



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

THE DIRECTOR

November 5, 1999

The Honorable Richard A. Gephardt
Democratic Leader
United States House of Representatives
Washington, D.C. 20515

Dear Mr. Leader:

This letter responds to your request on our views of the Balanced Budget Act adjustment bills that are currently being considered in Congress. As you know, the President is committed to moderating policies in the Balanced Budget Act of 1997 that are flawed or have unintended consequences for Medicare beneficiaries and providers. The Administration has taken numerous administrative actions to this end and believes that the Congress should not conclude its first session until necessary legislative changes are made.

Most of the Administration's specific policy suggestions and concerns with the House and Senate bills have been discussed at the staff level, and we will continue that collaboration. I want to take this opportunity to restate our commitment to broader Medicare reform and concern about the potential effect of the adjustment bills on the budget and Medicare trust fund.

The problems caused by the 1997 Balanced Budget Act that we have mutually identified are serious and require immediate action. However, even greater challenges are presented by the demographic and health changes of the 21st century. The doubling of the Medicare population in the next 30 years and advances in medicine will strain Medicare's ability to provide basic health services to seniors and people with disabilities. This is why the President developed a plan to strengthen and modernize Medicare, including adding a long-overdue, voluntary prescription drug benefit. This plan remains one of the Administration's top priorities and we hope to work with you to ensure its passage in 2000.

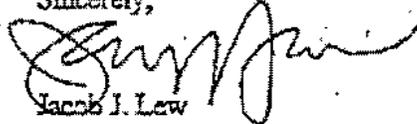
In the absence of broader reforms, the Administration continues to believe that legislation to correct problems with the Balanced Budget Act policies should be paid for and not undermine the solvency of the Medicare trust fund. The President's Medicare reform plan included a set of proposals to modernize traditional Medicare and reduce costs which would help in this regard. Other offsets, which could include appropriate tax offsets, could also be used. Regardless of the approach, I strongly encourage you to protect the progress we have made in extending the life of the Medicare trust fund and not reverse the gains which we have worked so hard together to achieve.

There are several provisions of the bills that we have identified in staff discussions that could be modified or eliminated. I want to reiterate our concern about a further slow-down of the implementation of the managed care risk adjustment system. The BBA required that payments to managed care plans be risk adjusted. To ease the transition to this system, we proposed a 5-year, gradual phase-in of the risk adjustment system. This phase-in forgoes approximately \$4.5 billion in payment reductions that would have occurred if risk adjustment were fully implemented immediately. The Medicare Payment Advisory Commission and other experts support our planned phase-in. These experts also believe that Medicare continues to overpay managed care plan. In light of this, we think that increased payments to managed care plans through this mandated slow-down of risk adjustment are unwarranted at this time.

The Administration would also support the inclusion of language to clarify the intent of Congress for determining aggregate payments to hospitals under OPD PPS. A technical drafting error in the BBA language authorizing the PPS system has produced some confusion over the aggregate payment formula for this system. The enactment of clarifying language on the subject would be most useful in eliminating the confusion caused by this drafting error.

BBA was an historic and major, bipartisan achievement. Because of its magnitude, it is not surprising that there are a number of modifications that we mutually agree are necessary to address its unintended and negative consequences. The Administration looks forward to working with you on these modifications to ensure that Medicare continues to provide high-quality, accessible health care.

Sincerely,



Jacob J. Lew
Director

**SUMMARY OF THE
BALANCE BUDGET REFINEMENT ACT OF 1999**

TITLE I - PROVISIONS RELATING TO PART A

Subtitle A - Adjustments to PPS Payments for Skilled Nursing Facilities

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

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

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

Allows for SNFs to elect to bypass the transition to the PPS and instead to be paid at the full federal rate beginning with their next cost reporting period. Facilities can elect to be paid the full federal rate as of December 15, 1999, but the election is not effective for cost reporting periods beginning before January 1, 2000.

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

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

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

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

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

This provision allows SNFs that specialize in the treatment of AIDS patients, to be paid a 50-50 blend of their facility-specific and federal rates starting with the first cost reporting period beginning after enactment and ending on September 30, 2001. It also requires a Secretarial Report to Congress by March 1, 2001 on the resource use of AIDS patients to determine whether adjustments in the SNF PPS payment categories (RUGs) are needed to account for the special needs of AIDS patients.

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

Requires MedPAC to study SNFs in Alaska and Hawaii to determine the need for a cost-of-living adjustment to the PPS rates to account for unique circumstances in those two states. The study is to be

submitted no later than 18 months after enactment.

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

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

Subtitle B - PPS Hospitals

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

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

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

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

Subtitle C - PPS-exempt Hospitals

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

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

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

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

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

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

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

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

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

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

Subtitle D - Hospice Care

Temporary Increase in Payment for Hospice Care (Section 131)

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

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

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

Subtitle E - Other Provisions

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

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

Subtitle F - Transitional Provisions

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

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

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

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

Wage Index Correction (Section 153)

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

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

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

Special Rule for Certain Skilled Nursing Facilities (Section 155)

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

TITLE II - PROVISIONS RELATING TO PART B

Subtitle A - Hospital Outpatient Services

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

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

Transitional Pass-Through Payments - The provision also creates "transitional pass-through payments" for specific items in the outpatient setting. This means Medicare can, temporarily, pay above and beyond the prospective payment rate for orphan drugs, cancer therapy drugs, biologic agents, brachytherapy, radiopharmaceuticals, and new medical devices, drugs and biologic agents. New medical devices, drugs, and biologic agents shall receive a pass-through payment only if the cost is not insignificant in relation to the OPD fee schedule amount. For drugs and biologic agents, the pass-through payment will equal the difference between the otherwise applicable portion of the OPD PPS payment related to the drug or agent and 95 percent of the average wholesale price. For devices, the pass-through payment will equal the difference between that portion of the OPD PPS payment related to the device and the hospital's cost for the device (determined based on adjusting charges). Pass-through payments are limited to a period of two to three years. Total additional payments cannot exceed 2.5 percent of total program payments for outpatient hospital services for each year before 2004 and no more than 2 percent in subsequent years. If the Secretary estimates, before the beginning of the year, that total pass-through payments for the year will exceed those caps, the Secretary shall reduce pro rata the amount of each pass-through payment to ensure the limit is not exceeded.

Budget Neutrality - These outlier and pass-through payments must be made in a budget neutral manner so that they generate no increase or decrease in total payment for outpatient hospital services.

No Impact on Copayments - The outlier and pass-through payments shall have no effect on beneficiary copayment amounts.

Limitation on Judicial Review for New Adjustments - The following components of the outlier adjustments shall not be subject to administrative or judicial review: the threshold for determining whether a service shall receive an outlier payment; the marginal cost of care beyond the threshold; and the percentage used to limit aggregate outlier adjustments. The following components of the transitional

pass-through payments shall not be subject to administrative or judicial review: the determination of insignificance of cost for new devices, drugs, and biologic agents; the duration of additional payments; the portion of the OPD fee schedule amount associated with particular devices, drugs, or biologicals; and the application of any pro rata reduction to ensure that the aggregate limit is not exceeded.

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

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

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

Allows the HHS Secretary to base payment weights for the OPD PPS on mean hospital costs.

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

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

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

Requires the Secretary to review components of the OPD PPS not less often than annually.

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

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

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

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

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

Requires the Secretary to study the extent to which intravenous immune globulin (IVIG) could be delivered and reimbursed by Medicare outside of a hospital or physician's office.

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

Transitional Corridors - Establishes transitional corridors until January 1, 2004 for the OPD PPS to

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

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

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

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

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

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

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

- between 90 percent and 100 percent of the pre-BBA amount, 60 percent of that loss will be made up by additional Medicare payments.
- less than 90 percent of the pre-BBA amount, the hospital will receive additional payments equal to 6 percent of the pre-BBA amount.

Temporary Treatment for Small Rural Hospitals - If a hospital with not more than 100 beds is located in a rural area, Medicare payments shall be increased to that hospital to ensure that their PPS amount is no lower than their pre-BBA amount for each year before 2004.

Permanent Treatment for Cancer Hospitals - In the case of cancer hospitals, Medicare payments shall be increased to ensure that their PPS amount in each year is no lower than their pre-BBA amount.

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

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

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

Subtitle B - Physician Services

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

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

Subtitle B - Physician Services

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revise the SGR for the current year and two preceding years. The SGR for the third preceding year would be final.

Requires a Federal Register notice by November 1 of each year, beginning with 2000, publishing the update, conversion factor, and allowed expenditures that will apply for the next year. It requires, by March 1 of each year beginning with 2000, that an estimate of the next year's sustainable growth rate and of the conversion factor and the data used in making the estimate be made available to the Medicare Payment Advisory Commission (MedPAC) and the public. It requires MedPAC to include in their June 1st annual report to Congress a review of the estimate of the conversion factor for the next year.

Requires the Agency for Health Care Policy & Research to study: (1) ways to accurately estimate the impact on Medicare physician expenditures from: (a) improvements in medical capabilities; (b) advances in technology; (c) Medicare demographic changes; and (d) changes in geographical locations where beneficiaries receive services; (2) the rate of use of physician services in the original Medicare fee-for-service program among beneficiaries between ages 65 and 74, 75 and 84, 85 and over, and disabled beneficiaries under age 65; and (3) other factors that may reliably predict Medicare fee-for-service use of physician services. The Secretary must report to Congress within 3 years of enactment. MedPAC must report to Congress, within 6 months of the Secretary's report to Congress, including an analysis and evaluation of the Secretary's report and recommendations.

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

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

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

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

Subtitle C - Other Services

Revision of Provisions Relating To Therapy Services (Section 221)

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

Focused Medical Reviews of Claims - Requires the Secretary, during the 2-year suspension, to conduct focused medical reviews of therapy claims, with an emphasis on claims for services in skilled nursing facilities.

Revision of BBA Report - Requires the Secretary to submit a report, by January 1, 2001, including recommendations on: (a) the establishment of a mechanism for assuring appropriate utilization of outpatient therapy services; and (b) the establishment of an alternative payment policy for such services based on classification of individuals by diagnostic category, functional status, prior use of services, and other criteria determined appropriate by the Secretary. The report shall recommend how such a policy can be implemented in a budget-neutral manner.

Study and Report on Utilization - Requires the Secretary to conduct a study, by June 30, 2001, which compares utilization patterns of therapy services provided on or after January 1, 2000 with utilization patterns for services provided in 1998 and 1999. The Secretary is required to review a statistically significant number of claims. The report must include recommendations for legislation that the Secretary determines to be appropriate.

Referrals by Optometrists - Allows optometrists to refer patients for therapy services as well as establish and review the plan of care.

Update In Renal Dialysis Composite Rate (Section 222)

Increases all composite rate payments in the year 2000 by 1.2 percent above 1999 payment rates. Increases year 2001 composite rate payments by 1.2 percent above 2000 rates. Sunsets OBRA 1986 language (as amended by OBRA 1989 and 1990) which sets current composite rate. OBRA 1986 composite rate setting language is no longer effective as of January 1, 2000. Requires MedPAC to study the difference in payment for home and facility hemodialysis and make recommendations regarding potential changes. Due 18 months after enactment.

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

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

Increased Reimbursement for Pap Smears (Section 224)

Requires the Secretary to establish a national minimum payment amount for all diagnostic and screening Pap smear technologies approved by the Food and Drug Administration (FDA) as a primary screening method for detection of cervical cancer. The minimum payment amount shall be \$14.60 for tests furnished in 2000, and in subsequent years, the amount would be updated along with the rest of the clinical laboratory fee schedule. Expresses the sense of Congress that HCFA has been slow in providing incentives for use of new cervical cancer screening technologies, and should institute an appropriate payment increase for such technologies that have been approved by the FDA and that are significantly more effective than conventional Pap smears.

Refinement of Ambulance Services Demonstration Project (Section 225)

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

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

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

Extension of Medicare Benefits for Immunosuppressive Drugs (Section 227)

Increases the number of months of coverage of immunosuppressive drug therapy for post-transplant beneficiaries by 8 months, from 36 to 44 months, for the year 2000, for individuals who exhaust their 36 months of coverage during that year.

For individuals who exhaust the 36-month period for immunosuppressive drugs in calendar year 2001, the statute provides for 8 months (or more) of additional coverage. The Secretary must specify what any increase in the number of additional months of benefits beyond 8 months will be by May 1, 2001.

For beneficiaries who exhaust the 36-month period in 2002, 2003 and 2004, the number of additional months of benefits may be more or less than 8 months. The Secretary must specify what the number of additional months of benefits will be for each of these years by May 1 of the preceding year.

The Secretary must compute the number of additional months of coverage for 2001 through 2004 (if any) using appropriate actuarial methods and make such computation so that, based on the best available data at the time the computation is made, the total expenditures for the additional months for FY 2000 through FY 2004 do not exceed \$150 million. The Secretary is directed to seek to provide for a level number of months of extension for FY 2001 through FY 2004. The Secretary is required to make an annual adjustment in the number of months of extension applicable to 2001 through 2004, to the extent necessary, based on differences between actual and estimated expenditures consistent with the \$150 million five-year figure.

For the year 2000, for Medicare+Choice plans, the Secretary is required to treat the additional months of coverage in the same manner that a national coverage determination is treated.

The Secretary must issue a report to Congress by March 1, 2003 including an analysis of the impact of the extension provision, and recommendations regarding an appropriate cost-effective method of providing coverage of immunosuppressive drugs under Medicare on a permanent basis.

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

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

Studies and Reports (Section 229)

Requires the following studies:

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

TITLE III - PROVISIONS RELATING TO PART A AND B

Subtitle A - Home Health Services

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

All home health agencies will be paid \$10 per Medicare beneficiary served during each agency's cost reporting period beginning in FY 2000 to help cover the cost of complying with the OASIS requirements. They will be paid about half of this amount by April 1, 2000 and the rest upon settlement of each agency's cost report.

GAO will conduct a study of the costs incurred in complying with OASIS, and analyze the impact on patient privacy. The report must be submitted to Congress within 180 days from the date of enactment, and the HHS Secretary must comment on the report. The GAO will, no later than 180 days following receipt of this report, submit audit findings on the cost incurred by agencies in collection of OASIS data.

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

This provision delays the 15 percent payment reduction until one year after implementation of the home health prospective payment system (PPS). The provision also eliminates the requirement for a 15 percent reduction if the PPS does not occur. Six months following implementation of the PPS, the HHS Secretary is required to submit a report to Congress analyzing the need for the 15 percent reduction, or for any reduction in base payment amounts for home health services under the PPS.

Increase in the Per Beneficiary Limits (Section 303)

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

Clarification of Surety Bond Requirements (Section 304)

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

Refinement of Home Health Agency Consolidated Billing (Section 305)

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

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

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

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

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

Subtitle B - Direct Graduate Medical Education

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

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

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

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

BBA Technical Corrections (Section 321)

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

TITLE IV--RURAL PROVIDER PROVISIONS

Subtitle A - Rural Hospitals

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

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

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

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

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

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

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

Extends the enhanced payment system for Medicare dependent hospitals for another five years.

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

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

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

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

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

This provision: (1) expands the number of residents Medicare will pay for in rural hospitals by 30 percent; (2) allows non-rural facilities that operate separately accredited rural training programs in rural areas, or that operate accredited training programs with integrated rural tracks, to also increase their resident limits, as determined by the Secretary; (3) allows hospitals to increase their residency caps by

up to three if a primary care resident was on approved leave during the 1996 cost reporting period used to determine the cap; and (4) allows a resident who was at a Veterans' hospital and then transferred to a non-Veterans' hospital between January 1, 1997 and July 31, 1998, to be included in the residency cap at the non-Veteran's hospital.

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

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

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

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

GAO Study on Geographic Reclassification (Section 410)

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

Subtitle B - Other Rural Provisions

MedPAC Study of Rural Providers (Section 411)

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

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

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

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

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

TITLE V - MEDICARE+CHOICE & OTHER MANAGED CARE

Subtitle A - Provisions to Accommodate and Protect Medicare Beneficiaries

Changes in Medicare+Choice Enrollment Rules (Section 501)

Gives beneficiaries the option of access to an alternative Medicare+Choice plan and Medigap, either within 63 days of receiving notice from their plan that the plan is leaving the program, or within 63 days of when their coverage is terminated. Beneficiaries exercising the first option must disenroll from the Medicare+Choice plan before their coverage is terminated. Institutionalized persons would be permitted to enroll in a Medicare+Choice plan or change from one plan to another at any time that a plan is accepting new enrollees. Permits a Medicare+Choice plan that is reducing its service area to offer its enrollees, in all or part of the affected area, the option of staying in the plan so long as the enrollees agree to obtain all basic services (except for urgent or emergency services) exclusively through the plan's providers located in the plan's reduced service area. This is permitted only if no other Medicare+Choice plan is available at the time the plan elects to provide this option to its enrollees.

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

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

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

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

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

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

Changes the phase-in schedule for risk adjustment of Medicare+Choice payments. Provides that payments shall be based on 10% of the new risk adjustment methodology in 2000 and 2001 and no more than 20% in 2002. Requires MedPAC to study and make recommendations to Congress by December 1, 2000 on several aspects of the risk adjustment methodology. Requires the Secretary of HHS to study and report to Congress by January 1, 2001 on reducing cost and burden on managed care organizations in complying with the reporting requirements on encounter data for implementation of risk adjustment.

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

This provision increases Medicare+Choice payments in areas where enrollment in a Medicare managed care plan has not been offered since 1997 or for which all Medicare+Choice organizations serving the area filed notice by October 13, 1999 that they would no longer provide service in the area as of January 1, 2000. Payments are increased by an additional 5% for the first 12 months the plan is offered and by an additional 3% for the second 12 months the plan is offered. The bonus only applies to plans

which are first offered during the 2-year period beginning January 1, 2000, and to the first plan approved in any given area unless more than one plan is approved on the same date. These payment increases are temporary.

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

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

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

Requires the Secretary to annually publish, beginning with 2001 and at the time Medicare+Choice rates are published, the following county-specific fee-for-service information for the second preceding year: 1) total monthly per capita expenditures, separately for Part A and Part B; 2) total monthly per capital expenditures, reduced by the estimate of expenditures not related to payment of claims (e.g., graduate medical education); 3) average risk factors based on diagnoses for inpatient services; and 4) average risk factors based on diagnoses for inpatient and other sites of service.

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

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

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

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

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

Changes the reduction in the update for 2002 to 0.3 percentage points from 0.5 points.

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

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

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

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

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

Requires preferred provider organizations to meet the same quality requirements as private

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

Effective Date:

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

Hospitals may specify, or limit, the information provided to those facilities that contract with the enrollees' Medicare+Choice plan.

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

Medicare+Choice user fees for education are available without further appropriation and will be based on the percentage of Medicare+Choice enrollees compared to all Medicare beneficiaries.

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

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

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

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

Subtitle C - Demonstration Projects and Special Medicare Populations

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

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

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

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

Medicare+Choice Competitive Bidding Demonstration Project (Section 533)

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

Extension of Medicare Municipal Health Services Demonstration Project (MHSP) (Section 534)
Extends the MHSP demonstration project by two years, until December 31, 2002.

Medicare Coordinated Care Demonstration Projects (Section 535)

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

Medigap Protections for PACE Program Enrollees (Section 536)

Extends Medigap protections to PACE program enrollees.

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

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

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

Subtitle E - Studies and Reports

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

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

Medicare Payment Advisory Commission Studies and Reports (Section 552)

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

GAO Studies, Audits, and Reports (Section 553)

Requires GAO to study and report on the following issues related to Medigap Insurance: 1) the level of coverage provided by each type of policy; 2) current enrollment levels in each type of policy; 3) availability of each type of policy to beneficiaries over age 65 ½; 4) the number and type of policies offered in each state; and 5) the average out-of-pocket costs per beneficiary under each type of policy. Beginning in 2000, requires GAO to conduct an annual audit of the Medicare+Choice beneficiary education program and to report on the results of the audit, along with an evaluation of the effectiveness of the education program.

TITLE VI—MEDICAID

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

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

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

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

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

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

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

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

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

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

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

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

Making the Medicaid DSH Transition Rule Permanent (Section 607)

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

Medicaid Technical Corrections (Section 608)

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

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

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

Stabilizes the formula for determining how much federal funding each State may receive for SCHIP and creates floors and ceilings that must be implemented in a budget neutral manner. Changes the Current Population Survey (CPS) data and the Census data used to count the number of low-income and low-income uninsured children from the three most recent fiscal years to the three most recent calendar years.

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

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

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

Gives \$10 million to the Department of Commerce to increase the sample size of the Current Population Survey (CPS) so that reliable estimates of the number of uninsured children by income, age and race can be determined on a State-by-State basis. Gives \$10 million to the HHS Secretary for a federal evaluation of the SCHIP program using a sample of 10 States. Directs the Inspector General to audit, and the GAO to report to Congress, every three years on State compliance with the requirement that SCHIP applicants that are found to be eligible for Medicaid be enrolled in Medicaid. Requires that all data relating to children in SCHIP and Medicaid be coordinated with the data requirements in the Maternal and Child Health block grant. Directs the Secretary, through the Assistant Secretary for Planning and Evaluation, to establish a data clearinghouse on Federal health programs and children's health.

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

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

SCHIP Technical Corrections (Section 705)

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

BALANCED BUDGET REFINEMENT ACT OF 1999: HIGHLIGHTS

November 18, 1999

The Medicare, Medicaid and SCHIP Balanced Budget Refinement Act (BBRA) of 1999 addresses flawed policy and excessive payment reductions resulting from the Balanced Budget Act (BBA) of 1997. The President, Vice President and Secretary Shalala are pleased that Medicare beneficiaries' access to high-quality health care is improved through this bipartisan legislation. All parties to the agreement, in particular, Mr. Archer, Mr. Rangel, Mr. Thomas, Mr. Stark, Mr. Bliley, Mr. Dingell, Mr. Bilirakis, Mr. Brown, Senator Roth, and Senator Moynihan, played critical roles in achieving this outcome.

This BBRA addresses many of the problems raised by the Administration and Congress, by, for example, placing a moratorium on the therapy caps that have proven harmful to beneficiaries; increasing payments for very sick patients in nursing homes this year; restoring funding to teaching hospitals; and easing the transition to the new prospective payment system for hospital outpatients, among others. Unfortunately, it includes provisions that are not justifiable, such as a \$4.8 billion payment increase to managed care plans that are already overpaid according to most experts. This is troubling because any excess payments from the Medicare trust fund put the program at greater risk. This legislative package costs about \$1.2 billion in 2000 and \$16 billion over 5 years.¹ The major provisions (not all provisions) are described below, along with their 5-year costs.

HOSPITALS (\$6.8 billion)

- **Modifies outpatient department policies.** The BBA created a new prospective payment system (PPS) for hospital outpatient care that pays set amounts for services that are similar clinically and in their use of resources. This bill adjusts the PPS. It:
 - **Smooths the transition to the PPS.** During the first 3 and a half years of the PPS, this bill creates payment floors to minimize the disruption of the new system. Small rural hospitals would be held harmless for 4 years while cancer hospitals are permanently held harmless from the PPS. In addition, there will be a budget-neutral 3-year pass-through for certain drugs, devices and biologicals and outlier policy for high-cost cases. The bill also extends the current hospital outpatient capital policy through the implementation of PPS.
 - **Clarification of budget-neutral implementation of PPS.** This bill clarifies Congress's intent that the new system is not supposed to impose an additional reduction of 5.7 percent on top of the removal of formula-driven overpayment. (Note: OMB would not score this clarification)
- **Increases Indirect Medical Education Payments.** Under the BBA, teaching hospitals' indirect medical education (IME) payment add-on was reduced to 6.0 percent in 2000, and 5.5 percent in 2001 and subsequent years. This proposal would raise the add-on to 6.5 percent in FY 2000, 6.25 percent in 2001, and 5.5 percent in 2002 and thereafter. This provides critical assistance to teaching hospitals adjusting to the changes in the health care system.

¹ All estimates from CBO preliminary score, 11/18/99. The total cost also includes changes in premium revenue.

- **Takes Steps Towards Reforming Direct Medical Education.** This bill begins to reduce the geographic disparity in payments for direct medical education. It raises the minimum payment for hospitals to 70 percent of the national, geographically adjusted average payment and limits growth in payments for hospitals with costs above 140 percent of the geographically adjusted average payment. For these hospitals, payments per resident will be frozen for FY 2001 and 2002 and increased at a rate of inflation (consumer price index) minus 2 percentage points for FY 2003 through 2005.
- **Increases disproportionate share hospital (DSH) payments.** The BBA reduced DSH payments by 3 percent in 2000, 4 percent in 2001, and 5 percent in 2002. This proposal increases the payment rates set in the BBA. Under this bill, DSH would be reduced by 3 percent in 2001 and 4 percent in 2002. This restoration helps these hospitals care for the uninsured.
- **Increases payments for PPS-exempt hospitals.** The BBA authorized the creation of a PPS system for inpatient rehabilitation hospitals. This bill makes adjustments to this PPS and requires the development of PPS systems for long-term care and psychiatric hospitals. It also includes a wage adjustment of the percentile cap for existing PPS-exempt hospitals and enhanced payments for long-term care and psychiatric hospitals.
- **Improves rural hospital programs.** This bill modifies and improves a series of Medicare policies that support rural health care providers. They complement the special protection for rural hospitals in the outpatient PPS system.
 - Allows certain hospitals to reclassify to rural for purposes of designation as a Critical Access Hospital (CAH), Sole Community Hospital or Rural Referral Center. Updates certain standards applied for geographic reclassification.
 - Extends Medicare dependent hospital (MDH) program for five years; improves the CAH program.
 - Provides exceptions to residency caps for rural graduate medical education.
 - Rebases the targets for Sole Community Hospitals and provides for the full market basket increase in 2001.
- **Administrative actions.** This complements the Administration's actions to delay the expansion of the hospital transfer policy; stop recouping of DSH payments based on unclear guidance; delay implementation of the volume control system and refine the ambulatory payment classification system under the outpatient PPS; change to the wage threshold to allow rural hospitals to reclassify for payment purposes; and others.

SKILLED NURSING FACILITIES & THERAPY SERVICES (\$2.7 billion)

- **Provides immediate increases in payment for high-cost cases.** The BBA created a new prospective payment system (PPS) for skilled nursing facilities that was implemented on July 1, 1998. Under this system, payments are based on service needs of patients adjusted for area wages. Effective April through October 1, 2000, 20 percent will be added to 12 resource utilization groups (RUGs) for medically complex cases and 3 rehabilitation RUGs. The bill also creates special payments to facilities that treat a high proportion of AIDS patients for 2000-2001 and excludes certain services (certain ambulance services, prostheses, chemotherapy) from consolidated billing and the PPS system.
- **Increases payment rates.** This bill increases payments across-the-board by 4 percent for 2001 and 2002. It also gives nursing homes the option to elect to be paid at the full Federal rate for SNF PPS.
- **Imposes two-year moratorium on payment caps.** The BBA limited yearly payments for physical / speech therapy and occupational therapy to \$1,500 each per beneficiary. This limit is too low, causing a large number of therapy users to have payments exceed the caps and have to pay for services out-of-pocket. This bill puts a two-year moratorium on the caps, steps up medical review to prevent fraud, and revises a BBA-mandated study to develop an alternative, more rational system for therapy services payment.
- **Administrative actions.** Apart from this bill, the Administration will increase payment for high acuity patients and exclude certain types of services furnished in hospital outpatient departments from SNF PPS.

HOME HEALTH (\$1.3 billion)

- **Delays 15 percent to one year after the implementation of the home health prospective payment system (PPS).** In addition to creating a new PPS for home health, the BBA also required a 15 percent reduction in payment limits. This bill delays implementation of the 15 percent reduction until after the first year of implementation of PPS.
- **Provides immediate adjustments.** The bill raises the per beneficiary limit by 2 percent for agencies subject to the per beneficiary limit with limits below the national average in 2000; pays \$10 per beneficiary in 2000 to agencies to help cover the cost associated with OASIS data collection and reporting requirements; eases and clarifies the surety bond provision; and excludes durable medical equipment from home health consolidated billing.

- **Administrative actions.** This bill complements the Administration's actions to delay tracking and pro-rating payments; provide for extended interim payment system repayment schedules; postpone and change surety bond requirements; among others.

BENEFICIARY IMPROVEMENTS (\$0.3 billion)

- **Limits beneficiary hospital outpatient coinsurance.** The BBA included a provision to reduce the Medicare beneficiary coinsurance for hospital outpatient department services from its current approximately 50 percent of costs to 20 percent over a number of years. This policy would provide an additional protection by limiting the amount of coinsurance that a beneficiary pays for outpatient care to the Part A deductible (\$776 in 2000).
- **Increases coverage of immunosuppressive drugs.** Currently, Medicare pays for the prescription drugs that help prevent rejection of transplants for 36 months. This proposal would, for the next 5 years, extend coverage of these drugs for another 8 months for beneficiaries whose coverage would otherwise expire.

MANAGED CARE (\$4.8 billion)

- **Alters the plan for risk adjustment for managed care plans.** The BBA requires that payments to managed care plans be risk adjusted, to prevent adverse selection and to encourage plans to enroll sicker beneficiaries. Rather than implement this immediately, the Administration developed a 5-year phase-in plan which is supported by virtually all independent experts. This proposal alters the phase-in by reducing the amount of risk adjustment scheduled for 2001 and 2002.
- **Increases rates.** Although the General Accounting Office and other independent experts believe that managed care plans continue to be overpaid – even after the BBA – this proposal raises the annual rate increase for 2002 from the fee-for-service growth rate minus 0.5 to the fee-for-service growth rate minus 0.3. It also provides an entry bonus for plans entering counties not previously served and for plans that had previously announced that they were withdrawing from counties.
- **Changes provider participation rules and quality standards.** The bill includes a number of provisions to accommodate health plans, including: giving plans more time to submit adjusted community rates; providing greater flexibility in benefits and reducing the user fees paid for the Medicare education campaign; reducing quality standards for preferred provider organizations; and expanding deeming provisions.
- **Changes demonstrations.** This bill delays the competitive pricing demonstration project and extends the social health maintenance organization demonstration and several others.

- **Interaction with fee-for-service policies.** Medicare+Choice rates are linked to growth in fee-for-service spending. Since the policies in the bill increase fee-for-service spending, they increase managed care payments.
- **Administrative actions.** The Administration has and will continue to take administrative actions to improve beneficiary protections and access to information, ease provider participation rules and extend the frail elderly demonstration.

OTHER PROVIDERS (\$0.8 billion)

- **Fixes the fluctuation in physician payments (sustainable growth rate).** This change stabilizes physician payments and is budget-neutral over 5 years.
- **Increases payments for Pap smears.** Sets the minimum payment rate at \$14.60 beginning in 2000.
- **Increases payments for renal dialysis.** Medicare's payments for dialysis have not increased since 1991. Consistent with a recommendation from the Medicare Payment Advisory Commission, this bill increases the composite payment rate by 1.2 percent in 2000 and another 1.2 percent in 2001.
- **Increases updates for hospice, durable medical equipment, and oxygen.** Payment rate increases to hospices would be temporarily increased by 0.5 for 2001 and 0.75 for 2002 and DME and oxygen suppliers by 0.3 for 2001 and 0.6 for 2002.
- **Delays authority to adopt competitive purchasing practice.** The bill delays the Secretary's inherent reasonableness authority until a GAO report is issued and she issues a final rule.
- **Provides hospital / area-specific adjustments.** The bill includes several changes to local demonstration, hospital designations, etc.

MEDICAID & CHILDREN'S HEALTH INSURANCE PROGRAM (\$0.8 billion)

- **Extends the phase-out of cost-based reimbursement for community health centers.** The BBA phased out the Medicaid requirement to pay federally-qualified health centers and rural health clinics based on cost. The 2000 phase-out – where payments are based on 95 percent of costs – would be extended for 2001 and 2002 under this bill. In 2003, payments are based on 90 percent and in 2004 on 85 percent of costs. A study would determine how these clinics should be paid in subsequent years.

- **Extends the availability of the \$500 million fund for children's health outreach.** The welfare reform law put aside a \$500 million fund for states to use for the costs of simplifying their eligibility systems and conducting outreach. To date, only about 10 percent of this fund has been spent, and for nearly 30 states, the funding sunsets this year. This bill eliminates the sunset and extends the availability of this fund until it is expended.
- **Changes Medicaid disproportionate share hospital (DSH) payments and rules.** The BBA included a number of significant changes in the Medicaid DSH program, changing states' allotments. The base year data used to set the DSH allotments in the BBA were flawed for some states. This bill adjusts the allotments for DC, Minnesota, New Mexico and Wyoming. It also makes the DSH transition rule permanent and does not allow states to use enhanced Federal matching payments under the State Children's Health Insurance Program (SCHIP) for DSH.
- **Stabilizes SCHIP allocation formula; adjusts allotment for territories.** Under the BBA, states receive an allotment of the total Federal funding based on their proportion of low-income uninsured children. This formula would result in large, annual fluctuations in state allotments. This bill alters the formula, and puts floors and ceilings on the allotment changes to make funding for states more predictable. It also increases the available funding for territories.
- **Improves data collection and evaluation of SCHIP.** One of the centerpieces of the BBA was the creation of this new program to provide health insurance to children in families with incomes too high for Medicaid but too low to afford private insurance. However, the BBA did not provide funding for monitoring and evaluating the implementation and outcomes of SCHIP. This bill adds funding for data collection and evaluation of this program.