report within 18 months of enactment on the need for additional payments for SNFs in Alaska and Hawaii.

S.1788, as Reported

No provision.

Agreement

The agreement includes the House provision.

Sec. 107. Study and Report Regarding State Licensure and Certification Standards and Respiratory Therapy Competency Examinations

Current Law

No provision.

H.R. 3075, as Passed

No provision.

S.1788, as Reported

Requires the Secretary to report within 1 year of enactment on variations in state licensure and certification standards for workers providing respiratory therapy in SNFs and to make recommendations regarding Medicare requirements for licensing or certification.

Agreement

The agreement includes the Senate provision with modification.

Subtitle B-PPS Hospitals

Sec. 111. Modification in Transition for Indirect Medical Education (IME) Percentage Adjustment

Current Law

Medicare pays teaching hospitals for its share of the direct costs of providing graduate medical education, and the indirect costs associated with approved graduate medical education programs. Prior to BBA 97, Medicare's indirect medical education (IME) payments increased 7.7% for each 10% increase in a hospital's ratio of interns and residents to beds. BBA 97 reduced the IME adjustment to 6.5% in FY1999; to 6.0% in FY 2000 and to 5.5% in FY 2001 and subsequent years.

H.R. 3075, as Passed

Freezes the IME adjustment at 6.0% for FY 2001 and then reduces the adjustment to 5.5% in FY 2002 and subsequent years.

S.1788, as Reported

Freezes the IME adjustment at 6.5% through FY 2003 and then reduces the adjustment to 5.5% in FY 2004 and subsequent years.

Agreement

The agreement includes the Senate provision with modifications. The IME adjustment would be frozen at 6.5% through FY 2000. The adjustment would be reduced to 6.25% in FY 2001 and then to 5.5% in FY 2002 and subsequent years.

The parties to the agreement include in this provision a special adjustment to achieve the 6.5 percent IME payment for the first six months of FY 2000. Because the PPS rates for FY 2000 were set prior to enactment and claims have already been paid at the IME percentage adjustment of 6.0 percent as mandated in the Balanced Budget Act of 1997, reverting to the 6.5

percent IME percentage adjustment provided in this legislation would require re-processing of beneficiary claims. Due to necessary Year 2000 computer adjustments, the Secretary is unable to make payment changes until April 1, 2000, thus requiring a special adjustment to accommodate the changes made under this section. To prevent reprocessing of over 5 million beneficiary claims and reissuing an FY 2000 PPS payment rule, the payment difference between a 6.0 and a 6.5 IME percentage adjustment will be accomplished through an aggregate adjustment to teaching hospital payments.

Sec. 112. Decrease in Reductions for Disproportionate Share Hospitals; Data Collection Requirements

Current Law

Medicare makes additional payments to hospitals that serve a disproportionate share of low-income Medicare and Medicaid patients. BBA 97 reduced the disproportionate share hospital (DSH) payment formula by 1% in FY 1998; 2% in FY 1999; 3% in FY 2000; 4% in FY 2001; 5% in FY 2002 and 0% in FY 2003 and in each subsequent year.

H.R. 3075, as Passed

Freezes the reduction in the DSH payment formula to 3% in FY 2001. Changes the reduction to 4% in FY 2002.

Requires the Secretary to collect hospital cost data on uncompensated inpatient and outpatient care, including non-Medicare bad debt and charity care as well as Medicaid and indigent care charges. Requires the submission of the data in cost reports for cost reporting periods beginning on or after the enactment date.

S.1788, as Reported

Freezes the reduction in the DSH payment formula to 3% in FY 2001.

Agreement

The agreement includes the House provision with modification by requiring the Secretary to have hospitals submit the data requested in cost reports for cost reporting periods beginning on or after October 1, 2001.

This provision eases the financial burden of hospitals caring for a disproportionate share of low-income individuals. In addition, the Secretary is required to collect additional data necessary to develop a DSH payment methodology that takes into account the cost of serving uninsured and underinsured patients, as recommended by MedPAC. Presently, the DSH formula is based only on the costs associated with Medicaid patients and Medicare patients eligible for Supplementary Security Income (SSI). MedPAC has recommended that the formula be amended to include inpatient and outpatient costs associated with services provided to low-income patients, defined

broadly to include all care to the poor.

In order to develop such a revised formula, it is necessary first to collect additional data. MedPAC recommends that data be collected on patients enrolled in state and local indigent care programs, as well as uncompensated care associated with uninsured or underinsured patients. State and local indigent care programs would include non-federally financed programs with specific eligibility criteria for specified health care services. Financial data on state and local appropriations that offset uncompensated care expenses should also be collected. Uncompensated care costs and charges are those identified more typically as bad debt and charity care. While the parties to the agreement recognize that there may be problems in defining and appropriately measuring such costs and charges in a way that avoids duplication, such problems can best be overcome by developing standard definitions at the national level. The parties to the agreement expect the Secretary to report on the financial interactions and potential for shifts between Federal and State governments.

Subtitle C--PPS-Exempt Hospitals

Sec. 121. Wage Adjustment of Percentile Cap for PPS-Exempt Hospitals

Current Law

BBA 97 established a national cap on the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) limits for PPS-exempt hospitals at 75% of the target amount for that class of hospital.

H.R. 3075, as Passed

Adjusts the labor-related portion of the 75% cap to reflect differences between the wage-related costs in the area of the hospital and the national average of such costs within the same class of hospitals beginning for cost reporting periods on or after October 1, 1999.

S.1788, as Reported

No provision.

Agreement

The agreement includes the House provision.

Sec. 122. Enhanced Payments for Long-Term Care and Psychiatric Hospitals Until Development of Prospective Payment Systems (PPS) for those Hospitals

Current Law

BBA 97 established the amount of bonus and relief payments for eligible PPS-exempt providers.

H.R. 3075, as Passed

Increases the amount of continuous bonus payments to the eligible long-term care and psychiatric providers from 1% to 1.5% for cost reporting periods beginning on or after October 1, 2000 and before September 30, 2001 and 2% for cost reporting periods beginning on or after October 1, 2001 and before September 30, 2002.

S.1788, as Reported

No provision.

Agreement

The agreement includes the House provision.

Sec. 123. Per Discharge Prospective Payment System (PPS) for Long-Term Care Hospitals

Current Law

BBA 97 requires the Secretary to develop a legislative proposal for a PPS for long-term care hospitals that includes an adequate patient classification system by October 1, 1999.

H.R. 3075, as Passed

Requires the Secretary to report to the appropriate Congressional committees by October 1, 2001 on a discharge-based PPS with an adequate patient classification system for long-term care hospitals which would be implemented in a budget-neutral fashion for cost reporting periods beginning on or after October 1, 2002. The Secretary may require such long-term care hospitals to submit information to develop the payment system.

S.1788, as Reported

No provision.

Agreement

The agreement includes the House provision. In developing and evaluating the new PPS system, the parties to the agreement encourage the Secretary to measure the quality of outcomes.

Sec. 124. Per Diem Prospective Payment System (PPS) for Psychiatric Hospitals

Current Law

No provision.

H.R. 3075, as Passed

Requires the Secretary to report to the appropriate Congressional committees by October 1, 2001 on a per diem-based PPS with an adequate patient classification system for psychiatric hospitals and distinct-part units which would be implemented in a budget-neutral fashion for cost reporting periods beginning on or after October 1, 2002. The Secretary may require such psychiatric hospitals and units to submit information to develop the system.

S.1788, as Reported

Requires the Secretary to report to Congress within 2 years of enactment on a PPS for psychiatric hospitals and units. The study should take into account the unique circumstances of psychiatric hospitals in rural areas.

Agreement

The agreement includes the House provision. The parties to the agreement are aware that changes to payments for psychiatric units and hospitals contained in this bill could affect the provision of mental health services in rural areas. Accordingly, the parties to the agreement request that MedPAC evaluate the impact of these changes and make recommendations if further modifications are needed to maintain the availability of rural hospitals to provide critical behavioral health services.

Sec. 125. Refinement of Prospective Payment System (PPS) for Inpatient Rehabilitation Hospitals

Current Law

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

H.R. 3075, as Passed

Changes the phase-in requirements to permit rehabilitation facilities to elect to have their payment based entirely on the PPS amount in FY 2001 and FY 2002. Changes the budget neutrality requirement for FY 2001 and FY 2002 to account for the facilities that have elected to be fully reimbursed on the PPS amount during the transition period. Requires the Secretary, after

obtaining substantially complete FY 2001 data, to analyze the extent to which changes in case-mix (or changes in the severity of illnesses) are attributable to changes in medical record coding and patient classification and do not reflect real changes in case-mix. Based on the analysis of the case-mix change attributable to coding and classification change, the Secretary shall adjust FY 2004 PPS rates by 150% of the estimate of the PPS percentage adjustment that would have achieved budget neutrality in FY 2001 if it had applied to setting the rates for that fiscal year. If this FY 2004 adjustment resulted in a percentage decrease in the rates, the Secretary shall increase the FY 2005 PPS rates by a percentage equal to 1/3 of such percentage decrease. If this FY 2004 adjustment resulted in a percentage increase in the rates, the Secretary shall decrease the FY 2005 PPS rates by a percentage equal to 1/3 of such percentage increase.

Requires the Secretary to base PPS on discharges. Requires the Secretary to establish classes of patient discharges of rehabilitation facilities by functional-related groups, based on impairment, age, comorbidities, and functional capability of the patient and such other factors as the Secretary deems appropriate to improve the explanatory power of Functional Independence Measure-Function Related Groups (FIMFRGs). Clarifies that the Secretary may adjust payments to account for the early transfer of a patient from a rehabilitation facility to another site of care. Requires the Secretary to submit a study to Congress not later than 3 years after the implementation of the PPS of its impact on utilization and access.

S.1788, as Reported

Bases the PPS on discharges classified according to functional-related groups based on impairment, age, comorbidities, and functional capability of the patient as well as other factors deemed appropriate to improve the explanatory power of FIMFRGs. Requires the Secretary to submit a study to Congress, not later than 2 years after implementation of PPS, of its impact on service utilization, beneficiary access, non-therapy ancillary services and other factors that the Secretary determines to be appropriate. The study should include legislative recommendations on payment adjustments as appropriate.

Agreement

The agreement includes the House provision with amendments.

Subtitle D--Hospice Care

Sec. 131. Temporary Increase in Payment for Hospice Care

Current Law

Hospice payments are based on one of four prospectively determined daily rates which correspond to levels of care. Before BBA 97, the rates were updated annually by the hospital market basket; BBA 97 reduced the updates to market basket minus 1 percentage point for FY 1999 through FY 2002 and required the Secretary to collect hospice cost data.

H.R. 3075, as Passed

No provision.

S.1788, as Reported

Changes the hospice update to market basket minus 0.5 percentage point through FY 2002.

Agreement

The agreement includes the Senate provision with an amendment. For each of fiscal years 2001 and 2002, hospice payment rates (otherwise in effect for those years) are increased by 0.5 percent and 0.75 percent, respectively. The Secretary is prohibited from including these additional payments in the updates of payment rates after FY 2002.

Sec. 132. Study and Report to Congress Regarding Modification of the Payment Rates for Hospice Care

Current Law

The Secretary is required to collect data from hospices on the costs of care provided for each fiscal year beginning with FY 1999.

H.R. 3075, as Passed

No provision.

S.1788, as Reported

Requires the GAO to conduct a study on the feasibility and advisability of updating the hospice rates and certain capped payment amounts, including an evaluation of whether the cost factors used to determine the rates should be modified, eliminated, or supplemented with additional cost factors. The report and recommendation are to be submitted to Congress within 1 year of enactment.

Agreement

The agreement includes the Senate provision.

Subtitle E–Other Provisions

Sec. 141. MedPAC Study on Medicare Payment for Non-Physician Health Professional Clinical Training in Hospitals

Current Law

BBA 97 required that, not later than 2 years after enactment, MedPAC submit to Congress a study of Medicare's graduate medical education payment policy and reimbursement methodologies including whether and to what extent payments are being made (or should be made) for training in nursing and other allied health professions.

H.R. 3075, as Passed

Requires MedPAC, within 18 months of enactment, to submit to Congress a study of Medicare payment policy with respect to professional clinical training of different types of non-physician health care professionals (such as nurses, nurse practitioners, allied health professionals, physician assistants, and psychologists).

S.1788, as Reported

No provision.

Agreement

The agreement includes the House provision. The parties to the agreement recognize that MedPAC has considered non-physician clinical training in its report to the Congress on long-term policies for graduate medical education. However, the parties to the agreement require additional explicit information on Medicare's role in financing clinical training for non-physician health professionals. A continuation of the existing effort, combined with quantitative analysis, will provide the Congress with all aspects of Medicare's support for health professional training, including possible methodologies for making payments and the entities that should receive them.

The parties to the agreement are pleased that the Secretary, consistent with language included in the Conference Report (Report 105-217) of the Balanced Budget Act of 1997, is considering a proposal to initiate graduate medical education payments to institutions involved in the training of clinical psychologists. The parties to the agreement urge the Secretary to issue a notice of proposed rulemaking to accomplish this modification before June 1, 2000.

Subtitle F–Transitional Provisions

Sec. 151. Exception to CMI Qualifier for One Year

Current Law

The Secretary is authorized to allow for exceptions and adjustments to the amount paid under PPS for hospitals that act as regional or national referral centers for patients transferred from other hospitals. Generally, a referral center is located in a rural area, has at least 275 or

more beds, can show that at least 50% of its Medicare patients are referred from other hospitals, and that at least 60% of its Medicare patients live more than 25 miles from the hospital or that 60% of all the services that the hospital furnishes to Medicare beneficiaries are furnished to those that live more than 25 miles from the hospital.

Alternatively, a hospital may meet certain other specified criteria including (1) a case-mix index above the national average or above the median case-mix value for urban hospitals located in that region; (2) a number of discharges greater than 5,000 or, if less, above the median number of discharges for urban hospitals in the region; (3) more than 50% of the hospital's active medical staff are specialists; (4) at least 60% of all its discharges are for patients who live more than 25 miles from the hospital; or (5) at least 40% of all patients treated at the hospital are referred from other hospitals or by physicians not on the hospital's staff. These referral centers receive preferential treatment in the Medicare inpatient PPS for the disproportionate share hospital payment adjustment and when considered for geographic reclassification.

H.R. 3075, as Passed

No provision.

S.1788, as Reported

Deems that Northwest Mississippi Regional Medical Center meets the case-mix index criterion for classification as a referral center for FY 2000.

Agreement

The agreement includes the Senate provision.

Sec. 152. Reclassification of Certain Counties and Areas for Purposes of Reimbursement Under the Medicare Program

Current Law

Medicare's inpatient hospital PPS payments vary by urban/rural classification and the geographic area where a hospital is located or to which a hospital is assigned.

H.R. 3075, as Passed

No provision.

S.1788, as Reported

Deems that: Iredell County, NC is to be considered part of the Charlotte-Gastonia Rock Hill NC-SC Metropolitan Statistical Area (MSA); and Orange County, NY is to be considered part of the large urban area of New York, NY for discharges occurring on or after October 1,

1999.

Agreement

The agreement contains the Senate provision with modifications. For purposes of Medicare reimbursement, Lake County, Indiana and Lee County, Illinois are deemed to be considered part of the Chicago, Illinois MSA; Hamilton-Middletown, Ohio is deemed to be considered part of the Cincinnati, Ohio-Kentucky-Indiana MSA; Brazoria County, Texas is deemed to be considered part of the Houston, Texas MSA; and Chittenden County, Vermont is deemed to be considered part of the Boston-Worcester-Lawrence-Lowell-Brockton, Massachusetts-New Hampshire MSA. These counties would be reclassified for the purposes of the Medicare inpatient PPS in FY 2000 and FY 2001.

Sec. 153. Wage Index Correction

Current Law

Medicare's inpatient hospital PPS payments are adjusted to reflect the wage level in the geographic area where a hospital is located or to which a hospital is assigned. Hospitals can only submit and correct wage data during specified times. All payment changes that result from changes to the wage data are implemented in a budget-neutral fashion.

H.R. 3075, as Passed

No provision.

S.1788, as Reported

Requires the Secretary to recalculate and apply the Hattiesburg, MS MSA wage index for FY 2000 using FY 1996 wage and hour data for Wesley Medical Center. The Secretary is instructed to adjust PPS to take into account the corrected wage index.

Agreement

The agreement includes the Senate provision with modifications. The wage index recalculation would not affect the wage indices for any other areas.

Sec. 154. Calculation and Application of Wage Index Floor for a Certain Area

Current Law

Medicare's inpatient hospital PPS payments are adjusted to reflect the wage level in the geographic area where a hospital is located or to which a hospital is assigned. Hospitals can only submit and correct wage data during specified times. All payment changes that result from changes to the wage data are implemented in a budget-neutral fashion.

H.R. 3075, as Passed

No provision.

S.1788, as Reported

No provision.

Agreement

The agreement would require the Secretary to calculate and apply the wage index for the Allentown-Bethlehem-Easton MSA for FY 2000 as if Lehigh Valley Hospital were classified in such area. Such recalculation would not affect the wage index for any other area. For FY 2001, Lehigh Valley Hospital would be treated as being classified to the Allentown-Bethlehem-Easton MSA.

Sec. 155. Special Rule for Certain Skilled Nursing Facilities

Current Law

The SNF prospective payment system pays SNFs a per diem amount for all covered services provided to Medicare beneficiaries. During a transition period lasting through the three cost reporting periods beginning on or after July 1, 1998, a portion of the per diem payment to a SNF will be based on a facility-specific rate, and the remaining portion on a federal rate. By the end of the transition, 100% of the per diem payment will be based on the federal rate. Federal and facility-specific payments are based on updated 1995 cost reports.

H.R. 3075, as Passed

No provision.

S.1788, as Reported

No provision.

Agreement

The agreement includes provisions to require the Secretary to establish for each cost reporting period beginning in FY 2000 and in FY 2001, special per diem payments for SNFs: (1) that began participation in the Medicare program before January 1, 1995; (2) for which at least 80 percent of total inpatient days of the facility in the cost reporting beginning in 1998 were comprised of persons entitled to Medicare; and (3) that are located in Baldwin or Mobile County, Alabama. The payment amount would be equal to 100 percent of the facility-specific rate, which would be based on allowable costs for the cost reporting period beginning in FY 1998.

TITLE II–PROVISIONS RELATING TO PART B

Sec. 201. Outlier Adjustment; Transitional Pass-through for Certain Medical Devices, Drugs, Biologicals

Current Law

Under the hospital outpatient PPS, payments will be uniform for all patients undergoing a certain procedure in certain hospitals. Currently, beneficiaries pay 20% of charges for outpatient services. Under the outpatient PPS, beneficiary copayments will be limited to frozen dollar amounts based on 20% of the national median of charges for services in 1996, updated to the year of implementation of the PPS.

H.R. 3075, as Passed

For certain high cost (or "outlier") patients, permits the Secretary to determine and provide additional payments to hospitals for each covered service for which the hospital's costs exceed a fixed multiple of the PPS amount, including any "transitional pass-through" payments and including other adjustments. The pool of funds for such outlier payments may not exceed 2.5% of total program costs in years before 2004 and 3.0% thereafter, but must be budget-neutral.

Allows for 2 to 3 years of payments to be made in addition to PPS payments ("transitional pass through" payments) for innovative medical devices, drugs, and biologicals, including orphan drugs, cancer therapy drugs and biologicals, and certain "new" medical devices, drugs, and biologicals. The pool of funds for such items would be 2.5% for years up to 2004 and 2% thereafter, but must be budget-neutral.

For the outpatient PPS, defines covered outpatient services to include implantable medical devices; gives the Secretary the option of basing the system's relative payment weights on the mean or the median of hospital costs.

Limits cost range of services and items (except for orphan drugs) comprising a cost group on which a prospective payment is based. Provides that beneficiary copayments will not reflect Medicare payments to hospitals for outlier costs or transitional pass through payments for certain drugs, biologicals, and devices.

S.1788, as Reported

Similar to House provision with additional transitional pass-through payments for

radiopharmaceuticals.

Agreement

The agreement includes the House provision with amendments: the agreement includes a transitional pass-through of costs of radiopharmaceuticals. In addition, the agreement allows the Secretary to apply outlier payments for covered outpatient services furnished before January 1, 2002, for individual outpatient encounters, using an appropriate cost-to-charge ratio for the hospital rather than for the specific departments within the hospital.

It is the intent of the conferees that the phase-down in beneficiary coinsurance for hospital outpatient services enacted by the Balanced Budget Act of 1997 not be delayed further by any changes to the hospital outpatient prospective payment system included in this bill. The BBA 97 provision was intended to fix an anomaly in the law that resulted in Medicare beneficiaries paying more than 20 percent in coinsurance for hospital outpatient services. There has already been a one-year delay in the implementation of the BBA 97 provision. The conferees fully expect that the beneficiary coinsurance phase-down will commence, as scheduled, on July 1, 2000, and that beneficiary coinsurance for outpatient department (OPD) services will be frozen until it equals 20 percent of the Medicare OPD fee schedule amount, which should be determined without regard to any outlier adjustments, adjustments that limit payment declines, or transitional add-on payments.

The parties to the agreement believe that HCFA's plans for implementing the outpatient prospective payment system (PPS), as described in HCFA's September 7, 1998 proposed regulation, raise many concerns. The proposal: (1) fails to provide adjustments for high cost care; (2) does not adequately provide a transition to include medical devices, drugs and biologicals in the system, and; (3) will not be updated annually to keep pace with changes in technology and medical practice. The Committee is making several structural changes to improve the design of the outpatient PPS and to assure that patients are not denied access to needed care.

In the proposed regulation, HCFA classified many different services with varying costs into a single payment group. In one example, brachytherapy has been placed in a group with other procedures that are much less costly. This could provide disincentives to use this technology. The Committee believes that while some level of variation is unavoidable, there should not be wide variation that could potentially restrict access to the most costly services. To address this problem, this agreement would place an upper limit on the variation of costs among services included in the same group. The most costly item or service in a group could not have a mean or median cost that was more than twice the mean or median cost of the least costly item or service in the group. To provide additional flexibility, the parties to the agreement give the Secretary the option to base the relative payment weights on either the mean or median cost of the items and services in a group. Further, in classifying drugs and biologicals into payment categories, the parties to the agreement expect that consideration will be given to products that are therapeutically equivalent.

The parties to the agreement recognize that there may be unusual cases, such as low volume items and services, and the Secretary is given discretion to exempt these exceptional cases from

the limitation. The parties expect that the Secretary would not use this exception to include orphan drugs in a group that contains very different resources.

In the proposed regulation, HCFA stated its intention not to update the payment groups and rates annually. This is different from the agency's process of annually updating the inpatient prospective payment system. Given the rapid pace of technological change as well as changes in medical practice, the parties to the agreement require the Secretary to review the outpatient payment groups and amounts annually and to update them as necessary.

BBA 97 gave the Secretary the discretion to make additional payments (called outlier payments) to hospitals for particularly costly cases. The parties to the agreement require the Secretary to make outlier payments in a budget neutral manner and in a similar way as is currently done in the inpatient PPS. The outlier pool would be established at any level up to 2.5 percent of total payments for the first three years under the new system. After the third year, the pool could be set at any level up to 3 percent of total payments.

While the statutory provisions for the inpatient PPS require an outlier pool equal to a level between 5 and 6 percent of total inpatient PPS payments, the Committee believes that the lower levels of 2.5 and 3.0 percent are more appropriate for the outpatient PPS because the outpatient PPS will make separate payments for most individual services performed during an outpatient encounter. The allowed upper limit on the size of the pool is increased after the third year because the need for outlier payments may increase after the temporary add-on payments for drugs and biologicals, described below, are replaced with a transitional provision that applies only to new products.

The parties to the agreement are concerned that HCFA's proposed payment system does not adequately address issues pertaining to the treatment of drugs, biologicals and new technology. The parties believe that these oversights could lead to restricted beneficiary access to drugs, biologicals and new technology. The provisions would establish transitional payments to cover the added costs of certain services involving the use of medical devices, drugs and biologicals. Hospitals using these drugs, biologicals and devices would be eligible for additional payments.

The duration of the transitional payment would be for a period of at least two years but not more than three years. For drugs, biologicals, and brachytherapy used in cancer therapy and orphan drugs, the period would begin with the implementation date of the outpatient PPS. This also would be the period applicable to medical devices first paid as an outpatient hospital service after 1996 but before implementation of the outpatient PPS (as well as for any other item or service eligible for the additional payments at the inception of the outpatient PPS because of insufficient data or use of the Secretary's discretion). For products first paid as an outpatient service after implementation of the outpatient PPS, the transitional payment would begin with the first date on which payment is made for the device, drug or biological as an outpatient hospital service and continue for at least two, but not more than three, years.

The parties to the agreement expect the Secretary to develop a process to address new devices, drugs and biologicals introduced after the outpatient fee schedule for a particular year has

been set. This process should include assigning an appropriate code (or codes) to the product and establishing the amount of the add-on payment. New codes and add-on payment amounts should be made effective quarterly.

The amount of the additional payment to hospitals, before applying the limitation described below, should equal the amount specified for the new technology less the average cost included in the outpatient payment schedule for the existing technology. Specifically, for drugs and biologicals, the amount of the additional payment is the amount by which 95 percent of the Average Wholesale Price (AWP) exceeds the portion of the applicable outpatient fee schedule amount that the Secretary determines is associated with the drug or biological. Similarly, for new medical devices, the add-on payment is the amount by which the hospital's charges for the device, adjusted to cost, exceed the outpatient fee schedule amount associated with the device.

The total amount of additional pass-through payments in a year should not exceed a prescribed percentage of total projected payments under the outpatient prospective payment system. The applicable percentages are: (1) 2.5 percent for the first three years after implementation of the new outpatient payment system; and (2) up to 2.0 percent in subsequent years. In setting the hospital outpatient department (OPD) rates and add-on amounts for a particular year, the Secretary will estimate the total amount of additional payments that would be made based on the add-on amounts specified above and the expected utilization for each service. If the estimated total amount exceeds the percentage limitation, the Secretary will apply a *pro rata* reduction to the add-on payment amounts so that projected total payments are within the limitation.

The parties to the agreement believe that the current DMEPOS fee schedule is not appropriate for certain implantable items, since their use in the hospital setting involves the provision of services by the hospital. It is the parties' intent that payment for implantable medical items (for example, pacemakers, defibrillators, cardiac sensors, venous grafts, drug pumps, stents, neurostimulators, and orthopedic implants), as well as for items that come into contact with internal human tissue during invasive medical procedures (but are not permanently implanted), will be made through the outpatient PPS system – regardless of how these products might be classified on current HCFA fee schedules.

The parties to the agreement understand that the Secretary is committed to creating separate payment categories for blood, blood products, and plasma-based and recombinant therapies. The parties to the agreement continue to be concerned that the inadequate payment for these products and therapies could represent a barrier to patient access. Accordingly, the parties to the agreement expect the Secretary to carefully analyze potential patient access issues and create sufficient payment categories to adequately differentiate these products.

The agreement also requires the Secretary to conduct a study of intravenous immune globulin (IVIG) services in settings other than hospital outpatient departments and physicians' offices to be completed within 1 year of enactment. In addition, the agreement requires the Secretary to make recommendations on the appropriate manner and settings under which Medicare should pay for these services in such settings.

The parties to the agreement encourage the Secretary to examine Medicare policies regarding outpatient rehabilitation services (including cardiac and pulmonary rehabilitation services) in hospital outpatient departments and other ambulatory settings in light of advances in medical technology.

Sec. 202. Establishing a Transitional Corridor for Application of OPD PPS

Current Law

The hospital outpatient PPS is to be implemented in full and simultaneously for all services and hospitals (estimated for July 2000).

H.R. 3075, as Passed

Provides payments in addition to PPS payments to a hospital during the first 3 years of the PPS if its PPS payments are less than the payments that would have been made prior to the PPS. During the first year, a hospital would receive an additional amount equal to 80% of the first 10% of the difference between its payments under the prior system and under the PPS, 70% of the next 10% of reduced payments, and 60% of the next 10%. If PPS payments are less than 70% of prior levels, the additional sum is 21% of the pre-BBA amount. During the second year, the payments as a proportion of reduced payments would change to 70% of the first 10% and 60% of the second 10%. If PPS payments are less than 80% of prior amounts the additional sum is 13% of the pre-BBA amount. In the third year, the payment would be 60% of the first 10% of reduced payments, and if the PPS payments are less than 90% of the prior amounts, the additional payment is 6% of the pre-BBA amount. These additional payments would be made through 2003.

Until January 1, 2004, for rural hospitals with fewer than 100 beds, provides special payments to bring payments to hospital outpatient departments up to their pre-PPS amounts if their PPS payments are less than under the prior system. Waives budget neutrality for these payments; applies BBA 97 beneficiary copayment rules. Requires the Secretary to report by July 1, 2002, on whether the outpatient PPS should apply to Medicare dependent small rural hospitals; sole community hospitals; rural health clinics; rural referral centers; rural hospitals with 100 or fewer beds; other rural hospitals as determined by the Secretary.

S.1788, as Reported

Requires the Secretary to increase payments under the hospital outpatient PPS in amounts such that the ratio of Medicare payments (after correction for the formula-driven overpayment) plus beneficiary copayments to hospital costs would be no less than 90%, 85%, and 80% of the ratio of the hospital's 1996 payments-to-costs in the first, second, and third years of the new system, respectively. Authorizes the Secretary to make interim payments to hospitals during these 3 years and to make subsequent retroactive adjustments. The budget neutrality requirement of the PPS is waived. For each year beginning in 2000, the Secretary is authorized to increase

permanently PPS payments to Medicare dependent small rural hospitals, sole community hospitals, and cancer hospitals to amounts such that the ratio of Medicare payments plus beneficiary copayments to a hospital's costs would be not less than that ratio in 1996. Beneficiary copayment reductions in BBA 97 would be protected for care in these facilities. The BBA 97 budget neutrality requirements would be waived for these payments.

Agreement

The agreement includes the House and Senate provisions with amendments. The agreement includes the House corridor amounts and a temporary hold harmless provision for small rural hospitals with modifications. It also includes the Senate's permanent hold harmless provision for cancer hospitals under the PPS. For services furnished before January 1, 2004, by rural hospitals with not more than 100 beds, Medicare payments will equal 100% of the hospitals' pre-BBA outpatient payment amounts if their PPS amount is less than the pre-BBA amount. On a permanent basis, Medicare payments to cancer hospitals will equal 100% of their pre-BBA amount if their PPS amount is less than their pre-BBA amount. Pre-BBA amount is defined as the amount equal to the product of the reasonable cost of the hospital for such services for the portions of the hospital's cost reporting period (or periods) occurring in the year and the base OPD payment-to-cost ratio for the hospital, excluding formula-driven overpayments.

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

Current Law

No provision.

H.R. 3075, as Passed

Requires the Secretary to submit a report and recommendations to Congress by July 1, 2002 on whether a hospital outpatient prospective payment system (PPS) should continue to apply to Medicare Dependent Hospitals, Sole Community Hospitals, rural health clinics, rural referral centers, and other rural hospitals.

S.1788, as Reported

Requires MedPAC to prepare a report to the Secretary of HHS and the Congress within 2 years of enactment regarding the feasibility and advisability of including cancer hospitals and rural hospitals in the outpatient PPS. After submission of the report, the Secretary shall submit comments on the report within 60 days.

Agreement

The agreement includes the Senate provision with modifications.

Sec 204. Limitation on Outpatient Hospital Copayment for a Procedure to the Hospital Deductible Amount

Current Law

When the hospital outpatient PPS is implemented, BBA 97 freezes beneficiary copayments at the dollar amount that is equal to 20% of national median changes for a procedure in 1996 updated to 1999 (or the year of implementation of the PPS).

H.R. 3075, as Passed

Caps beneficiary copayments under the PPS for care and services in hospital outpatient departments to the dollar amount of the deductible for an inpatient hospital stay under Part A. Provides Medicare payments to make up the difference between the frozen copayment amount and the new limit. Effective retroactively to enactment of the BBA 97.

S.1788, as Reported

No provision.

Agreement

The agreement includes the House provision.

Subtitle B–Physician Services

Sec. 211. Modification of Update Adjustment Factor Provisions to Reduce Update Oscillations and Require Estimate Revisions

Current Law

Payments to physicians are made on the basis of a fee schedule which assigns a relative value unit to each service. The conversion factor is a dollar figure that converts the geographically adjusted relative value into a dollar payment amount. This amount is updated each year. Beginning in 1999, the update percentage equals the Medicare Economic Index (MEI), subject to an adjustment to match actual spending to target spending for physicians services under the sustainable growth rate (SGR) system.

H.R. 3075, as Passed

Makes technical changes to limit oscillations in the annual update to the conversion factor beginning in 2001 by: (a) requiring that future update adjustment factors be calculated using data measured on a calendar year basis; (b) modifying the formula for determining the update by adding a new component to the formula to measure past year variances from allowed spending

growth; and (c) mitigating the year-to-year impact of these measures on the update by the addition of dampening multipliers. Provides for a budget-neutral transition to the revised system. Provides that the SGR is to be calculated on a calendar basis. Requires that an estimate of the conversion factor and SGR be made available to MedPAC and the public by March 1 of each year, MedPAC comments in its annual report, and final publication November 1. Requires the Secretary to use the best available data to revise prior SGR estimates for up to 2 years after the estimate is first published. Provides that provision would not apply to or affect any update for any year before 2001.

S.1788, as Reported

Nearly identical provision. In addition, requires the Secretary, acting through the Administrator of the Agency for Health Care Policy and Research, to conduct a study on the utilization of physicians services under the fee-for-service program.

Agreement

The agreement includes the House provision with Senate amendment to include the AHCPR study. With regard to physician supervision of anesthesia services under Medicare's Conditions of Participation, if the Secretary determines that there is insufficient current scientific data comparing mortality and adverse outcome rates in the provision of anesthesia services to Medicare patients, the Secretary should conduct a comparative outcome study and report back to the parties to the agreement. If the Secretary believes that she has sufficient mortality and quality information regarding the provision of anesthesia services by nurse anesthetists and anesthesiologists, then she could make the appropriate regulatory changes to ensure access to quality care for Medicare beneficiaries.

Sec. 212. Use of Data Collected by Organizations and Entities in Determining Practice Expense Relative Values

Current Law

The Social Security Act Amendments of 1994 (P.L.103-432) required the Secretary to develop a methodology for a resource-based system for calculating practice expenses which would be implemented in calendar year 1998. BBA 97 delayed implementation of a resource-based practice expense methodology for a year, until 1999. BBA 97 also reduced certain practice expense relative value units in 1998. The new resource-based system is being phased-in beginning in calendar year 1999; 1998 is used as the base year for the calculation. Beginning in 2002, the values will be totally resource-based.

H.R. 3075, as Passed

Requires the Secretary to establish by regulation a process (including data collection standards) under which the Secretary would accept for use and would use, to the maximum extent practicable and consistent with sound data practices, data collected by organizations and entities

other than HHS. Requires a report to the Secretary on the process and the extent to which such data has been used.

S.1788, as Reported

No provision.

Agreement

The agreement includes the House provision. The parties to the agreement direct the Secretary to give fair consideration to data submitted by external entities. The parties to the agreement are particularly concerned about the instances when HCFA may not have adequate data for rate setting.

Sec. 213. GAO Study on Resources Required to Provide Safe and Effective Outpatient Cancer Therapy

Current Law

No provision.

H.R. 3075, as Passed

Requires a study and report to Congress on resources required to provide safe and effective outpatient cancer therapy and the appropriate payment rates for such services.

S.1788, as Reported

No provision.

Agreement

The agreement includes the House provision. The parties to the agreement direct the Comptroller General to determine the adequacy of practice expenses associated with the utilization of outpatient cancer clinical resources, examine the current level of work values in the practice expense formula, and assess various standards to assure the provision of safe outpatient cancer therapy services. The parties to the agreement also direct the Comptroller General to submit to Congress a report on this study. As part of the study, the Comptroller General is directed to make recommendations regarding adjustments to practice expense values in effect under Part B of the Medicare program and the impact on program costs. In addition, the parties to the agreement encourage the Comptroller General to examine the variation in Medicare payments for these services in hospital and non-hospital settings.

Subtitle C–Other Services

Sec. 221. Revision of Provisions Relating to Therapy Services

Current Law

BBA 97 set annual payment limits for *all* outpatient therapy services provided by *non-hospital* providers. There are two per beneficiary limits. The first is a $1,500 per beneficiary annual cap for all outpatient physical therapy services and speech language pathology services. The second is a $1,500 per beneficiary annual cap for all outpatient occupational therapy services. The Secretary is required to report to Congress by Jan. 1, 2001 on recommendations for establishing a revised payment policy based on diagnostic groups.

H.R. 3075, as Passed

Creates separate $1,500 caps for physical therapy and speech-language pathology services which would be applied to services furnished on a per beneficiary, per facility (or provider) basis beginning in 2000. The cap on occupational therapy services would also be applied on a per beneficiary, per facility (or provider) basis. Directs the Secretary to establish a process so that a facility or provider may apply for an increase in the limitation for a beneficiary for services furnished in 2000 or 2001; limits additional payments to $40 million in FY2000, $60 million in FY2001, and $20 million in FY2002.

In addition, H.R. 3075 specifies that an optometrist may meet the physician supervision requirement for outpatient physical therapy services. Current law limits outpatient occupational therapy services to services furnished to individuals who are under the care of a medical doctor, doctor of osteopathy, or podiatrist. Persons suffering from low vision (visual impairments not correctable using conventional eyewear) may be under the care of either a medical doctor, doctor of osteopathy, or optometrist. The provision would clarify that rehabilitation services for these individuals may be covered when the patient is under the care of, and the treatment plan has been ordered by, either a medical doctor, doctor of osteopathy, or optometrist.

S.1788, as Reported

Provides that the cap would not apply in 2000 and 2001. Modifies current report to Congress to include recommendation for assuring appropriate utilization and incorporation of functional status in recommended payment modifications. Requires Secretary to study utilization patterns in 2000 compared to those in 1998 and 1999.

Agreement

The agreement includes the Senate provision with a modification requiring the Secretary to conduct focused medical reviews of therapy services during 2000 and 2001, with emphasis on claims for services provided to residents of SNFs.

The agreement also includes the House provision regarding optometrists and the supervision of outpatient physical therapy services. The parties to the agreement note that the extent to which

these rehabilitation services are covered is a coverage decision made by carriers and the Health Care Financing Administration. Based on an agreement between organizations representing ophthalmology and optometry on appropriate low vision rehabilitation services, the parties to the agreement expect that referral for low vision rehabilitation services by optometrists would be limited to three codes – 97530, 97535, and 97537.

Sec. 222. Update in Renal Dialysis Composite Rate

Current Law

Dialysis facilities providing care to beneficiaries with end-stage renal disease (ESRD) receive a fixed prospective payment amount for each dialysis treatment. The base composite rate is $126 for hospital-based providers and $122 for free-standing facilities.

H.R. 3075, as Passed

Updates the composite rate by 1.2% for dialysis services furnished during CY2000 and an additional 1.2% for services furnished in CY2001. Requires a MedPAC study on the use of home dialysis services by Medicare beneficiaries.

S.1788, as Reported

Updates the rate for services furnished after October 1, 2000 by 2.0%.

Agreement

The agreement includes the House provision.

Sec. 223. Implementation of the Inherent Reasonableness (IR) Authority

Current Law

The Secretary has the authority to modify payment rates for Part B services (other than physicians services) if such rates (as determined by prevailing payment methodologies) are "grossly excessive or grossly deficient" and therefore inherently unreasonable. The Secretary is required, by regulation, to describe the factors to be used in making inherent reasonableness determinations. Interim final regulations describing such factors were issued January 7, 1998.

H.R. 3075, as Passed

Prohibits the Secretary from exercising inherent reasonableness authority until after the Secretary has issued final rule-making. Specifies that final rule-making must be preceded by new proposed rule-making and a minimum 60-day public comment period.

S.1788, as Reported

Prohibits the Secretary from using inherent reasonableness authority until 90 days after the GAO issues a report regarding this issue.

Agreement

The agreement includes the House and Senate provisions with modifications to prohibit the Secretary from using inherent reasonableness authority until after (1) the GAO releases a report regarding the Secretary's recent use of the authority; and (2) the Secretary has published a notice of final rulemaking in the Federal Register that responds to the GAO report and to comments received in response to the Secretary's interim final regulation published January 7, 1998. In promulgating the final regulation, the Secretary is required to (1) reevaluate the appropriateness of the criteria included in the interim regulation for identifying payments which are excessive or deficient; and (2) take appropriate steps to ensure the use of valid and reliable data when exercising the authority. The parties to the agreement believe that the inherent reasonableness authority provided by section 1842(b) should be administered judiciously and applied only after public concerns and suggestions about proposed administrative criteria have been openly addressed. Also, the rules should include an explanation of the Secretary's costing methodology which should be based on statistically reliable and relevant data.

Sec. 224. Increase Reimbursement for Pap Smears

Current Law

Medicare pays for Pap smears under the clinical laboratory fee schedule.

H.R. 3075, as Passed

Sets the minimum payment for the test component of a Pap smear at $14.60. Expresses Sense of Congress that HCFA should institute appropriate increases for new cervical cancer screening technologies approved by the FDA.

S.1788, as Reported

Similar payment provision, but does not include the language relating to the sense of Congress.

Agreement

The agreement includes the House provision.

Sec. 225. Refinement of Ambulance Services Demonstration Project

Current Law

BBA 97 authorized a demonstration project under which a unit of local government could

enter into a contract with the Secretary to furnish ambulance services for individuals living in the local government unit. Capitated payments in the first year are to equal 95% of the amount which would otherwise be payable. Requires on a capitated basis the Secretary to publish a request for proposals for the project by July 1, 2000. Specifies that the capitation rate is to be based on the most current data and that the aggregate payments do not exceed what would otherwise be paid.

H.R. 3075, as Passed

Requires the Secretary to publish a request for proposals for the project by July 1, 2000. Specifies that the capitation rate is to be based on the most current data and that the aggregate payments do not exceed what would otherwise be paid.

S.1788, as Reported

No provision.

Agreement

The agreement includes the House provision.

Sec. 226. Phase-in of PPS for Ambulatory Surgical Centers (ASC)

Current Law

Medicare payments for services in ASCs have been based on a fee schedule (a form of PPS) since such services were first covered by Medicare in 1982. On June 12, 1998, HCFA published proposed rules rebasing, regrouping, and revising ASC rates which are to be implemented with the hospital outpatient PPS. These new rates are based on 1994 survey data.

H.R. 3075, as Passed

For ASC rates based on pre-1999 survey data, requires the new rates to be phased in over a period of at least three years. In the first year, new payment rates cannot exceed 1/3 of the payment totals made to an ASC; in the second year, new payment rates cannot exceed 2/3 of the payment totals made to an ASC.

S.1788, as Reported

No provision.

Agreement

The agreement includes the House provision. The parties to the agreement note that the data upon which HCFA's proposed payment system is based was collected in 1994 and that there have

been substantial changes in costs and technologies associated with these procedures since that time. In addition, the parties to the agreement note that HCFA is now completing a new cost survey intended to yield more reliable information and encourages the Secretary to obtain adequate cost data for rate setting. Should HCFA move forward with its new payment policy, this provision will ensure that the Agency has the flexibility necessary to implement the new ASC system over a period of three years or longer.

Sec. 227. Extension of Medicare Benefits for Immunosuppressive Drugs

Current Law

Medicare pays for drugs used in immunosuppressive therapy during the first 36 months following a Medicare covered organ transplant.

H.R. 3075, as Passed

Requires the Secretary to provide for an extension of the 36-month time period. Prohibits any extension after September 30, 2004. Permits the Secretary to limit (or provide priority in) eligibility to those persons who because of income or other factors would be less likely to continue the regimen in the absence of the extension. Limits total expenditures under the extension to $40 million in FY2000 and $200 million overall. Requires a report on the operation of the extension.

S.1788, as Reported

No provision.

Agreement

The agreement includes the House provision with amendments. The extension would apply to beneficiaries whose benefits under current law expire during the 5-year period beginning January 1, 2000 and ending December 31, 2004. Beneficiaries who current law benefits are set to expire in 2000 would be provided an additional eight months of coverage. Those whose benefits are set to expire in calendar year 2001 would receive a minimum of eight months of additional coverage. Beginning in 2001, the Secretary would be required to compute and specify in May what period of such additional months (which may be portions of months) qualifying beneficiaries would receive in the following year. In May 2001, the Secretary could also extend the period of coverage provided in statute for 2001, if her actuarial estimates supported such an extension. The Secretary is required to compute additional months of coverage in such a manner as to limit total expenditures for the extension to $150 million over the 5-year period. The Secretary would be required to adjust the number of additional months of coverage specified for each year beginning in 2001 and ending 2004 to the extent necessary to take into account differences between actual and estimated expenditures and to assure compliance with the limitation on spending for the extension. The Secretary's computations for any given year is to be based on the best data available to her at the time of computation in the preceeding May. The additional months of

coverage established for a given year would apply to an individual who exhausts their 36-month period of coverage during that year. The Secretary's report on the extension would be due March 1, 2003.

Sec. 228. Temporary Increase in Payment Amount for Durable Medical Equipment (DME) and Oxygen

Current Law

The DME fee schedules are updated annually by the CPI-U; BBA 97 eliminated the updates for 1998 through 2002.

H.R. 3075, as Passed

Provides an update to the DME payments in 2001 and 2002 by the CPI minus 2 percentage points, for the 12-month period ending with June of the previous year.

S.1788, as Reported

No provision.

Agreement

The agreement includes the House provision, with a modification to provide temporary adjustments to the DME fee schedule payments equaling 0.3 percent in FY 2001 and 0.6 percent in FY 2002. The Secretary is prohibited from including the additional payments for FY 2001 and 2002 in updates for future years.

Sec. 229. Studies and Reports

Current Law

No provision.

H.R. 3075, as Passed

Requires the following studies: (1) MedPAC study on cost-effectiveness of covering services of a post-surgical recovery center (that provides an intermediate level of recovery care following surgery); (2)AHCPR study comparing differences in the quality of ultrasound and other imaging services provided by credentialed individuals versus those provided by non-credentialed individuals; (3) MedPAC comprehensive study of the regulatory burdens placed on all classes of providers under fee-for-service Medicare and the associated costs; and (4) GAO monitoring of Department of Justice application of guidelines on use of False Claims Act in civil health care matters.

S.1788, as Reported

No provision.

Agreement

The agreement includes the House provision. The parties to the agreement are concerned that federal regulations governing health care providers participating in the Medicare program are overly complex and administratively burdensome. Therefore, the parties direct MedPAC to conduct a comprehensive study to review the regulatory burdens placed on all classes of health care providers under Parts A and B of the Medicare program. The purpose of the study is to determine the costs these burdens impose on the nation's health care system and the impact on patients and providers, and their ability to deliver cost-effective quality care to Medicare beneficiaries.

The parties to the agreement note that the Congress has expressed concern regarding the application of the False Claims Act (FCA) to Medicare billing errors that are the result of a complex regulatory system. The Department of Justice issued written guidance ("Guidance") to the United States Attorneys on the appropriate use of the FCA in health care investigations. In 1998, the Congress directed the General Accounting Office (GAO) to monitor the implementation of and compliance with the "Guidance" and report to Congress. The provision directs the GAO to continue its monitoring of the issue.

The parties to the agreement request that AHCPR focus its report on the role and the value of credentialing. In designing the study, the Administrator should consult with groups with expertise in ultrasound procedures, including the Society of Diagnostic Medical Sonographers, the Society of Vascular Technology, the American Society of Echocardiography and the American Registry of Diagnostic Medical Sonographers.

TITLE III–PROVISIONS RELATING TO PARTS A AND B

Subtitle A–Home Health Services

Sec. 301. Adjustment to Reflect Administrative Costs not Included in the Interim Payment System; GAO Report on Costs of Compliance with OASIS Data Collection Requirements

Current Law

Home health agency workers are required to collect clinical and social data on new home health patients using the standard Outcome and Assessment Information Set (OASIS) data collection instrument.

H.R. 3075, as Passed

Authorizes payments to home health agencies of $10 for each beneficiary served during a cost reporting period beginning in FY 2000. By April 1, 2000, the Secretary shall pay an estimated 50% of the aggregate annual amount. The payments are to be made from the Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund as determined appropriate by the Secretary. Requires the GAO to report to Congress within 180 days of enactment on the cost of OASIS data collection and the effects on patient privacy. Requires the GAO to perform an audit of the costs of OASIS and report to Congress 180 days after the first cost and privacy report.

S.1788, as Reported

No provision.

Agreement

The agreement includes the House provision.

Sec. 302. Delay in Application of 15 Percent Reduction in Payment Rates for Home Health Services Until 1 year after Implementation of Prospective Payment System (PPS)

Current Law

PPS is to be designed to reduce Medicare payments to home health agencies by 15% from pre-PPS payments; if PPS is not implemented by October 1, 2000, payment limits per visit and per beneficiary are to be reduced by 15%.

H.R. 3075, as Passed

Delays the 15% reduction in home health payments under the PPS until 12 months after implementation of the PPS. Total Medicare payments to home health agencies in the first year of the PPS shall be the same in total as would have been paid had the PPS not been in effect. The 15% reduction to begin 12 months after the start of the PPS shall be applied to the level of total payments in FY 2001 with updates. Within 6 months of implementation of the PPS, the Secretary shall report to Congress on the need for the 15% or other reduction.

S.1788, as Reported

Repeals the 15% reduction to the interim cost limits if PPS is not ready for implementation on October 1, 2000. Phases in the 15% reduction under the PPS by 5% over 3 years, starting in FY 2001.

Agreement

The agreement includes the House provision. The parties to the agreement encourage the Secretary to consider what changes would be necessary to provide home health care agencies with the flexibility to adopt new market innovations and new technologies that can improve health outcomes while maintaining the goals of quality of care and cost containment. The parties to the agreement also encourage the Secretary to eliminate barriers to the use of branch offices, by allowing the use of technology for means of supervision and oversight by the parent agency. The adequate level of onsite supervision from the parent agency should be determined based on quality outcomes.

Sec. 303. Increase in Per Beneficiary Limits

Current Law

Under the home health care interim payment system established in BBA 97, aggregate payments to home health agencies are computed using the least of reasonable costs, payments based on per visit limits (applied in the aggregate), or payments based on an average payment per beneficiary in FY 1994, with certain updates, applied in the aggregate. No limit applies to individual beneficiaries.

H.R. 3075, as Passed

No provision.

S.1788, as Reported

Increases agency per beneficiary limits by 1% starting in October 1, 1999. The increase does not affect per visit limits and is not included in the payment base for establishing the PPS.

Agreement

The agreement includes the Senate provision with an amendment to raise the increase in per beneficiary limits for cost reporting periods beginning during or after FY 2000 by 2% for home health agencies with per beneficiary limits below the national median per beneficiary limit for agencies with cost reporting periods starting during or before FY 1994. This increase will not be included in the base on which payments under the home health PPS are determined.

Sec. 304. Clarification of Surety Bond Requirements

Current Law

Home health agencies must provide the Secretary on a continuing basis with a surety bond that is not less than $50,000. HCFA regulations require the bond to be not less than 15% of the agency's Medicare payments in the previous year.

H.R. 3075, as Passed

Establishes the lesser of $50,000 or 10% of the agency's Medicare payments in the previous year as the annual amount of an agency's surety bond requirement. Requires the bond to be in effect for 4 years, or longer if agency ownership changes; prior periods covered by a bond may be counted. Coordinates Medicare and Medicaid surety bonds.

S.1788, as Reported

No provision.

Agreement

The agreement includes the House provision. The parties to the agreement encourage the Secretary to provide home health agencies with the opportunity to repay overpayments (due to incorrect interim payment system estimates) over a three-year period without interest costs.

Sec. 305. Refinement of Home Health Agency Consolidated Billing

Current Law

When the home health PPS is implemented, home health agencies will be responsible for billing Medicare and paying all other providers for services supplied on behalf of individual home health beneficiaries.

H.R. 3075, as Passed

No provision.

S.1788, as Reported

Excludes durable medical equipment, including oxygen and oxygen supplies, from the consolidated billing requirement.

Agreement

The agreement includes the Senate provision.

Sec. 306. Technical Amendment Clarifying Applicable Market Basket Increase for Prospective Payment System (PPS)

Current Law

When the home health PPS is in effect, the payments are to be updated in FY 2002 "or" 2003 by the market basket minus 1.1 percentage points.

H.R. 3075, as Passed

Clarifies that the PPS market basket increase minus 1.1 percentage points applies to FY 2002 and FY 2003.

S.1788, as Reported

No provision.

Agreement

The agreement includes the House provision.

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

Current Law

No provision.

H.R. 3075, as Passed

No provision.

S.1788, as Reported

Requires MedPAC to report to Congress within 2 years on the feasibility and advisability of exempting rural home health agencies or services to individuals residing in rural areas from the home health PPS.

Agreement

The agreement includes the Senate provision.

Subtitle B–Direct Graduate Medical Education

Sec. 311. Use of National Average Payment Methodology in Computing Direct Graduate Medical Education Payments

Current Law

Medicare pays hospitals for its share of direct graduate medical education (DGME) costs in approved training programs using a hospital-specific historic cost per resident, updated for inflation and multiplied by a hospital's number of full-time equivalent (FTE) residents.

H.R. 3075, as Passed

Establishes a national average per resident payment amount, adjusted for differences in area wages, starting on or after October 1, 2000. Hospitals would receive the greater of the national average per resident amount or a blended amount of the hospital-specific amount and the national average amount for a transition period for cost reporting periods on or after October 1, 2000 and before October 1, 2004. For cost reports starting on or after October 1, 2004, teaching hospitals would receive Medicare's share of a wage-adjusted national average per resident amount. The national per resident amount would be calculated using each hospital's combined primary care and non-primary care per resident amount, weighted by the number of full time equivalent residents in each hospital with an approved program, and standardized for differences in area wages. The amount would be calculated with data from cost reporting periods ending during FY 1997 updated by the CPI to the midpoint of the FY 2001 cost reporting period. Subsequent updates would be based on the CPI. During the transition period, a hospital with a wage index of less than 1.00 would not have its payment based on the national average adjusted by its area wage index.

S.1788, as Reported

No provision.

Agreement

The agreement includes the House provision with amendments. This provision establishes a direct graduate medical education payment methodology based on the national average per resident amount modified by the geographic adjustment factor (GAF) used to adjust physician payments, that is the weighted average of the three geographic practice cost indices (GPCIs) weighted by the national average percentage as published in the Federal Register on October 31, 1997. A national average per resident payment amount, based on FY 1997 data, would be calculated from each hospital's combined primary care and non-primary care per resident amounts and would be standardized by the average of the three geographic index values (weighted by the national average weight for each of the work, practice expense, and malpractice components) as applied for 1999 in the fee schedule in which the hospital is located. The national average per resident amount, standardized for locality, would be calculated using each hospital's amount weighted by the number of FTE residents and would be updated to FY 2001 by the consumer price index for urban areas (CPI).

Beginning during FY 2001, a lower bound would be calculated at 70% of the locality-adjusted, or standardized, national average per resident amount. An upper bound of 140% of the locality-adjusted national average per resident amount also would be calculated. Each hospital's FY 2001 per resident amount would then be compared to the upper and lower bounds adjusted by the GAF for the locality in which the hospital is situated. Hospitals with per resident amounts below 70% of the locality-adjusted threshold would have their per resident amounts increased to the 70% locality-adjusted threshold. Hospitals with per resident amounts that exceed 140% of their locality-adjusted upper bound would receive no update to their per resident amounts for two years (FY 2001 and FY 2002), and would receive updates of CPI minus two percentage points (but not below zero) for three years (FY 2003, FY 2004 and FY 2005). Hospitals with per resident amounts within the locality-adjusted boundaries of 70% and 140% would continue to be

paid portions of their per resident amounts and would receive updates for inflation.

The parties to the agreement concur that the GAF seems to be an appropriate measure for adjusting per resident payment amounts, and represents an initial attempt to adjust for differences among geographic areas in the costs related to physician training. The parties to the agreement request that MedPAC study the use of the GAF for this purpose and, if appropriate, make recommendations by March 2002 on the development of a more sophisticated or refined index to adjust payment amounts for physician training.

Sec. 312. Initial Residency Period for Child Neurology Residency Training Programs

Current Law

Each full-time intern and resident is counted as a 1.0 full time equivalent (FTE) resident during the initial residency period. After the initial residency period, a full-time resident can be counted only as 0.5 FTE for Medicare's direct graduate medical education payment. Generally, the initial residency period is the minimum number of years in which a resident must train to be eligible for certification in a medical specialty as listed in the American Medical Association's (AMA) Graduate Medical Education Directory. With a combined primary care specialty program, such as internal medicine-pediatrics, the initial residency period is defined as the minimum number of years for the longer of the two programs, plus one additional year. However, with a combined program where one of the programs is not primary care, then the initial residency period is based on the minimum years to qualify for the longer of the composite programs.

H.R. 3075, as Passed

Establishes a 3-year period where an individual in a child neurology residency program shall be treated as part of the initial residency period and shall not be counted against any limitation of the initial residency period.

Requires MedPAC to include in its March 2001 report to Congress a recommendation on whether the initial residency period for other combined residency training programs should be extended.

S.1788, as Reported

No provision.

Agreement

The agreement includes the House provision with amendment. A resident enrolled in a child neurology residency training program would have a period of board eligibility and initial residency of the board eligibility for pediatrics plus 2 years. This provision would be effective on or after July 1, 2000 to residency programs that began before, on, or after the enactment of this division.

MedPAC would be required to include in its March 2001 report to Congress a recommendation on whether the initial residency period for other combined residency training programs should be extended.

Sec. 321. BBA Technical Corrections

H.R. 3075, as Passed

Includes various technical corrections to the Balanced Budget Act of 1997.

S.1788, as Reported

Includes various technical corrections to the Balanced Budget Act of 1997.

Agreement

The agreement includes amendments to Medicare law that are needed as a result of the Balanced Budget Act of 1997.

TITLE IV–RURAL PROVIDER PROVISIONS

Subtitle A–Rural Hospitals

Sec. 401. Permitting Reclassification of Certain Urban Hospitals as Rural Hospitals

Current Law

Medicare's inpatient hospital PPS payments vary by urban/rural classification and the geographic area where a hospital is located or to which a hospital is reassigned. Several mechanisms within the Medicare program permit hospitals that meet certain criteria to apply to the Secretary to change their geographic designation.

H.R. 3075, as Passed

Instructs the Secretary to treat certain urban hospitals as rural hospitals no later than 60 days after their application for such treatment if the hospitals: (1) are located in a rural census tract of a Metropolitan Statistical Area (as determined by the Goldsmith Modification published in the Federal Register on February 27, 1992); (2) are located in an area designated by State law or regulation as a rural area or designated by the State as rural providers; or (3) meet other criteria as the Secretary specifies. Permits otherwise qualifying urban hospitals to be classified as sole community hospitals, regional referral centers, rural referral centers, or national referral centers. Extends this rural designation for use in outpatient PPS. Updates other federal criteria used to

designate rural providers.

Provides that a hospital in an urban area may apply to the Secretary to be treated as if the hospital were located in a rural area of the State in which the hospital is located. Hospitals qualifying under this section shall be eligible to qualify for all categories and designations available to rural hospitals, including sole community, Medicare dependent, critical access, and referral centers. Additionally, qualifying hospitals shall be eligible to apply to the Medicare Geographic Reclassification Review Board for geographic reclassification to another area. The Board shall regard such hospitals as rural and as entitled to the exceptions extended to referral centers and sole community hospitals, if such hospitals are so designated.

S.1788, as Reported

Provides alternative federal criteria to designate providers as rural.

Agreement

The agreement includes the House provision with clarification that the most recent Goldsmith Modification will be used.

Sec. 402. Update of Standards Applied for Geographic Reclassification for Certain Hospitals

Current Law

Section 1886(d)(8)(B) of the Social Security Act requires the Secretary to treat a hospital located in a rural county adjacent to one or more urban areas as being located in the urban Metropolitan Statistical Area (MSA) to which the greatest number of rural workers commute if the rural county's aggregate commuting rate (to all the contiguous MSAs) meets the standards for designating outlier counties to MSAs (and New England County Metropolitan Statistical Areas) that were published in the Federal Register on January 3, 1980.

H.R. 3075, as Passed

Updates the standards which are used to classify hospitals located between two Metropolitan Statistical Areas (MSAs) from 1980 to 1990 census data and then to the most recently available decennial population data for FY 2003 and subsequent years. For FY 2000, the 1980 census data would be used. A transition is provided for discharges occurring during cost report periods during FY 2001 and 2002 for hospitals to choose between the standards published in 1980 and 1990. Beginning with cost reporting periods during FY 2003, standards would be based on the most recent decennial population data published by the Bureau of the Census as revised by the Office of Management and Budget. This provision is effective with discharges occurring during cost reporting periods beginning on or after October 1, 1999.

S.1788, as Reported

No provision.

Agreement

The agreement includes the House provision. The parties to the agreement believe that a transition period for hospitals that might be negatively affected by the change in the standard is appropriate.

Sec. 403. Improvements in the Critical Access Hospital (CAH) Program

Current Law

BBA 97 established criteria for a small, rural, limited service hospital to be designated as a critical access hospital (CAH). These are geographically remote, rural nonprofit or public hospitals that are certified by the state as a necessary provider and have hospital stays of no more than 96 hours except under certain circumstances.

H.R. 3075, as Passed

Applies the 96-hour length of stay limitation on an average annual basis. Permits for-profit hospitals and hospitals that have closed within the past 10 years to be CAHs. Permits States to designate a facility as a CAH if the facility: (1) was a hospital that ceased operations on or after 10 years before enactment of this legislation; (2) is a State-licensed health clinic or health center; (3) was a hospital that was downsized to a health clinic or health center; and (4) meets the criteria for designation as a CAH. Permits CAHs to elect either a cost-based hospital outpatient service payment plus a fee schedule payment for professional services or an all-inclusive rate. Eliminates coinsurance for clinical laboratory tests. Clarifies CAH's ability to participate in the swing bed program.

S.1788, as Reported

Applies the 96-hour length of stay limitation on an average annual basis.

Agreement

The agreement includes the House provision.

Sec. 404. 5-Year Extension of Medicare Dependent Hospital (MDH) Program

Current Law

Medicare dependent hospitals (MDH) are small rural hospitals, not classified as sole community hospitals, that treat relatively high proportions of Medicare patients. BBA 97 reinstated and extended the MDH program to FY 2001.

H.R. 3075, as Passed

Extends the Medicare Dependent Hospital program through FY 2006.

S.1788, as Reported

Authorizes Medicare Dependent Hospitals to receive the market basket update in FY 2000 and subsequent years.

Extends the Medicare Dependent Hospital program through FY 2003.

Agreement

The agreement includes the House provision.

Sec. 405. Rebasing for Certain Sole Community Hospitals

Current Law

Sole community hospitals are paid based on whichever of the following amounts yields the greatest Medicare reimbursement: (1) a hospital-specific amount based on its updated FY 1982 costs; (2) a hospital-specific amount based on its updated FY 1987 costs; or (3) the federal amount.

H.R. 3075, as Passed

Permits sole community hospitals that are now paid the federal rate to transition over time to Medicare payment based on their FY 1996 costs.

S.1788, as Reported

No provision.

Agreement

The agreement includes the House provision.

Sec. 406. One-Year Sole Community Hospital Payment Increase

Current Law

Sole community hospitals are paid based on whichever of the following amounts yields the greatest Medicare reimbursement: (1) a hospital-specific amount based on its updated FY 1982 costs; (2) a hospital-specific amount based on its updated FY 1987 costs; or (3) the federal amount.

H.R. 3075, as Passed

No provision.

S.1788, as Reported

Provides for market basket update for sole community hospitals and Medicare Dependent Hospitals in FY 2000 and subsequent years.

Agreement

The agreement includes the Senate provision with modifications. Sole community hospitals will receive a market basket update for one year only for discharges occurring in FY 2001.

Sec. 407. Increased Flexibility in Providing Graduate Physician Training in Rural and Other Areas

Current Law

BBA 97 limited the number of residents that a hospital may count for graduate medical education (GME) to the number of full-time equivalent residents recognized in the hospital's most recent cost reporting period ending on or before December 31, 1996.

H.R. 3075, as Passed

Permits rural hospitals to increase their resident limits by 30% for direct graduate medical education payments for cost reporting periods starting on or after October 1, 1999 and indirect medical education payments for discharges occurring on or after October 1, 1999.

Permits non-rural facilities that operate separately accredited rural training programs in underserved rural areas, or that operate accredited training programs with integrated rural tracks, to increase their resident limits for purposes of calculating direct graduate medical education payments effective for cost reporting periods starting on or after October 1, 1999 and for indirect medical education payments effective for discharges occurring on or after October 1, 1999.

S.1788, as Reported

Expands the number of residents reimbursed by Medicare to those appointed by the hospitals for periods ending on or before December 31, 1996; allows hospitals with only one residency program to increase their resident count by one per year, up to a maximum of three; allows hospitals to count residents associated with new training programs established on or after January 1, 1995 and before September 30, 1999; gives special consideration to facilities that are not located in a rural area but have established separately accredited rural training tracks.

Provides an exception to the count of residents to include those who participated in GME at a Veterans Affairs (VA) facility and were subsequently transferred on or after January 1, 1997 and before July 31, 1998 to the hospital because the program would lose accreditation if residents were trained at the VA facility. If the Secretary determines that the hospital is owed retroactive payments, these payments shall be made within 60 days of enactment.

Agreement

The agreement includes the House provision with amendment. It would allow hospitals to increase the number of primary care residents that it counts in the base year limit by up to 3 full-time equivalent residents if those individuals were on maternity, disability, or a similar approved leave of absence. The provision also permits non-rural facilities that operate separately accredited rural training programs in rural areas, or that operate accredited training programs with integrated rural tracks, to receive direct graduate medical education and indirect medical education payments for cost reporting periods beginning on of after April 1, 2000 and for discharges occurring on or after April 1, 2000. In addition, the agreement includes the Senate provision regarding an exception to the count of residents to include those who participated in GME at a Veterans Affairs (VA) facility and were subsequently transferred.

Sec. 408. Elimination of Certain Restrictions with Respect to Hospital Swing Bed Program

Current Law

Medicare permits certain rural hospitals with fewer than 50 beds to use their inpatient facilities, as necessary, to furnish long-term care services. Rural hospitals with less than 100 beds can operate swing beds under certain circumstances.

H.R. 3075, as Passed

Eliminates requirement that States review the need for swing beds through the Certificate of Need (CON) process. Constraints on length of stay are also eliminated.

S.1788, as Reported

No provision.

Agreement

The agreement includes the House provision.

Sec. 409. Grant Program for Rural Hospital Transition to Prospective Payment

Current Law

BBA 97 replaced and modified the existing Essential Access Community Hospital (EACH)

program. The Secretary was authorized to award grants for certain limited purposes.

H.R. 3075, as Passed

Permits rural hospitals with fewer than 50 beds to apply for grants not to exceed $50,000 for meeting the costs of implementing data systems required to meet BBA 97 amendments. A hospital receiving a grant may use the funds for the purchase of computer software and hardware, for the education and training of hospital staff, and costs related to the implementation of PPS systems. Requires the Secretary to report to Congressional committees at least annually on the grant program including the number of grants, the nature of projects that are funded, the geographic distribution of the grant recipients, and other matters that are deemed appropriate. Requires the Secretary to submit a final report no later than 180 days after the completion of all projects funded by such grants.

S.1788, as Reported

No provision.

Agreement

The agreement includes the House provision.

Sec. 410. GAO Study on Geographic Reclassification

Current Law

No provision.

H.R. 3075, as Passed

Requires the GAO to submit a report to Congress no later than 18 months after enactment on the current laws and regulations for geographic reclassification of hospitals under Medicare. The purpose of the GAO study is to determine the need for geographic reclassification, whether reclassification is appropriate for the application of wage indices, and whether reclassification results in more accurate payments to all hospitals. The study shall evaluate: (1) the magnitude of the effect of geographic reclassification on rural hospitals that do not reclassify; (2) whether the current thresholds used in geographic reclassification assign hospitals to appropriate labor markets; (3) the effect of eliminating geographic reclassification through the use of data on occupational mix; (4) the group reclassification process; (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 there are sufficient controls over the intermediary evaluation of wage data reported by hospitals.

S.1788, as Reported

Requires the Secretary, in consultation with the Medicare Geographic Classification Review Board, to conduct a study to determine whether acute hospital PPS payment rates are an adequate proxy for the costs of inpatient hospital services and whether the standard for county-wide geographic reclassification needs to be updated or revised.

Agreement

The agreement includes the House provision. The parties to the agreement note that in recent years the geographic reclassification process and the increasing number of special designations for groups of hospitals have resulted in a system that is administratively cumbersome. In addition, the system, which relies on exceptions and waivers, lacks consistency and undermines the ability of hospitals to implement long-term planning. Most hospitals are required to reapply annually for geographic reclassification with no certainty that they will receive the desired wage index or standardized amount.

The parties to the agreement expect the GAO study to assess the background, rationale, and analytic justification for the current rural definitions and exceptions process. The parties to the agreement hope that this report will be an important tool in helping the Congress craft a more objective and equitable approach to Medicare payment for rural hospitals. This will only become more critical as the Congress considers extending geographic reclassification to other types of prospective payment systems. The parties to the agreement specifically ask the GAO to consider in its analysis whether the geographic reclassification process should be extended to other types of providers, particularly to skilled nursing facilities.

Subtitle B–Other Rural Provisions

Sec. 411. MedPAC Study of Rural Providers

Current Law

No provision.

H.R. 3075, as Passed

Requires MedPAC to conduct a study of rural providers, evaluate the adequacy and appropriateness of the categories of special Medicare payments (and payment methodologies) for rural hospitals, and their impact on beneficiary access and quality of health services. MedPAC shall submit its recommendations to Congress no later than 18 months after the date of enactment.

S.1788, as Reported

No provision.

Agreement

The agreement includes the House provision.

Sec. 412. Expansion of Access to Paramedic Intercept Services in Rural Areas

Current Law

BBA 97 authorized coverage of advanced life support (ALS) services provided by a paramedic intercept service provider in a rural area when medically necessary for the individual being transported and provided under contract with one or more qualified volunteer ambulance services. The volunteer ambulance service is certified, provides only basic life support services, and is prohibited by State law from billing for any services. The entity supplying the advanced life support services is Medicare-certified and bills all recipients who receive ALS services, regardless of whether the recipients are Medicare-eligible.

H.R. 3075, as Passed

Expands the areas to be treated as rural areas to include those designated as rural areas by any State law or regulation or those located in a rural census tract of a Metropolitan Statistical Area (as determined under the Goldsmith Modification, published in the Federal Register on February 27, 1992).

S.1788, as Reported

No provision.

Agreement

The agreement includes the House provision with modification to clarify that the most recent Goldsmith Modification should be used. The parties to the agreement believe that a State-determined designation of a rural area or an area located in a rural census tract of a Metropolitan Statistical Area should be acceptable for purposes of expanding access to paramedic intercept services.

Sec. 413. Promoting Prompt Implementation of Informatics, Telemedicine, and Education Demonstration Project

Current Law

BBA 97 authorized Medicare payment for professional consultations via telecommunications systems to beneficiaries residing in rural areas designated as health professional shortage areas (HPSA). HPSAs encompass either a full county or part of a county. BBA 97 also authorized a telehealth demonstration project for beneficiaries with diabetes mellitus in medically underserved rural or inner-city areas.

H.R. 3075, as Passed

Requires the Secretary to award without additional review the diabetes mellitus demonstration project no later than 3 months after enactment to the best technical proposal as of the bill's enactment date. Clarifies that qualified medically underserved rural or urban inner-city areas are federally-designated medically underserved areas or HPSAs at the time of enrollment in the project. Changes the project's data requirements. Limits beneficiary cost sharing.

S.1788, as Reported

No provision.

Agreement

The agreement includes the House provision.

TITLE V–PROVISIONS RELATING TO PART C (MEDICARE+CHOICE PROGRAM) AND OTHER MEDICARE MANAGED CARE PROVISIONS

Subtitle A--Provisions to Accommodate and Protect Medicare Beneficiaries

Sec. 501. Changes in Medicare+Choice Enrollment Rules

Current Law

Beneficiaries enrolled in a Medicare+Choice (M+C) plan that terminates its contract with HCFA are guaranteed access to certain Medicare supplemental insurance policies (i.e. "Medigap" policies) offered in their area of residence if they sign up within 63 days of their Medicare+Choice plan termination.

In addition, beneficiaries, at their election, may enroll or disenroll from a M+C plan offered in their area any time during the year. Beginning in 2002, however, beneficiaries generally will be able to enroll in a M+C plan or change plans only during an annual, month-long, open enrollment period.

If a M+C plan withdrawals from a M+C payment area (typically a county), enrollees who reside in that county may only elect to retain their enrollment in the plan (and travel to neighboring counties to obtain covered services) in certain circumstances.

H.R. 3075, as Passed

Specifies that an individual who is enrolled in a M+C plan that announces its intention to withdrawal from the M+C program may elect to exercise their guaranteed issue rights with (respect to obtaining a Medicare supplemental insurance policy) within 63 days of being notified

of the plan's intention to terminate.

Permits continuous open enrollment in M+C plans after 2002 for institutionalized beneficiaries. Permits a plan leaving a M+C payment area (typically a county) to offer enrollees in that county the option of continuing enrollment in the plan, so long as they agree to obtain all basic services through plan providers located in other counties.

S.1788, as Reported

Similar provision regarding Medigap special election period.

Agreement

The agreement includes the House provision with a modification clarifying that the continuous open enrollment provisions for the institutionalized only permit enrollment in a M+C plan or changing from one M+C plan to another.

Sec. 502. Change in Effective Date of Elections and Changes of Elections of Medicare+Choice Plans

Current Law

Medicare+Choice plan enrollees may elect to disenroll from their M+C plan at any time, and either switch to another M+C plan offered in their area or elect to obtain benefits through the fee-for-service Medicare program. Beginning in 2002, generally enrollees will be only be able to change coverage options once a year.

H.R. 3075, as Passed

No provision.

S.1788, as Reported

Specifies that any request to enroll in or disenroll from a M+C plan made after the 10th of the month will not be effective until the first day of the second calendar month thereafter.

Agreement

The agreement includes the Senate provision.

Sec. 503. 2-Year Extension of Medicare Cost Contracts

Current Law

Prior to enactment of BBA 97, beneficiaries were able to enroll in organizations with cost

contracts. BBA 97 specified that cost-based contracts could not be renewed after December 31, 2002.

H.R. 3075, as Passed

Extends the cost contract program through 2004.

S.1788, as Reported

Similar provision. However, after December 31, 2003, no new persons could enroll in a plan.

Agreement

The agreement includes the House provision.

Subtitle B - Provisions to Facilitate Implementation of the Medicare+Choice Program

Sec. 511. Phase-In of New Risk Adjustment Methodology; Studies and Reports on Risk Adjustment

Current Law

Currently, M+C payments to plans are adjusted using only demographic factors, including age, gender, coverage by Medicaid, institutionalized status, and working status. The law requires implementation of a risk adjustment payment methodology based on health status, effective January 1, 2000.

The Secretary has proposed use of the principal inpatient diagnostic cost groups (PIP-DCG) method of risk adjustment, which is based on diagnoses of beneficiaries with an inpatient hospitalization as well as demographic characteristics.

The Secretary has proposed a phase-in of the new risk adjustment methodology by blending the current demographic method with the new PIP-DCG method. The proposed phase-in schedule would be:

Year	Demographics	PIP-DCG
2000	90%	10%
2001	70	30
2002	45	55
2003	20	80

A new comprehensive risk adjustment method based on inpatient and other settings would be

used beginning in 2004.

H.R. 3075, as Passed

The phase-in schedule is modified as follows:

Year	Demographic	Health status
2000	90%	10%
2001	90	10
2002	80	20
2003	70	30

Beginning in 2004, M+C rates would be adjusted by a risk adjuster based 100% on data from multiple settings.

S.1788, as Reported

The Senate phase-in would be identical to the House provision from 2000 through 2003.

In 2004, the risk adjuster would be 45% demographic/55% health status based, with 67% of health status rate based on data from inpatient settings and 33% based on data from inpatient and other settings. In 2005, it would be 20% demographic/80% health status based, with 33% of health status rate based on data from inpatient settings and 67% on data from inpatient and other settings. Beginning in 2006, 100% of the risk adjuster would be based health status data, and be completely determined using data from inpatient and other settings.

Exempts frail elderly beneficiaries enrolled in EverCare demonstration projects for the frail elderly from the new risk adjustment system in 2000.

Requires Secretary to: (a) conduct a study on the effects, costs, and feasibility of requiring fee-for-service providers and entities to comply with quality standards and related reporting requirements which are comparable to those required for M+C plans; and (b) study and report to Congress regarding data submissions used to establish risk adjustment methodology under M+C.

Agreement

The agreement includes the identical House/Senate provisions for 2000-2002, only. The parties to the agreement note that in 1997, when Congress required the Secretary to develop a risk adjuster for Medicare+Choice plans, it was concerned that those plans that treated the most severely ill enrollees were not adequately paid. The Congress envisioned a risk adjuster that would be more clinically-based than the old method of adjusting payments. The Congress did not instruct HCFA to implement the provision in a manner that would reduce aggregate Medicare+Choice payments. In addition, the Congressional Budget Office did not estimate that the provision would reduce aggregate Medicare+Choice payments. Consequently, the parties to the agreement urge the Secretary to revise the regulations implementing the risk adjuster so as to

provide for more accurate payments, without reducing overall Medicare+Choice payments.

The parties to the agreement also note that as currently designed, the proposed Medicare+Choice risk adjuster fails to account for several unique aspects of Medicare's frail elderly population. The parties to the agreement note that the Secretary recently acknowledged her authority to address this problem by waiving application of the risk adjuster within the frail elderly demonstration project commonly known as EverCare. The parties to the agreement note that the Secretary will begin implementation of a multi-setting risk adjuster for all enrollees in 2004, and that such a risk adjuster should be designed to better predict the unique costs associated with caring for frail elderly beneficiaries. Consequently, the parties to the agreement encourage the Secretary to consider her ability to waive the application of the new risk adjuster to such beneficiaries until that time.

The parties to the agreement also believe Medicare enrollees with end-stage renal disease (ESRD) could benefit by being offered the opportunity to enroll in Medicare+Choice plans. However, the parties to the agreement understand that the current risk adjuster may not adequately reflect the varying costs of these patients and requests further information from the Secretary so that it might address this issue in the future. The parties to the agreement also encourage the Secretary to develop proposed quality of care requirements for Medicare beneficiaries with ESRD in this report.

The parties agreed to the Senate proposed study requiring the Secretary to: (a) conduct a study on the effects, costs, and feasibility of requiring fee-for-service providers and entities to comply with quality standards and related reporting requirements which are comparable to those required for M+C plans; and (b) study and report to Congress regarding data submission used to establish risk adjustment methodology under M+C.

Sec. 512. Encouraging Offering of Medicare+Choice Plans in Areas Without Plans

Current Law

A M+C plan receives the M+C payment rate applicable to the payment area (typically a county) in which the enrollee resides, adjusted for risk. This rate is based on a formula which assigns to the county the highest of three different rates -- a floor, a minimum update or a blended rate.

H.R. 3075, as Passed

Would establish added bonus payments to encourages new M+C plans to enter counties that would otherwise not have a plan participating. The first plan to enter a previously unserved county would receive a 5% added payment during their first year and a 3% added payment during their second year.

S.1788, as Reported

No provision.

Agreement

The agreement includes the House provision. In some counties, beneficiaries have access to only one Medicare option: the fee-for-service Medicare program. The parties to the agreement expect that this temporary enhancement of payments will encourage new plans to enter areas without Medicare+Choice options.

Sec. 513. Modification of 5-Year Re-Entry Rule for Contract Terminations

Current Law

The Secretary cannot enter into a M+C contract with a M+C organization, if within the preceding 5 years, that organization had a M+C contract which it did not renew. This prohibition may be waived under special circumstances.

H.R. 3075, as Passed

Allows, under certain circumstances, a plan to re-enter a county if a legislative or regulatory change that would increase M+C payments in the area occurred within 6 months of the plan's notification to the Secretary of its intent to terminate its M+C contract. Permits re-entry only if, at the time it notified the Secretary, there is no more than one other M+C plan offered in the area.

S.1788, as Reported

Reduces the exclusion period from 5 years to 2 years.

Agreement

The agreement includes the House and Senate provisions with modifications. The parties recognize that some plans left the Medicare+Choice program because of increased administrative requirements and payment growth that was lower than expected. Since this bill would make payment changes affecting Medicare+Choice plans, this provision would provide an opportunity for the plans to return to a county, and therefore, increase options for beneficiaries.

The general exclusion period is reduced from 5 to 2 years, with specific exceptions permitted where there is a change in payment policy. Further, nothing is to be construed as affecting the authority of the Secretary to provide additional exceptions, including those specified in Operational Policy Letter Number 103.

Sec. 514. Continued Computation and Publication of Medicare Original Fee-for-Service Expenditures on a County-Specific Basis

Current Law

The Secretary is required to announce each year the M+C payment rates for each payment area, as well as risk and other factors that are used in adjusting those payments. The Secretary is not currently required to publish adjusted annual per capita cost (AAPCC) data.

H.R. 3075, as Passed

Requires the Secretary to continue to publish estimates of adjusted annual per capita cost data (AAPCCs) for each M+C payment area, which represent county-specific per capita fee-for-service expenditure information.

S.1788, as Reported

Requires Secretary to provide county-level data on fee-for-service spending.

Agreement

The agreement includes the Senate provision with modifications to require the Secretary to publish for the original Medicare fee-for-service program under Parts A and B for each M+C payment area: 1) total expenditures per capita separately for Parts A and B; 2) expenditures as in "1" reduced by best estimates of expenditures (such as graduate medical education and disproportionate share hospital payments) not related to payment of claims; 3) average risk factors based on diagnoses reported for medicare inpatient services; and 4) average risk factors based on diagnoses reported for inpatient and other sites of service. The Secretary is required to provide information for 1998 and 1999 in the 2001 report.

Sec. 515. Flexibility to Tailor Benefits Under Medicare+Choice Plans

Current Law

In general, M+C managed care plans offer benefits in addition to those provided under Medicare's benefit package, and may, subject to regulation, charge for these additional benefits. Under current law, the monthly basic and supplemental premiums and benefits cannot vary among individuals enrolled in the plan.

H.R. 3075, as Passed

Permits a M+C plan to waive part or all of a premium if the M+C capitation rates the plan receives vary, so long as premiums do not vary within payment areas.

S.1788, as Reported

Allows plans to vary premiums, benefits, and cost-sharing across individuals enrolled in the plan so long as these are uniform within a separate segment of a service area. A segment would comprise one or more counties within the plan's service area.

Agreement

The agreement includes the Senate provision. The parties to the agreement are also concerned about allegations that some Medicare beneficiaries enrolled in the Medicare+Choice program are being denied certain Medicare-covered benefits. It was the clear intent of Congress in passing the Medicare+Choice program in BBA 97 that all beneficiaries enrolled in Medicare+Choice plans should be guaranteed access to all benefits covered by the traditional Medicare fee-for-service program. Therefore, the parties to the agreement would like to clarify that, pursuant to this fundamental requirement of the Balanced Budget Act of 1997, all Medicare beneficiaries enrolled in a Medicare+Choice plan under Part C are entitled to treatment by means of manual manipulation of the spine to correct a subluxation.

Sec. 516. Delay in Deadline for Submission of Adjusted Community Rates

Current Law

BBA 97 required M+C plans to submit adjusted community rate (ACR) proposals by May 1 of the previous calendar year. The Secretary is required to make available, during the open enrollment period, comparative information on plans.

H.R. 3075, as Passed

Changes the date for ACR submission from May 1st to July 1st. Specifies that, the Secretary will provide information to the extent it is available.

S.1788, as Reported

Similar provision. Also specifies that if a M+C organization intends to terminate a contract, it must provide notice to the Secretary 6 months in advance.

Agreement

The agreement includes the Senate provision with an amendment which retains the current law provisions relating to the information the Secretary is required to make available during the open enrollment period, and which reduces the required period of advance notification from 6 months to 4 months.

Despite this change, the parties to the agreement note that HCFA will know by mid-August of each year what the final plan premiums and benefits will be for each Medicare+Choice plan for the following calendar year. To help employers who sponsor retiree health benefits coordinate their own annual enrollment procedures, the parties to the agreement urge the Secretary to make this information available to such employers as soon as possible.

Sec. 517. Reduction in Adjustment in National Per Capita Medicare+Choice Growth Percentage for 2002

Current Law

The M+C payment rate is based on a formula which gives the payment area (generally a county) the highest of three different rates -- a floor, a minimum update, or a blended rate. The blended capitation rates are subject to a budget neutrality provision. Each year, the Secretary projects national per capita growth rates in expenditures in fee-for-service Medicare. These projected rates are reduced by 0.8 percentage points for 1998, and by 0.5 percentage points annually from 1999 through 2002 to determine the national M+C growth percentage for that year. Growth rates are used to update the floor and blend payments in the M+C payment rate formula. Because the blend payments are subject to budget neutrality, they may not always be fully funded; thus annual increases in payment rates to these counties may be limited.

H.R. 3075, as Passed

The provision would increase the national per capita M+C growth rate by 0.2 percentage points in 2002, by replacing the adjustment of -0.5 percentage points with -0.3 percentage points. The adjustment would remain at 0 for a year after 2002.

S.1788, as Reported

No provision.

Agreement

The agreement includes the House provision. The parties to the agreement expect that the increase in payments that will result from this provision will help to increase the number of counties paid a blended capitation payment rate.

Sec. 518. Deeming of Medicare+Choice Organization to Meet Requirements

Current Law

A M+C organization is required to meet certain standards. It is deemed to meet standards relating to quality assurance and confidentiality of records if it is accredited by a private organization that applies standards that are no less strict than M+C standards.

H.R. 3075, as Passed

Requires the Secretary, within 210 days of receiving an application from a private accrediting organization, to determine whether such organization's accreditation procedures meet the requirements. If it does, the Secretary would be required to deem a M+C organization accredited by such accrediting entity as meeting the requirements relating to quality assurance and confidentiality of records.

S.1788, as Reported

No provision.

Agreement

The agreement includes the House provision with amendments. The Secretary would be required to recognize accreditation with respect to M+C requirements relating to anti-discrimination, access to services, information on advance directives, and provider participation. In approving accrediting bodies for M+C program purposes, the Secretary would be required to use the same basic organizational criteria that are used to approve accrediting bodies who survey hospitals under the fee-for-service program. The agreement also clarifies that the accreditation bodies may choose to deem M+C plans' compliance with one or more of the specified requirements.

This provision would clarify the deeming process so that it is consistent with deeming in the Medicare fee-for-service program. The provision puts in place incentives for M+C plans to seek higher standards achievable through accreditation and would reduce redundancy in the oversight process. This will help ensure that improvements in the quality of care are made available through M+C plans.

Although accredited plans will be deemed to meet HCFA's standards, the parties to the agreement note that HCFA will continue to have broad authority to establish the actual standards that the accrediting bodies enforce. Moreover, HCFA continues to have broad authority to conduct independent oversight activities with respect to plans and to respond to any concerns beneficiaries may raise about a M+C plan. HCFA will also be able to approve or disapprove of the deeming process submitted by private accreditation bodies and maintain its authority to review periodically an approved accreditation body's standards and performance in the field. Nevertheless, the parties to the agreement emphasize that the intent of Congress in 1997 was clear that private accreditation procedures should be utilized in the Medicare+Choice program. The parties to the agreement's intent in this regard has not changed. Consequently, the parties to the agreement expect that the Secretary shall recognize and utilize qualified accreditation entities that have the ability to certify and enforce any of the requirements specified in the provision.

Sec. 519. Timing of Medicare+Choice Health Information Fairs

Current Law

There is an annual coordinated period in November of each year during which beneficiaries may sign up for or change their M+C plan. Beginning in 2002, this enrollment period generally will be the only time during the calendar year that such an election or change of election may be made. A nationally coordinated information and publicity campaign is held in November each year to provide beneficiaries with information about their plan options.

H.R. 3075, as Passed

No provision.

S.1788, as Reported

Permits HCFA to conduct the annual information campaign during the fall season.

Agreement

The agreement includes the Senate provision. The parties intend to give HCFA the flexibility to begin the annual information campaign earlier. For the purpose of this provision the parties intent for the Fall season to mean the months of September, October or November.

Sec. 520. Quality Assurance Requirements for Preferred Provider Organization Plans

Current Law

M+C program requirements mandate that participating plans maintain ongoing quality assurance programs. Quality assurance program requirements are more extensive for coordinated care plans (which rely upon networks of providers with whom they contract to provide coordinated services) than they are from MSA and fee-for-service M+C plans. In implementing these quality assurance requirements, the Secretary has required that participating plans meet Quality Improvement System for Managed Care (QISMC) standards and guidelines.

H.R. 3075, as Passed

No provision.

S.1788, as Reported

Exempts M+C preferred provider organizations from the QISMC requirements unless the Secretary establishes similar requirements for Medicare fee-for-service providers.

Agreement

The agreement includes the Senate provision with modifications. The provision would clarify that preferred provider organizations (PPOs) only be required to meet the quality assurance requirements currently applied to private fee-for-service and MSA plans. The provision further requires MedPAC to conduct a study on the appropriate quality assurance standards that should apply to each type of M+C plan (including each type of coordinated care plan) and to the original Medicare program. A report on this study is due within 2 years of enactment.

The changes incorporated in this provision are in response to the lack of preferred provider organizations participating in the M+C program, especially in rural counties. The parties to the agreement have taken these steps to help ensure that PPOs can reasonably comply with the quality assurance requirements under Part C, and strongly encourage PPO plans to begin offering

coverage in rural counties.

Sec. 521. Clarification of Nonapplicability of Certain Provisions of Discharge Planning Process to Medicare+Choice Plans

Current Law

BBA 97 modified hospital discharge planning process to assure that patients are not directed to a single post-acute facility.

H.R. 3075, as Passed

Provides an exemption for M+C enrollees.

S.1788, as Reported

No provision.

Agreement

The agreement includes the House provision with a modification specifying that a M+C discharge planning evaluation is not required to include information on the availability of home health services provided by individuals or entities that do not have a contract with the M+C organization. Further, the plan may specify or limit the provider or providers of post-hospital home health services or other post-hospital services.

Sec. 522. User Fee for Medicare+Choice Organizations Based on Number of Enrolled Beneficiaries

Current Law

Requires the Secretary to collect a user fee from each M+C organization for use in carrying out Medicare+Choice education and enrollment activities. The activities are directed at all Medicare beneficiaries, including the 84% still enrolled in the original medicare fee-for-service program under Parts A and B. The user fee is equal to the organization's pro rata share of the aggregate amount of fees authorized to be collected from M+C organizations. The Secretary is authorized to collect $100 million in user fees each year.

H.R. 3075, as Passed

No provision.

S.1788, as Reported

Specifies that the aggregate amount of fees collected from M+C organizations would be

limited to a pro rata share of the total budget for the education and enrollment related activities. This pro rata share is to be based on the number of beneficiaries in M+C plans as compared to the total number of Medicare beneficiaries. Limits total amount available in a fiscal year to the Secretary to carry out functions to $100 million. Authorizes the Secretary to draw upon the trust funds to finance that portion of authorized activities that are not financed by user fees imposed on M+C plans.

Agreement

The agreement includes the Senate provision with modifications. The program is authorized for $100 million per year. A Medicare+Choice plan's share of the total is the same proportion as their share of the total Medicare population. For example, if a particular Medicare+Choice plans enrolled 2.5 percent of the total Medicare population, that plan would be responsible for 2.5 percent of the costs associated with the information campaign, up to the $100,000,000 authorized.

Sec. 523. Clarification Regarding the Ability of a Religious Fraternal Benefit Society to Operate any Medicare+Choice Plan

Current Law

Religious fraternal benefit societies may restrict enrollment in their M+C plans to their members. This allowable restriction applies only to coordinated care plans.

H.R. 3075, as Passed

Extends the authority to all M+C plans.

S.1788, as Reported

Extends the authority to all M+C plans except MSAs.

Agreement

The agreement includes the House provision.

Sec. 524. Rules Regarding Physician Referrals for Medicare+Choice Program

Current Law

Currently it is unlawful for physicians who bill Medicare to refer patients to certain entities if the physician has an ownership interest in or a compensation arrangement with the entity to which the patient is referred. There is an exception for referrals to certain specified health plans that agree to provide care on a prepaid basis**.**

H.R. 3075, as Passed

No provision.

S.1788, as Reported

Specifies that the exception applies to M+C coordinated care plans.

Agreement

The agreement includes the Senate provision.

Subtitle C - Demonstration Projects and Special Medicare Populations

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

Current Law

Under waivers from the Secretary of HHS, SHMOs provide integrated health and long-term care services on a prepaid capitation basis. Medicare demonstration project waivers are to expire on December 31, 2000. The Secretary is required to submit to Congress by January 1, 1999, a report with a plan for integration and transition of SHMOs into an option under Medicare+Choice (this report is not yet completed) and a final report on the demonstration projects by March 31, 2001. Permits enrollment limits per site to be no fewer than 36,000.

H.R. 3075, as Passed

Extends the Medicare demonstration project waivers until 18 months after the Secretary submits an integration and transition plan report to Congress. Within 6 months after the Secretary's final report (due March 31, 2001), requires MedPAC to submit a report to Congress with recommendations regarding the demonstration project. Increases the aggregate limit on participants at all sites to not less than 324,000.

S.1788, as Reported

Extends Medicare demonstration project waivers until 1 year after the Secretary submits an integration and transition plan report to Congress. Requires the Secretary to submit a final report on the demonstration projects to Congress 1 year after the integration and transition plan report.

Agreement

The agreement includes the House provision.

Sec. 532. Extension of Medicare Community Nursing Organization Demonstration Project

Current Law

The community nursing organization 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. BBA 97 extended the availability of services through 1999. A final report is in progress.

H.R. 3075, as Passed

Extends the demonstration project for 2 years; requires the Secretary to submit a report to Congress on the results of the demonstration project no later than July 1, 2001.

S.1788, as Reported

No provision.

Agreement

The agreement includes the House provision with an amendment requiring the Secretary to provide for such reductions in payments under the project, in either year, which are necessary to ensure that federal expenditures under the project do not exceed those which would have been made in the absence of the project extension.

Sec. 533. Medicare+Choice Competitive Bidding Demonstration Project

Current Law

BBA 97 requires the Secretary to establish a demonstration project under which payments to Medicare+Choice organizations are determined by a competitive pricing methodology, in accordance with the recommendations of the Competitive Pricing Advisory Committee (CPAC), the composition and responsibilities of which were also established under BBA 97.

H.R. 3075, as Passed

Delays implementation of the project until January 1, 2002 or, if later, 6 months after CPAC submits reports on (a) incorporating original fee-for-service Medicare into the demonstration; (b) quality activities required by participating plans; (c) the viability of expanding the demonstration project to a rural site; and (d) the nature of the benefit structure required from plans that participate in the demonstration. The Secretary is also required, subject to recommendations by CPAC, to allow plans that make bids below the established government contribution rate, to offer beneficiaries rebates on their Part B premiums.

This provision is designed to give both CPAC and Congress more time to resolve some of the initial concerns that have been raised about the demonstration project, as it is currently designed. By delaying the start date an additional year, and by tasking CPAC to report back on the identified areas of concern, the parties to the agreement believe appropriate modifications to the project can be implemented before its inauguration so as to improve its chances of success. Similarly, the additional time provided by the delay will afford the Secretary, CPAC and the area advisory committees additional time to work with the communities designated under the project to resolve outstanding issues of concern.

S.1788, as Reported

No provision.

Agreement

The agreement includes the House provision.

Sec. 534. Extension of Medicare Municipal Health Services Demonstration Projects (MHSP)

Current Law

The MHSP is a multi-site demonstration to improve access to primary care services. BBA 97 extended the project through Dec. 2000 to provide a transition to mainstream Medicare.

H.R. 3075, as Passed

Extends the project through December 31, 2001.

S.1788, as Reported

No provision.

Agreement

The agreement includes the House provision, with an amendment to extend the project through December 31, 2002.

Sec. 535. Medicare Coordinated Care Demonstration Project

Current Law

BBA 97 provided for a coordinated care demonstration project in a cancer hospital. Funds would only be available as provided in any law making appropriations for the District of Columbia.

H.R. 3075, as Passed

Specifies that the funding is to be made from Medicare trust funds in such amounts as are necessary to cover the costs of the project.

S.1788, as Reported

No provision.

Agreement

The agreement includes the House provision.

The parties to the agreement are concerned that the Secretary has not acted upon a previously expressed Congressional mandate contained in the Balanced Budget Act of 1997 with respect to best practices in the area of coordinated care. Specifically, the mandate contained in Subchapter D, Section 4016 of the law required the Secretary no later than two years after enactment to conduct nine demonstration projects, that among other things, would evaluate best practices in the management of chronic illness. The parties to the agreement are aware that a solicitation for such proposals in the areas of, but not limited to, congestive heart failure and diabetes mellitus contained in the Health Care Financing Administration Federal Register Notice of June 11, 1998, Vol. 63, No. 112 has not yet been acted upon by the Department, despite clear Congressional interest to evaluate and understand the potential benefits of these programs for better delivery of care to Medicare beneficiaries.

Therefore, the parties direct the Secretary to implement no later than 90 days after enactment of this law demonstrations enunciated in BBA 97, including a demonstration focused on the best practices available in chronic illness. Specifically, the parties also direct the Secretary no later than 90 days after enactment of this law to implement the case management demonstration focused on congestive heart failure and diabetes mellitus contained in the HCFA Federal Register solicitation of June 11, 1998.

Sec. 536. Medigap Protections for PACE Program Enrollees

Current Law

The law guarantees issuance of specified Medigap policies to certain persons in terminating plans and, within their first twelve months of Medicare eligibility, to persons who enter directly into a M+C plan when becoming eligible for Medicare.

H.R. 3075, as Passed

No provision.

S.1788, as Reported

Extends protections to PACE enrollees in similar circumstances**.**

Agreement

The agreement includes the Senate provision with a modification to limit application of the provision to persons 65 years of age and older. The agreement does not include an extension of the disenrollment window for involuntarily terminated enrollees.

Subtitle D - Medicare+Choice Nursing and Allied Health Professional Education Payments

Sec. 541. Medicare+Choice Nursing and Allied Health Professional Education Payments

Current Law

Medicare's calculation of managed care rates incorporates the additional payments made to teaching hospitals that operate residency training programs. BBA 97 reduced these rates by carving out the costs attributable to graduate medical education payments for physicians. The payment reduction is phased in over 5 years. Teaching hospitals will receive additional payments depending upon the number of Medicare managed care beneficiaries they serve.

H.R. 3075, as Passed

Authorizes hospitals that operate approved nursing and allied health professional training programs to receive additional payments to reflect utilization of Medicare+Choice enrollees. The relationship of allied health direct graduate medical education (DGME) payments for Medicare+Choice enrollees to physician DGME payments for Medicare+Choice enrollees shall be in the same proportion as total allied health DGME payments to total DGME payments. The allied health payments to different hospitals are proportional to the direct costs of each hospital for such programs. In no case can this payment exceed $60 million. Physician DGME payment for Medicare+Choice utilization will be adjusted by the amount of additional payments that will be made for allied health professions under this provision.

S.1788, as Reported

No provision.

Agreement

The agreement includes the House provision with technical modifications. Hospitals that operate approved nursing and allied health professional training programs and receive Medicare reasonable cost reimbursement for these programs would receive additional payments to reflect utilization of Medicare+Choice enrollees for portions of the cost reporting periods occurring in a

year beginning in 2000. As specified by the Secretary, the payment amount would be calculated based on the proportion of physician direct graduate medical education (DGME) payments for Medicare+Choice enrollees to total physician DGME payments multiplied by the Secretary's estimate of total reasonable cost reimbursement for approved nursing and allied health professional training programs. In no case could this payment exceed $60 million. Hospitals would receive these allied health payments in proportion to amount of Medicare reasonable cost reimbursement for nursing and allied health programs received in the cost reporting period in the second preceding fiscal year to the total paid to all hospitals for such cost reporting period. Physician DGME payment for Medicare+Choice utilization would be reduced by the amount of additional payments that would be made for nursing and allied health professions under this provision.

Subtitle E - Studies and Reports

Sec. 551. Report on Accounting for VA and DOD Expenditures for Medicare Beneficiaries

Current Law

No provision.

H.R. 3075, as Passed

Requires the Secretaries of HHS, DOD, and VA no later than a year from enactment to submit to Congress a report on the use of health services furnished by DOD and VA to Medicare beneficiaries including Medicare+Choice enrollees and Medicare fee-for-service beneficiaries.

S.1788, as Reported

No provision

Agreement

The agreement includes the House provision with an amendment. The amendment requires the study to be conducted no later than April 1, 2001.

On a similar matter, the parties to the agreement are also concerned about the ability of Medicare beneficiaries who are also entitled to Veterans Administration health care services to obtain the full benefit of these separate entitlements. This issue is of particular concern in areas where VA health facilities are inadequate to fully meet the needs of these veteran beneficiaries. While beneficiaries in these areas are often able to readily obtain Medicare covered services from Medicare providers, the lack of Veterans Health Administration facilities often prevents them from obtaining more generous VA benefits for their health care needs. As a result, these beneficiaries often have to pay more in out-of-pocket health spending than similarly entitled veterans who reside near VA facilities.

To address this problem, the parties to the agreement encourage the Secretary to consult with the Secretary of the Department of Veterans Affairs and consider ways in which the two Secretaries could institute procedures that would allow for the greater coordination of benefits -- and consequently greater access to needed care -- for this special population.

Sec. 552. Medicare Payment Advisory Commission (MedPAC) Studies and Reports

Current Law

No provision.

H.R. 3075, as Passed

Requires MedPAC to submit to Congress a report on specific legislative changes that would make MSA plans a viable option under the M+C program.

S.1788, as Reported

Requires MedPAC to conduct a study that evaluates the methodology used by the Secretary in developing risk adjustment factors for M+C capitation rates. Requires MedPAC to conduct a study on the development of a payment methodology under M+C for frail elderly beneficiaries enrolled in specialized programs.

Agreement

The agreement includes the House and Senate provisions.

Sec. 553. GAO Studies, Audits, and Reports

Current Law

No provision.

H.R. 3075, as Passed

No provision.

S.1788, as Reported

Requires the GAO to conduct a study of Medigap policies. Requires the GAO to conduct annual audits of the Secretary's expenditures for providing M+C information to beneficiaries.

Agreement

The agreement includes the Senate provision.

TITLE VI–MEDICAID

Sec. 601. Increase in DSH Allotment for Certain States and the District of Columbia

Current Law

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

H.R. 3075, as Passed

Increases the ceiling on the federal share of DSH payments for the District of Columbia, from $23 million to $32 million for each of fiscal years 2000 through 2002; for Minnesota, from $16 million to $33 million for each of fiscal years 1999 through 2002; for New Mexico, from $5 million to $9 million for each of fiscal years 1998 through 2002; and for Wyoming, from 0 to $.1 million for each of fiscal years 1999 through 2002.

S.1788, as Reported

Same as House provision.

Agreement

The agreement follows the House bill and the Senate bill.

Sec. 602. Removal of Fiscal Year Limitation On Certain Transitional Administrative Costs Assistance

Current Law

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 replaced the Aid to Families with Dependent Children (AFDC) program and established the Temporary Assistance for Needy Families (TANF) program. Under the old program, people who qualified for AFDC were automatically eligible for Medicaid. Welfare reform de-linked Medicaid and TANF eligibility. Concerned that state Medicaid programs would face large new administrative costs for conducting Medicaid eligibility determinations that would otherwise not have occurred, Congress established a fund of $500 million to assist with the transitional costs of the new eligibility activities. The funds are available at an increased federal match for states that can demonstrate to the satisfaction of the Secretary that such additional administrative costs were attributable to welfare reform. The increased matching funds are available for the period beginning with fiscal year 1997 and ending with fiscal year 2000 and must relate to costs incurred during the first 12 quarters following the welfare reform effective date.

H.R. 3075, as Passed

No provision.

S.1788, as Reported

Extends the availability of the transitional increased federal matching funds beyond fiscal year 2000 and allows costs for which the increased matching funds are claimed to relate to costs incurred for the calender quarters beyond the first 12 following the effective date of welfare reform.

Agreement

The agreement includes the Senate provision.

Sec. 603. Two-Year Moratorium on Phase-Out of Payment for Federally-Qualified Health Center Services and Rural Health Clinic Services Based On Reasonable Costs

Current Law

States pay FQHCs and RHCs a percentage of the facilities' reasonable costs for providing services. This percentage decreases for specified fiscal years--100% of costs for services furnished during FY1998 and FY1999; 95% for FY2000; 90% for FY2001; 85% for FY2002; and 70% for FY2003. For services furnished on or after October 1, 2003, no required payment percentage will apply. Two special payment rules are applicable during FY1998-FY2002. In the case of a contract between an FQHC or RHC and a managed care organization (MCO), the MCO must pay the FQHC or RHC at least as much as it would pay any other provider for similar services. States are required to make supplemental payments to the FQHCs and RHCs, equal to the difference between the contracted amounts and the cost-based amounts.

H.R. 3075, as Passed

Creates a new Medicaid prospective payment system for FQHCs and RHCs beginning with FY2000. For the base year (defined as FY2000 for existing entities and the initial year of FQHC or RHC qualification for new entities established after FY1999), per visit payments are equal to 100% of the reasonable costs during the previous year for existing entities and the base year for new entities, adjusted for any increase in the scope of services furnished. For each fiscal year thereafter, per visit payments are equal to amounts for the preceding fiscal year increased by the percentage increase in the Medicare Economic Index applicable to primary care services for that fiscal year, and adjusted for any increase in the scope of services furnished during that fiscal year. In managed care contracts, States must make supplemental payments equal to the difference between contracted amounts and the cost-based amounts. Alternative payment methods are permitted only when payments are at least equal to amounts otherwise provided.

S.1788, as Reported

Retains the phase-out of cost-based reimbursement under Medicaid for FQHCs and RHCs as delineated in current law, and adds a new grant program. Beginning in FY2001, transitional grants outside the Medicaid program may be awarded to qualifying states to pay for services allowable under Medicaid when provided by FQHC and RHC to individuals who are not eligible for Medicaid. These grants will be made only to states that are paying 100% of reasonable costs to FQHCs and RHCs under Medicaid with one exception--states that have elected to pay FQHCs and RHCs 95% of reasonable costs in FY2000 and which revert to paying 100% of reasonable costs for FY2001 through FY2003 may also qualify for this new grant. For each of fiscal years 2001 through 2003, grant amounts are based on the ratio of the number of low-income persons in a state to the total number of such persons in all states. Counts of low-income persons equal the average number of such persons estimated using the 3 most recent March supplements of the CPS before the beginning of the calendar year in which the fiscal year begins. Annual grant amounts for any state will be no less than $400,000, and the Secretary will make pro rata adjustments as needed to achieve this requirement. There are no matching fund requirements for states. Also, each state awarded a grant will have 3 years in which to spend the funds allotted for a given fiscal year. States must distribute funds among all FQHCs and RHCs using uniform criteria based on factors such as size of caseload and treatment costs. Up to 15% of grant amounts per fiscal year may be used by states for administrative costs associated with this program. Total annual appropriations are $25 million for each of fiscal years 2001 through 2003. The GAO will conduct an annual study (due on November 1 of each year for 2000 through 2003) to determine the impact of the phase-out of cost-based reimbursement for FQHCs and RHCs and will report related recommendations for legislation.

Agreement

The agreement imposes a two-year moratorium on the phase-down of the cost-based reimbursement system set forth in the Balanced Budget Act of 1997. This will freeze the phase-down at 95 percent for fiscal years 2001 and 2002, and then the phase-down will resume at 90 percent in 2003, 85 percent in 2004. Cost-based reimbursement will be repealed in 2005. The General Accounting Office (GAO) will conduct an analysis of the impact of reducing or modifying payments based on the reasonable cost standard for federally qualified health centers and rural health clinics and the populations they serve. The GAO shall report back to Congress within 12 months with their findings and recommendations. This study shall evaluate a sampling of different payment approaches.

Sec. 604. Parity in Reimbursement for Certain Utilization and Quality Control Services; Elimination of Duplicative Requirements for External Quality Review of Medicaid Managed Care Organizations

a. Parity in Reimbursement for Certain Utilization and Quality Control Services

Current Law

Current Medicaid law provides that States will receive 75% federal financial participation (FFP) when contracting with a Peer Review Organization (PRO) for medical and utilization reviews and for quality reviews. In addition, states can receive 75% FFP when they contract

with a PRO-like entity but only for external quality reviews of Medicaid managed care. For all other reviews and entities, the standard 50% FFP applies.

A PRO is an entity that has a Medicare contract to perform medical and utilization reviews. A PRO-like entity is one that is certified by the Secretary as meeting the requirements of Section 1152 which defines standards for PROs under Medicare.

H.R. 3075, as Passed

States will receive 75% FFP when PRO-like entities conduct medical and utilization reviews for fee-for-service Medicaid, and quality reviews for Medicaid managed care.

S.1788, as Reported

No provision.

Agreement

The agreement includes the House provision.

b. Elimination of Duplicative Requirements for External Quality Review of Medicaid Managed Care Organizations

Current Law

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

H.R. 3075, as Passed

No provision.

S.1788, as Reported

Deletes the external review requirements of Section 1902 (a)(30)(C) and related parts of Sections 1902(d), 1903(a)(3)(C)(i) and 1903(m)(6)(B). Also requires the Secretary of HHS to certify to Congress that the external review requirement in Section 1932(c)(2) is fully implemented.

Agreement

The agreement includes the Senate provision.

Sec. 605. Inapplicability of Enhanced Match Under the State Children's Health Insurance Program to Medicaid DSH Payments

Current Law

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

H.R. 3075, as Passed

No provision.

S.1788, as Reported

Clarifies that Medicaid DSH payments are matched at the FMAP and not at the enhanced federal matching percentage authorized under Title XXI.

Agreement

The agreement includes the Senate provision.

Sec. 606. Optional Deferment of the Effective Date for Outpatient Drug Agreements

Current Law

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

H.R. 3075, as Passed

No provision.

S.1788, as Reported

Allows rebate agreements entered into after the date of enactment of this act to become effective on the date on which the agreement is entered into, or at State option, any date before or after the date on which the agreement is entered into.

Agreement

The agreement includes the Senate provision.

Sec. 607. Making Medicaid DSH Transition Rule Permanent

Current Law

Medicaid authorizes states to make special disproportionate share (DSH) payments to certain hospitals treating large numbers of low-income and Medicaid patients. States determine the formula used to calculate DSH payments to individual hospitals within minimum and maximum federal cr74iteria. For the period July 1, 1997 through July 1, 1999, hospital-specific disproportionate share payments for the State of California may be as high as 175% of the cost of care provided to Medicaid recipients and individuals who have no health insurance or other third-party coverage for services during the year (net of non-disproportionate share Medicaid payments and other payments by uninsured individuals).

H.R. 3075, as Passed

Removes the July 1, 1999, end date for increased hospital-specific disproportionate share payments for the State of California, extending the transition period indefinitely.

S.1788, as Reported

Same as House provision.

Agreement

The agreement follows the House bill and the Senate bill.

Sec. 608. Medicaid Technical Corrections

Current Law

No provision.

H.R. 3075, as Passed

No provision.

S.1788, as Reported

Makes technical corrections to cross-references in Title XIX.

Agreement

The agreement includes the Senate provision.

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

Sec. 701. Stabilizing the State Children's Health Insurance Program Allotment Formula

Current Law

States and the District of Columbia are allotted funds for SCHIP using a distribution formula based on the product of the "number of children" and a "state cost factor." For FY1998 through FY2000, the number of children is equal to the 3-year average of uninsured children in families with income below 200% FPL, using the three most recent March supplements of the Current Population Survey. For subsequent fiscal years, the number of children is a combination of low-income uninsured children and low-income children (75/25 percent split for FY2001 and a 50/50 percent split for FY2002 and thereafter). The state cost factor for a fiscal year equals the sum of .85 multiplied by the ratio of the annual average wages per employee to the national average wages per employee and .15. The measure for the annual average wages per employee is based on the 3 most recent years for employees in the health services industry. SCHIP allotments are subject to a floor of $2 million.

H.R. 3075, as Passed

Accelerates the phase-in of the use of low-income children in calculating the "number of children" in the allotment distribution formula. Changes the data set to be used to estimate the number of children for a fiscal year from the three most recent March supplements of the CPS to the three most recent supplements available before the calendar year in which the fiscal year begins. Specifies new methods for determining floors and ceilings on allotments for the states and the District of Columbia for FY2000 and beyond. The floor remains $2 million, stated as a proportion of the total amount available for allotments for a fiscal year. For each fiscal year, the floor will not be less than 90% of a state's allotment proportion for the preceding year. The cumulative floor is set at 70% of the proportion for FY1999. The cumulative ceiling is capped at 145% of a state's allotment proportion for FY1999. If these methods create a deficit in a given year, there will be a ceiling on the maximum increase permitted in that year to ensure budget neutrality; if these methods create a surplus in a given year, there will be a pro-rata increase for all states below the ceiling. These new methods do not apply to unspent allotments that are redistributed to states as specified in Section 2104(f) of Title XXI.

S.1788, as Reported

Same as House provision.

Agreement

The agreement follows the House bill and the Senate bill.

Sec. 702. Increased Allotments for Territories Under the State Children's Health Insurance Program

Current Law

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

H.R. 3075, as Passed

Requires additional allotments for the commonwealths and territories of $34.2 million for each of fiscal years 2000 and 2001, $25.2 million for each of fiscal years 2002 through 2004, $32.4 million for each of fiscal years 2005 and 2006, and $40 million for fiscal year 2007.

S.1788, as Reported

Same as House provision.

Agreement

The agreement follows the House bill and the Senate bill.

Sec. 703. Improved Data Collection and Evaluations of the State Children's Health Insurance Program

a. Funding for Reliable Annual State-by-State Estimates on the Number of Children Who Do Not Have Health Insurance Coverage

Current Law

No provision.

H.R. 3075, as Passed

No provision

S.1788, as Reported

Requires that the Secretary of Commerce make appropriate adjustments to the annual CPS to produce statistically reliable annual State-level data on the number of low-income children

without health insurance. Data should be stratified by family income, age, and race or ethnicity. Appropriate adjustments to the CPS may include expanding sample size and/or sampling units within States, and appropriate verification methods. Requires that $10 million be appropriated for FY-2000 and for each year thereafter. These changes to the CPS will improve critical data for evaluation purposes. They will also affect State-specific counts of number of low-income children and the number of such children who have no health insurance coverage that feed into the formula in existing law that determines annual State-specific allotments from federal SCHIP appropriations.

Agreement

The agreement includes the Senate provision.

b. Funding for Children's Health Care Access and Utilization State-by-State Data

Current Law

No provision.

H.R. 3075, as Passed

No provision.

S.1788, as Reported

Requires the Secretary of HHS, acting through the National Center for Health Statistics (NCHS), to collect data on children's health insurance through the State and Local Area Integrated Telephone Survey (SLAITS) for the 50 States and the District of Columbia. The data collected must provide reliable, annual State-by-State information on health care access and utilization by low-income children. Data must also allow for stratification by family income, age, and race or ethnicity. The Secretary must obtain input from appropriate sources, including States, in designing the survey and its content. Requires that $9 million be appropriated for FY-2000 and for each year thereafter. At State request, the Secretary may also collect additional SLAITS data to assist with individual State SCHIP evaluations, for which the States must reimburse NCHS for such services.

Agreement

The Senate provision is not included.

c. Federal Evaluation of State Children's Health Insurance Programs

Current Law

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

appropriate.

H.R. 3075, as Passed

No provision.

S.1788, as Reported

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

Agreement

The agreement includes the Senate provision.

d. Inspector General Audit and GAO Report on Enrollees Eligible for Medicaid

Current Law

No provision.

H.R. 3075, as Passed

No provision.

S.1788, as Reported

Requires that the Inspector General of HHS conduct an audit to determine how many Medicaid-eligible children are incorrectly enrolled in SCHIP among a sample of States that provide child health assistance through separate programs only (not via a Medicaid expansion). This audit will also assess progress in reducing the number of uninsured children relative to the goals stated in approved SCHIP plans. The first such audit will be conducted in FY2000, and will be repeated every third fiscal year thereafter. Requires the GAO to monitor these audits and report their results to Congress within six months of audit completion (i.e., by March 1 of the

fiscal year following each audit).

Agreement

The agreement includes the Senate provision.

e. Coordination of Data Collection with Data Requirements Under the Maternal and Child Health Services Block Grant

Current Law

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

H.R. 3075, as Passed

No provision.

S.1788, as Reported

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

Agreement

The agreement includes the Senate provision.

f. Coordination of Data Surveys and Reports

Current Law

No provision.

H.R. 3075, as Passed

No provision.

S.1788, as Reported

Requires that the Secretary of HHS establish a clearinghouse for the consolidation and coordination of all federal data bases and reports regarding children's health.

Agreement

The agreement includes the Senate provision.

Sec. 704. References to SCHIP and State Children's Health Insurance Program

Current Law

No provision.

H.R. 3075, as Passed

No provision.

S.1788, as Reported

No provision.

Agreement

Requires that the Secretary of Health and Human Services use the term State children's health insurance program and SCHIP instead of children's health insurance program and CHIP.

Sec. 705. State Children's Health Insurance Program Technical Corrections

Current Law

No provision.

H.R. 3075, as Passed

No provision.

S.1788, as Reported

Makes technical corrections to selected sections of Title XXI.

Agreement

The agreement includes the Senate provision.