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MEDICARE PROVISIONS OF THE BALANCED BUDGET REFINEMENT ACT OF 1999 (P.L. 106-113)

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Updated February 22, 2001

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Summary

On August 5, 1997, the President signed into law the Balanced Budget Act of 1997 (BBA97, P.L. 105-33). This legislation sought to reduce the federal budget deficit to zero by 2002. A significant amount of the spending reductions necessary to reach that target were achieved by slowing the rate of growth in Medicare payments to health care providers, including hospitals, physicians, skilled nursing facilities, and home health care agencies. The Congressional Budget Office (CBO) estimated that the legislation would achieve $116.4 billion in Medicare savings over 5 years (FY1998-FY2002), and $393.8 billion over 10 years (FY1998-FY2007).

In the 10 years prior to BBA 97, Medicare spending grew at an average annual rate of about 10%. After implementation of BBA 97, Medicare spending slowed significantly, and in FY1999, for the first time ever, spending dropped below the prior year's level by almost 1%. In March 1999, CBO revised its budget projections and lowered Medicare spending estimates by $80 billion over 5 years (FY1998-FY2002) and by $229 billion over 10 years (FY1998-FY2007). In July 1999, CBO revised and again reduced its Medicare spending estimates. Many analysts opine that, although the original estimates of the impact of the BBA 97 may have been too low, the improved economic conditions that CBO included in its revised estimates (e.g., reduced inflation in health care costs) and heightened federal efforts to reduce fraud and abuse also affected program spending.

Nevertheless, health care industry representatives argued that the payment system changes and the restrictions on payment rate increases required by BBA 97 threatened both their ability to provide services to beneficiaries. During congressional hearings in 1999, witnesses from the Medicare Payment Advisory Commission, the General Accounting Office, and others testified that little evidence was available regarding how the Medicare provisions of BBA 97 would affect providers or beneficiary access to care, but they urged watchful caution.

In the first session of the 106th Congress, the House and Senate considered bills to mitigate the impact of BBA 97 on Medicare providers. The Senate Finance Committee reported a bipartisan bill, S. 1788; the full House passed a different bill, H.R. 3075, the Medicare Balanced Budget Act of 1999. Informal negotiations between the House and Senate resulted in agreement on the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (H.R. 3426), which was incorporated by reference into H.R. 3194, the District of Columbia appropriations bill; it passed the Congress on November 19, 1999, as part of the Consolidated Appropriations Act, 2000 (P.L. 106-113). The CBO estimated that this legislation would increase Medicare spending by $16 billion over 5 years (FY2001-FY2005) and $27 billion over 10 years (FY2001-FY2010). About three-fourths of the additional spending would go to hospitals (including outpatient departments), skilled nursing facilities, home health agencies, and Medicare+Choice organizations. This report will not be updated.

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Introduction

The Medicare program is authorized in Title XVIII of the Social Security Act. Part A of that title includes coverage for inpatient hospital care and services, care in skilled nursing facilities (SNFs), hospice care, and some home health care. Enrollment in Part A is automatic at age 65 for all workers who paid the hospital insurance payroll tax during their working years or whose spouse is covered. Part B provides for payments to physicians and other health care practitioners; services and items provided on an outpatient basis; and some home health care. Part B is voluntary and requires participating beneficiaries to pay monthly premiums. Part C authorizes the Medicare+ Choice program under which beneficiaries may elect to participate in comprehensive managed care plans such as health maintenance organizations (HMOs), although they must pay premiums at least equal to the Part B premium.

In FY1999, the Medicare program spent $211 billion to provide health insurance coverage for 39 million disabled individuals and elderly persons age 65 or over. Beneficiary premiums for Part B coverage offset about $21.5 billion of program spending. In comparison, nearly 10 years earlier, in FY1990, Medicare spending totaled about $110 billion (including $11 billion in beneficiary premiums) and covered about 33.4 million beneficiaries.

During the 10 years preceding BBA 97, annual rates of growth in Medicare spending ranged from 5% to 15.5%. Total spending net of beneficiary Part B premiums grew at an average annual rate of about 10%, with some components of the program growing at much higher rates. For example, during this time period, home health care spending grew at an average annual rate of 24%, and payments to skilled nursing facilities grew at an average annual rate of 17%.

On August 5, 1997, the President signed into law the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33). In this legislation, the Administration and the Congress agreed to reduce the federal budget deficit to zero by 2002. A significant amount of the spending reductions necessary to reach that target were achieved by slowing the rate of growth in the Medicare program. The Medicare savings, which the Congressional Budget Office (CBO) estimated originally at $116.4 billion over 5 years (FY1998-FY2002), and $393.8 billion over 10 years (FY1998-FY2007), were achieved by restricting the rate of increase in payments to hospitals, physicians, and other providers, and by establishing new prospective payment systems for skilled nursing facilities, home health agencies, and hospital outpatient departments.

BBA 97 also established the Medicare+Choice program which modified the way payments are made to health maintenance organizations (HMOs), and it broadened

private plan options available to Medicare beneficiaries. The objective of these provisions was to expand participation in Medicare by private, managed care plans.

In the 2 years following enactment of BBA 97, Medicare spending slowed significantly. In FY1998, the first year in which many of the BBA 97 provisions were effective, Medicare spending grew by only 1.5%, and, in the following year, for the first time in the program's history, Medicare spending dropped by almost 1%, to an estimated $209.3 billion for FY1999.

In March 1999, CBO revised its budget projections and lowered Medicare spending estimates by $80 billion over 5 years (FY1998-FY2002), and by $229 billion over 10 years (FY1998-FY2007). A few months later, in July 1999, CBO projected further reductions in estimated Medicare spending. No one major cause can be identified for these large and unanticipated declines in Medicare spending; most analysts agree that they are attributable to a variety of factors. Although the original estimates of the impact of some of the changes made by BBA 97 may have been too low, changes in CBO's economic assumptions also affect the estimates. For instance, lower inflation rates would reduce provider payment rate updates. In addition, heightened anti-fraud and abuse initiatives reportedly have had substantial effects.

A number of health care provider organizations say that the larger than estimated Medicare spending reductions since BBA 97 are evidence of overreaching in many of that legislation's provisions. They have expressed concern that beneficiaries, particularly the sickest who need the most costly care, will experience increasing difficulty in obtaining needed services because providers will be unwilling to serve them, will drop out of Medicare, or will go out of business. On June 10, 1999, the Senate Finance Committee conducted a hearing on Medicare spending under the BBA 97, and, on October 1, 1999, the House Ways and Means Health Subcommittee held a similar hearing. Witnesses from the Medicare Payment Advisory Commission (MedPAC), the General Accounting Office (GAO), and others testified that little conclusive evidence was available at that time regarding how the BBA 97 would affect providers and access to care in the future, but generally urged watchful caution.

In the first session of the 106th Congress both the House and Senate considered bills to mitigate the impact of BBA 97 on Medicare providers. On October 21, 1999, the Senate Finance Committee reported a bipartisan bill, the *Medicare and Medicaid Budget Correction and Refinement Act of 1999 (S. 1788)*, and on November 5, 1999, the House passed the *Medicare Balanced Budget Refinement Act of 1999 (H.R. 3075)*. The Finance Committee bill was not taken up on the Senate floor, but the chairmen and majority staff of the relevant committees (Senate Finance, House Ways and Means, and House Commerce) met informally to reconcile Senate Committee and House-passed measures. They agreed on the *Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA99)* which was introduced in the House by Representative William Thomas on November 17, 1999, as H.R. 3426. This bill was incorporated by reference into the District of Columbia appropriations bill, H.R. 3194, and it passed the Congress on November 19, 1999, as part of the *Consolidated Appropriations Act, 2000*. President Clinton signed the bill on November 29, 1999, and it became P.L. 106-113.

CBO estimated that this legislation would increase Medicare spending by $16 billion over 5 years (FY2001-FY2005) and $27 billion over 10 years (FY2001-FY2010). About three-fourths of the additional spending would go to hospitals (including outpatient departments), skilled nursing facilities, home health agencies, and Medicare+Choice organizations.

This report summarizes the Medicare provisions in the BBRA99 and describes the prior law to which the changes in BBRA99 apply.[1] In general, the prior law provisions to which the BBRA99 is compared are those that were included in BBA 97. This report also includes provisions applicable to Medicare that are included in P.L. 106-113 but that are outside of the Medicare titles of the law.

[1]For additional information on Medicare and BBA 97, see CRS report 97-802, *Medicare Provisions in the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33)*, by Jennifer O' Sullivan, Celinda Franco, Beth Fuchs, Bob Lyke, Richard Price, and Kathleen Swendiman; and CRS Report RL30300, *Medicare Beneficiary Access to Care: The Effects of New Prospective Payment Systems on Outpatient Hospital Care, Home Health Care, and Skilled Nursing Facility Care*, by Carolyn Merck.

Title I — Provisions Relating to Part A

Subtitle A — Adjustment to PPS Payments for Skilled Nursing Facilities (SNFs)

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

Prior Law. BBA 97 required that a prospective payment system (PPS) for SNFs be phased in over 3 years, starting with facility cost reporting periods beginning on or after July 1, 1998. PPS-covered costs include (a) routine services such as room, board, nursing services, and minor medical supplies; (b) ancillary costs such as therapies, drugs, and lab services; and (c) capital costs, which are land, building, and equipment. The payment is made on a daily rate or "per diem" basis. During the 3-year PPS phase-in period, payments to SNFs under the PPS have two components: a federal per diem amount and a "facility-specific" per diem amount that is computed separately for each SNF to reflect the facility's own average daily costs under the pre-PPS system.

In the first year of the PPS, SNFs received per diem rates that were computed as 75% of the facility-specific rate plus 25% of the federal per diem rate. In each subsequent year, the proportion paid under the facility-specific rate and under the federal per diem rate shifts by 25 percentage points until, starting mid-2001, the federal rate is the full payment.

The SNF PPS described in BBA 97 reflects the Resource Utilization Group (RUG) design HCFA developed and tested on a demonstration project basis over several years. SNFs receive a payment for each day a beneficiary is a resident of the SNF. The per diem payment is first computed as an overall average daily rate, and that average payment is adjusted for "case mix, " which accounts for the clinical characteristics of individual SNF residents and the type and intensity of care each needs. The payment is further adjusted to account for the geographic location of the facility and for local area wage rates.

The RUG case-mix adjustment scheme is a hierarchical classification system reflecting the relative amount of resources required to provide a SNF resident's care. The original SNF PPS implemented in mid-1998 included seven basic categories of care, including, in hierarchical order: rehabilitation, extensive services, special care, clinically complex care, care for patients with impaired cognition, care for patients with behavior problems, and care for patients with reduced physical function. These seven categories were further differentiated into 44 more specific patient groupings. SNFs categorize each newly admitted beneficiary into one of the RUG categories using a protocol prescribed by HCFA. SNF residents may be reclassified during their stay in the facility as their condition or care needs change.

For each of FY2001 and FY2002 the federal per diem rates are to be increased by the increase in the SNF market basket index compared to the previous year minus one percentage point.

Like other PPSs that compensate health care providers for care to Medicare beneficiaries by the use of predetermined, fixed amounts, Medicare PPS payments to SNFs are intended to pay the provider for the cost of care to Medicare beneficiaries *on average*. That is, although the RUG payment for all residents in the same category is a fixed amount, a facility's actual

costs may be above or below that amount for an individual. The goal for the facility is to incur costs that, on average, over time, do not exceed the PPS average amounts.

As experience is gained with the SNF PPS and the RUG system, it will be revised and refined periodically.

BBRA 99. 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 (HHS) of a refined, revised RUG system, the BBRA 99 increased per diem payments by 20% for 15 RUGs, including those for extensive services, special care, clinically complex care, and certain high level and medium level rehabilitation services. The RUG codes for these 15 categories are: SE3; SE2; SE1; SSC; SSB; SSA; CC2; CC1; CB2; CB1; CA2; CA1; RHC; RMC; RMB. (Tables 3 and 4, 64 Fed. Reg. 41684.) In addition, if a revised RUG system is not implemented by October 1, 2000, the BBRA 99 calls for all federal per diem rates to be increased by 4% for FY2001 and FY2002. These are temporary additions to the PPS rates; they are not part of the market basket update procedure and are not included in the base on which future market basket updates are computed.

Effective Date. April 1, 2000.

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

Prior Law. The transition to the federal per diem rate under the SNF PPS is to be phased in over 3 years, starting with facility cost reporting periods beginning on or after July 1, 1998. In the first year, a facility's payment is equal to 75% of the facility-specific rate plus 25% of the federal per diem rate; in the second year the payment is 50% of the facility-specific rate plus 50% of the federal per diem rate; in the third year the payment is 25% of the facility-specific rate plus 75% of the federal rate. In subsequent years, 100% of the payment will be at the federal rate.

BBRA 99. Individual SNFs may elect, on or after December 15, 1999, immediate transition to 100% of the federal per diem rate for cost reporting periods beginning on or after January 1, 2000. SNFs may elect immediate transition up to 30 days after the start of their cost reporting period.

Effective Date. Enactment.

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

Prior Law. SNF per diem payments under the PPS/RUG system are intended to cover virtually all services needed by a SNF resident, including drugs, chemotherapy agents, and ancillary services needed by SNF patients. However, separate payments above and beyond PPS per diem amounts are made for renal dialysis services for SNF residents when they receive dialysis at centers away from the SNF, although the cost of ambulance transportation to and from a dialysis center is not paid separately. Also, separate payments are not made for certain prostheses delivered to patients during a SNF stay.

BBRA 99. Separate payments above and beyond the PPS/RUG rates will be paid for SNF residents needing (a) certain chemotherapy drugs and chemotherapy administration services;

(b) ambulance transportation to and from a renal dialysis center; and (c) certain radioisotope services identified by the Secretary of HHS. Also, separate payment will be made beyond the PPS per diem for certain customized prosthetic devises delivered to a SNF inpatient for use during and after the SNF stay. Items and services that would be paid for under Medicare Part A when included in the PPS per diem will be paid in amounts determined under Part B but financed with Part A funds.

In order to achieve budget neutrality, the Secretary of HHS is required to adjust overall PPS rates to reflect the increased costs of separate payments for the covered drugs, services, and items paid separately from PPS payments.

Effective Date. Effective for items and services furnished on or after April 1, 2000.

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

Prior Law. SNFs that had participated in the NHCMQ demonstration project that preceded implementation of the RUG system do not have the cost of Medicare Part B services to Medicare beneficiaries accounted for under the facility-specific component of the PPS during the transition period as do other SNFs.

BBRA 99. The cost of Part B services will be included in the computation of the facility-specific component of SNF per diem payments during the transition to the federal per diem PPS for SNFs that had participated in the NHCMQ demonstration, including updates based on the SNF market basket index increase minus one percentage point.

Effective Date. The provision is retroactive to implementation of the BBA 97.

Section 105. Special Consideration for Facilities Serving Specialized Patient Populations

Prior Law. No provision.

BBRA 99. For cost reporting periods starting on or after November 29, 1999, and until September 30, 2001, PPS payments to certain hospital-based SNFs furnishing Medicare-covered SNF services on the date of enactment of the BBRA 99 (November 29, 1999) will be computed as 50% of the facility-specific component in effect during the transition to the PPS and 50% on the federal per diem rate. This special payment rule applies to SNFs: (a) that were certified for Medicare before July 1, 1992; (b) that, in 1998, served patients who were immuno-compromised secondary to an infectious disease; and (c) if such patients made up more than 60% of the facility's total patient days in 1998. Not later than March 1, 2001, the Secretary of HHS is required to assess and report on the resource use of such patients and recommend whether permanent adjustments should be made to the RUGs in which they are classified.

Effective Date. Effective for cost reporting periods beginning on or after November 29, 1999.

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

Prior Law. No provision.

BBRA 99. MedPAC is required to study and report within 18 months of enactment on the need for an additional payment amount under the adjusted federal per diem rates for SNFs in Alaska and Hawaii.

Effective Date. Enactment.

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

Prior Law. No provision.

BBRA 99. The Secretary of HHS is required 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.

Effective Date. Enactment.

Subtitle B — PPS Hospitals

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

Prior Law. Medicare pays teaching hospitals for a share of the direct medical education (DME) costs of providing graduate medical education. (Medicare's direct cost payments are based on resident and faculty salaries and fringe benefits, overhead costs related to teaching activities, and the number of full-time equivalent residents the hospital employs.) Medicare payments for IME costs associated with approved graduate medical education are computed as an adjustment to hospital Diagnosis Related Group (DRG) payments. (Medicare's IME payment is designed to compensate teaching hospitals for their relatively higher costs attributable to the involvement of residents in patient care and patients requiring specialized services available only in teaching hospitals.) BBA 97 reduced the amount of the IME adjustment from the existing 7.7% increase (for each 10% increase in a hospital's ratio of interns and residents to beds) in FY1997 to 7.0% in FY1998; to 6.5% in FY1999; to 6.0% in FY2000; and to 5.5% in FY2001 and subsequent years.

BBRA 99. The IME adjustment is frozen at 6.5% through FY2000; reduced to 6.25% in FY2001 and then to 5.5% in FY2002 and subsequently.

Effective Date. Enactment.

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

Prior 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 amounts by 1% in FY1998; 2% in FY1999; 3% in FY2000; 4% in FY2001; 5% in FY2002 and 0% in FY2003 and in each subsequent year.

BBRA 99. The DSH payment reduction is frozen at 3% in FY2001and then changed to 4% in FY2002. The Secretary is required 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 for cost reporting periods beginning on or after October 1, 2001.

Effective Date. Enactment. Data collection requirements start with cost reporting periods starting on or after October 1, 2001.

Subtitle C — PPS Exempt Hospitals

Section 121. Wage Adjustment to Percentile Cap for PPS-Exempt Hospitals

Prior Law. Psychiatric, rehabilitation, and long-term care providers, including separate facilities and qualified distinct part units in acute general hospitals, were excluded from Medicare's inpatient hospital PPS when the system was implemented in FY1984. These Medicare providers are subject to payment limitations and incentives established by the Tax Equity and Fiscal Responsibility of 1982 (TEFRA) as modified by BBA 97.

Generally speaking, these PPS-exempt providers are paid based on their costs per discharge, subject to provider-specific limits established by TEFRA and to national limits established by BBA 97. A provider's target amount is based on its Medicare allowable costs per discharge in a base year, inflated to the current year by an annual update factor. A national limit or cap amount is calculated for these three classes of PPS-exempt providers. Each provider's limit is the lesser of its target and cap amount. Generally, a provider with costs under its limit is rewarded with a bonus payment; a provider with costs per discharge above its limit will receive a relief payment.

BBA 97 established a national cap on the TEFRA limits for PPS-exempt hospitals and units in cost reporting periods beginning on or after October 1, 1997, and before October 1, 2002. The cap is set at the 75th percentile of the target amount for each class of provider in FY1996, updated each year by the increase in the market basket.

BBRA 99. The 75% cap used to set limits for established PPS-exempt providers is to be adjusted to reflect differences in wage related costs in a hospital's area for cost reporting periods on or after October 1, 1999.

Effective Date. Enactment.

Section 122. Enhanced Payments for Long-term Care and Psychiatric Hospitals Until Development of Prospective Payment Systems for Those Hospitals

Prior Law. BBA 97 established the amount of bonus and relief payments paid to eligible PPS-exempt providers. A provider with costs under its limit is rewarded with a bonus payment that is equal to the lesser of (1) 15% of the amount by which the target amount exceeds the amount of operating costs, or (2) 2% of the target amount. In addition, eligible hospitals could also receive an increased bonus payment (called a continuous improvement payment) equal to the lesser of: (1) 50% of the amount by which the eligible hospital's operating costs are less than those expected for the period; or (2) 1% of the target amount for the period. The sum of these two possible bonus payments can equal up to 3% of a provider's limit. Alternatively, a PPS-exempt provider with costs over 110% of its limit is eligible for relief payments equal to half the amount by which these costs exceed 110% of the limit. Relief payments may equal up to 10% of the provider's limit.

BBRA 99. The amount of continuous bonus payments to eligible long-term and psychiatric providers is to be increased from 1% to 1.5% of the target amount for cost reporting periods beginning on or after October 1, 2000, and before September 30, 2001, and to 2% for cost reporting periods beginning on or after October 1, 2001, and before September 30, 2002.

Effective Date. Enactment.

Section 123. Per Discharge Prospective Payment System for Long-term Care Hospitals

Prior Law. BBA 97 requires the Secretary to collect data to develop, establish, administer, and evaluate a case-mix adjusted PPS for long-term care hospitals. The Secretary is required to develop a legislative proposal for establishing and administering a payment system that includes an adequate patient classification system that reflects differences in patient resource use. The Secretary may require these hospitals to submit necessary data to develop this proposal. The Secretary is instructed to consider several payment methodologies including the feasibility of expanding the diagnosis related groups and inpatient PPS for acute hospitals and submit a legislative proposal to the appropriate Congressional committees no later than October 1, 1999.

BBRA 99. The Secretary is required to report on a discharge-based PPS with an adequate patient classification system for long-term hospitals to appropriate Congressional committees by October 1, 2001. The PPS for long-term hospitals is to be implemented in a budget neutral fashion for cost reporting periods beginning on or after October 1, 2002.

Effective Date. Enactment.

Section 124. Per Diem Prospective Payment System for Psychiatric Hospitals

Prior Law. No provision.

BBRA 99. The Secretary is required to report on a per-diem based PPS with an adequate patient classification system for psychiatric hospitals to appropriate Congressional committees

by October 1, 2001. The PPS for psychiatric hospitals is to be implemented in a budget neutral fashion for cost reporting periods beginning on or after October 1, 2002.

Effective Date. Enactment.

Section 125. Refinement of Prospective Payment System for Inpatient Rehabilitation Services

Prior law. BBA 97 requires the Secretary to establish a case-mix adjusted PPS for rehabilitation hospitals and distinct part units, effective beginning in FY2001. 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 FY2001 and FY2002, the Secretary is required to establish prospective payment amounts that are budget neutral so that total payments for rehabilitation hospitals equal 98% of the amount that would have been paid if the PPS system had not been enacted. PPS will be fully implemented by October 1, 2002.

BBRA 99. The Secretary is required to base the PPS for rehabilitation facilities on discharges; establish classes of patient discharges by functional related groups, based on the patient's impairment, age, co-morbidities, and functional capabilities as well as other appropriate factors that improve the explanatory power of functional independence measures-function related groups; and submit a study to Congress not later than 3 years after PPS implementation on its impact on utilization and access.

Effective Date. Enactment.

Subtitle D — Hospice Care

Section 131. Temporary Increase in Payment for Hospice Care

Prior Law. Payment for hospice care is based on one of four prospectively determined rates for each day a beneficiary is under the care of the hospice. The four rate categories correspond to levels of care, which are: routine home care, continuous home care, inpatient respite care, and general inpatient care. Payment rates are adjusted to reflect differences in area wage levels; periodic updates are based on the hospital market basket index.

Medicare payments to a hospice are subject to an aggregate annual cap that is determined by multiplying the cap amount for a given year by the number of Medicare beneficiaries who receive hospice services during the year. (For example, the cap for the year from November 1, 1999, through October 31, 2000, was $15,313.) Updates to the annual cap amount are based on the medical care component of the Consumer Price Index for all Urban Consumers (CPI-U). Limited cost sharing applies to outpatient drugs and respite care.

Before BBA 97, the daily rates were updated annually by the hospital market basket index increase; BBA 97 reduced the updates to market basket index increase minus one percentage point for FY1999-FY2002 and required the Secretary of HHS to collect hospice cost data.

BBRA 99. The hospice daily payment rates for the four categories of care are increased by 0.5 in FY2001 and by 0.75% in FY2002. These increases are not included in the base for computing subsequent updates to these rates.

Effective Date. Enactment.

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

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

BBRA 99. The GAO is required to conduct a study on the feasibility and advisability of updating the hospice rates and 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 recommendations are to be submitted to Congress within 1 year of enactment.

Effective date. Enactment.

Subtitle E — Other Provisions

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

Prior law. No later than 2 years after enactment BBA 97 required that 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.

BBRA 99. Within 18 months of enactment, MedPAC is required 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).

Effective Date. Enactment.

Subtitle F — Transitional Provisions

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

Prior law. Regional or rural referral centers receive special treatment under the acute hospital prospective payment system with respect to their disproportionate share hospital adjustment and when considered for geographic reclassification. 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 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 (CMI) 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; (5) at least 40% of all patients treated at the hospital are referred from other hospitals or by physicians not on the hospital staff.

BBRA 99. The Northwest Mississippi Regional Medical Center is to be treated as if it meets the case mix index criterion in order to be classified as a referral center for FY2000.

Effective Date. Enactment.

Section 152. Reclassification of Certain Counties and Other Areas for Purposes of Reimbursement under the Medicare Program

Prior law. Medicare's payments to acute hospitals for inpatient services vary by urban/rural classification and the geographic area where a hospital is located or to which a hospital is assigned.

BBRA 99. For the purposes of Medicare inpatient hospital reimbursement in FY2001 and FY2001, Iredell County is considered to be part of the Charlotte-Gastonia-Rock Hill, North Carolina-South Carolina metropolitan statistical area (MSA); Orange County, New York is considered to be part of the large urban area of New York, NY; 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 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.

Effective Date. Enactment.

Section 153. Wage Index Correction

Prior 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.

BBRA 99. The FY2000 wage index for Hattiesburg, Mississippi MSA is to be recalculated without the data from Wesley Medical Center, and the resulting wage index change will not affect other areas.

Effective Date. Enactment.

Section 154. Calculation and Application of Wage Index to Certain Area

Prior 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.

BBRA 99. The FY2000 wage index for Allentown-Bethlehem-Easton Pennsylvania MSA is to be recalculated as if Lehigh Valley Hospital were classified in the area without affecting the wage index for any other area. For FY2001, Lehigh Valley Hospital is to be treated as if it is in Allentown-Bethlehem-Easton, Pennsylvania MSA.

Effective Date. Enactment.

Section 155. Special Rule for Certain Skilled Nursing Facilities

Prior Law. The SNF PPS pays a per diem amount for all covered services provided to Medicare beneficiaries. During a transition period lasting through three of a facility's cost reporting periods, the first of which began on or after July 1, 1998, a portion of the per diem payment to a SNF is 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.

BBRA 99. The Secretary of HHS is required to establish special per diem payments for certain SNFs for each cost reporting period beginning in FY2000 and in FY2001. These SNFs are those located in Baldwin or Mobile Counties, Alabama (a) that began participation in the Medicare program before January 1, 1995, and (b) for which Medicare beneficiary inpatient days accounted for at least 80% of total inpatient days of the facility in the cost reporting period beginning in 1998. If an eligible facility elects, the per diem payments for Medicare residents in these facilities would include a facility-specific component only and would be based on allowable costs in 1998 (rather than 1995) and updated for cost reporting periods in years after FY1998.

Effective Date. Enactment.

Title II — Provisions Relating to Part B

Subtitle A — Hospital Outpatient Services

Section 201. Outlier Adjustment; Transitional Pass-Through for Certain Medical Devices, Drugs, Biologicals

Subsection 201(a). Outlier Adjustment.

Prior Law. BBA 97 required that Medicare payment for hospital outpatient department (HOPD) care and services be paid under a PPS instead of the long-standing retrospective cost-based system. A PPS for HOPD care and services was scheduled for implementation July 1, 2000. (HCFA later delayed implementation until August 1, 2000.) The HOPD PPS payments are uniform for all patients undergoing a certain procedure. Under the new PPS, outpatient services that are similar clinically and in terms of resource utilization are arranged into groups according to an "ambulatory payment classification" (APC) system. The original APC system includes 451 payment groups. A payment amount is established for each group and is the same for each service in the group. The payments cover hospital facility and nonphysician personnel costs with adjustments for geographic location of the facility and area wages.

BBRA 99. The Secretary of HHS is required to provide additional payments to HOPDs for each covered service (or group of service) for which the HOPD costs ("charges adjusted to costs") exceed a fixed multiple of the PPS amount, plus pass-through payments under Subsection 201(b) (described below), plus additional amounts determined by the Secretary. The aggregate amount of these outlier payments may not exceed 2.5% of total program payments for HOPD services furnished in years before 2004 and 3% for years thereafter. As a transition to this outlier system, for HOPD services furnished before January 1, 2002, the base amount to which the multiple and the pass-through and add-ons are applied may be certain charges for a particular outpatient encounter (rather than for a service or group of services), and the charges adjusted to cost amount may be that applicable to the whole hospital, not just the outpatient department.

Effective date. See Section 201(m).

Subsection 201(b). Transitional Pass-Through for Additional Costs of Innovative Medical Devices, Drugs, and Biologicals.

Prior Law. Most PPS payments for HOPD services include costs for associated devices, drugs, and biologicals.

BBRA 99. For a defined period of time, the Secretary of HHS is required to provide additional payments for costs of certain "current innovative" devices, drugs, and biologicals, and certain "new" high cost devices, drugs, and biologicals used in HOPD care. These payments are referred to as "pass-through payments" because they would pass through the PPS and be paid over and above PPS payments. ("Current" is defined as something for which Medicare is paying under outpatient services on the first day of the PPS; "new" is defined as something for which Medicare was not paying on an outpatient basis on December 31, 1996.)

A pass-through for the cost of current innovative products applies to (1) orphan drugs; (2) certain cancer therapy drugs, biologicals, and brachytherapy; and (3) radiopharmaceutical drugs and biological products.

A pass-through of costs for "new" medical devices, drugs, and biologicals is required if the costs of those items is "not insignificant" in relation to the fee schedule amount payable for the service.

These transitional pass-through payments would be for a period of at least 2 years but not more than 3 years. For drugs, biologicals, and brachytherapy used in cancer therapy and for 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 2, but not more than 3 years.

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% of the average wholesale price 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, exceeds 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 the total projected payments under the outpatient PPS. The applicable percentages are (1) 2.5% for the first 3 years after implementation of the new outpatient payment system; and (2) up to 2% in subsequent years. In setting the HOPD 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 beyond the expected utilization for each service. If the estimated total amount exceeds the percentage limitation, the Secretary of HHS will apply a *pro rata* reduction to the add-on payment amounts so that projected total payments do not exceed the applicable percentage increase limits (i.e., 2.5% for the first 3 years and 2% in subsequent years).

Effective Date. See Section 201(m).

Subsection 201(c). Application of New Adjustments on a Budget Neutral Basis.

Prior Law. No provision.

BBRA 99. Outlier payments for costly outpatient cases provided under Subsection 201(a) and pass-through payments under Subsection 201(b) are required to be budget neutral to Medicare, meaning cost increases for providing those additional payments for outpatient care must be offset by reductions elsewhere in payments for outpatient care.

Effective Date. See Section 201(m).

Subsection 201(d). Limitation on Judicial Review for New Adjustments.

Prior Law. There is no provision for administrative or judicial review regarding the basic design features of the HOPD PPS.

BBRA 99. The outlier payments for costly outpatient cases and the pass-through payments for certain devices, drugs, and biologicals are not subject to administrative or judicial review.

Effective Date. See Section 201(m).

Subsection 201(e). Inclusion of Certain Implantable Items Under System.

Prior Law. Medicare-covered HOPD services include implantation of certain devices, although the cost of the devices themselves are paid according to a fee schedule generally applicable to durable medical equipment (DME).

BBRA 99. Payment for certain medical devices implanted in a hospital setting would be made through the HOPD PPS rather than according to the DME fee schedule. These devices include, for example, pacemakers, defibrillators, cardiac sensors, venous grafts, drug pumps, stents, neurostimulators, and orthopedic implants, as well as items that come into contact with internal human tissue during invasive medical procedures (but are not permanently implanted). The implantable device is to be classified to the PPS group that includes the service to which the item relates.

Effective Date. See Section 201(m).

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

Prior Law. In establishing the relative payment weights of payment groups in the HOPD PPS, the Secretary uses the median cost of the item or services in the group.

BBRA 99. The Secretary may elect to use either the median or the mean cost of the item or service in a group in establishing the relative payment weight of a group.

Effective Date. See Section 201(m).

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

Prior Law. The services classified within each group on which a PPS payment amount is established are to be comparable clinically and with respect to the use of resources.

BBRA 99. An upper limit is placed on the variation of costs among services included in the same group. The most costly item or service in a group may not have a mean or median cost that is more that twice the mean or median cost of the least costly item or service in the group.

Effective Date. See Section 201(m).

Subsection 201(h). Annual Review of Out Patient Department (OPD) PPS Components.

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

BBRA 99. The Secretary is required to carry out a review of the components of the HOPD PPS not less often than annually; is required to consult with an outside advisory panel composed of provider representatives; and such panel may use data collected or developed by entities or organizations other than HHS when consulting with the Secretary about the clinical integrity and weights of the payment groups.

Effective Date. The first annual review of the components of the PPS shall be conducted in 2001 for application in 2002, with the requirement for an outside advisory panel effective upon enactment.

Subsection 201(i). No Impact on Copayment.

Prior Law. Prior to BBA 97, beneficiary copayments for HOPD care and services were generally 20% of hospital charges; BBA 97 froze beneficiary payments at a specific amount for each type of outpatient procedure. These copayment amounts will not increase over time.

BBRA 99. Beneficiaries may not be required to pay additional copayments for procedures for which outlier or pass-through payments are provided to the facility.

Effective Date. See Section 201(m).

Subsection 201(j). Technical Correction in Reference Relating to Hospital-Based Ambulance Services.

This provision made a technical drafting change.

Subsection 201(k). Extension of Payment Provisions of Section 4522 of BBA Until Implementation of PPS.

Prior Law. For Medicare payments under the cost-based reimbursement system that preceded the PPS, OBRA 1993 and later BBA 97 required that Medicare payments for the capital-related costs of an HOPD be 90% of such allowable costs (a 10% reduction), and payments for allowable costs other than capital-related costs be 94.2% of such costs (a 5.8% reduction). These reductions were to continue through January 1, 2000.

BBRA 99. The payment reductions would continue until implementation of the HOPD PPS.

Effective date. See Section 201(m).

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

Prior Law. When the change from the cost-base reimbursement system to the PPS took place for HOPDs, Medicare's total, aggregate payments to HOPDs were to be the same as it would have been had the pre-PPS system remained in effect. However, limitation of beneficiary copaymets to "frozen" flat dollar amounts, per procedure, resulted in total payments to some hospitals being less that they would have been under the prior system. Therefore, some hospitals could realize a reduction in aggregate payments for Medicare beneficiaries.

BBRA 99. Without regard to the budget neutrality requirement of the PPS, Medicare will make up shortfalls in payments to hospitals that result from reduced beneficiary copayments for outpatient care.

Effective date. See Section 201(m)

Subsection 201(m). Effective date.

Prior Law. No provision.

BBRA 99. All the amendments in Section 201(a) through 201(l) are effective as if enacted with the BBA 97.

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

Prior Law. No provision.

BBRA 99. The Secretary of HHS shall conduct a study of the extent to which intravenous immune globulin could be reimbursed under Medicare when it is delivered outside of a hospital or physician's office, such as in a beneficiary's home. The Secretary shall submit a report on the study to the House Committee on Ways and Means and the Senate Committee on Finance within 18 months of enactment of BBRA 99.

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

Prior Law. The HOPD PPS was to be implemented in such a way that payments to these facilities from Medicare would be budget neutral compared with payments under the prior retrospective cost-based payment system. HCFA's analysis showed that the fiscal effects of the new system would differ among facilities, and some would receive less money than they would have received if the prior system had remained in place.

BBRA 99. Payments in addition to PPS payments will be made to a hospital outpatient department during the first 3 years of the PPS if the hospital's PPS aggregate payments from Medicare are less than they would have been under the pre-BBA cost-based reimbursement system. The law includes a formula for determining what a hospital's pre-BBA amount would be for a given year.

During the first year of the PPS, a hospital outpatient department would receive an additional amount equal to 80% of the first 10% of the difference between its payments under the pre-BBA system and under the PPS, 70% of the next 10% of the reduced payments, and 60% of the next 10%. If PPS payments are less than 70% of those under the pre-BBA system, the additional sum is 21% of the pre-BBA amount. During the second year, the payments as a proportion of reduced payments will change to 70% of the first 10%, and 60% of the second 10%. If PPS payments are less than 80% of pre-BBA 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, special "hold harmless" payments are provided for outpatient departments of rural hospitals with fewer than 100 beds, and permanently for outpatient departments of cancer hospitals, to bring payments to hospital outpatient departments up to the full amount of their pre-PPS Medicare payments if their PPS payments total less than under the prior system. The budget neutrality requirement of the PPS is waived to make these payments, but beneficiary copayments would remain at the "frozen" amounts required by BBA.

Effective Date. Effective as if included in BBA.

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

Prior Law. No provision.

BBRA 99. MedPAC is required to study and report to Congress within 2 years of enactment on the appropriateness of and method for covering certain rural and cancer hospitals under the PPS. The included hospitals are: Medicare-dependent small rural hospitals; sole community hospitals; rural health clinics; rural referral centers; and any other rural hospital with no more than 100 beds and others as determined by the Secretary. The Secretary is to submit a report commenting on the MedPAC study within 60 days of its completion.

Effective Date. Enactment.

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

Prior Law. When the hospital outpatient department PPS was implemented, BBA 97 froze beneficiary copayments at the dollar amount that is equal to 20% of national median charges for a procedure in 1996 updated to the date of implementation of the PPS.

BBRA 99. Beneficiary copayments under the PPS for HODP care and services are limited to the amount of the Medicare deductible for an inpatient hospital stay under Part A. Medicare funds are authorized to make up the difference between this capped copayment and 20% of the national median charge for the services to which the cap applies.

Effective Date. Effective retroactive to enactment of the BBA 97.

Subtitle B — Physician Payments

Section 211. Modification of Update Adjustment Factor to Reduce Update Oscillation

Prior Law. Payments for physicians' services are made on the basis of a fee schedule. The fee schedule is intended to relate payments for a given service to actual resources used. The fee schedule assigns relative values to services. The relative values reflect physician work, practice expenses and malpractice costs. The relative values are adjusted for geographic variations in costs. The adjusted relative values are then converted into a dollar payment amount by a conversion factor.

The conversion factor is updated each year according to a formula established in law. The update percentage equals the Medicare Economic Index (MEI), subject to an adjustment to match target spending for physicians services under the sustainable growth rate (SGR) system. In no case can the adjustment be more than three percentage points above or seven percentage points below the MEI.

Four factors make up the SGR: changes in spending due to fee increases, fee-for-service enrollment, gross domestic product (GDP) growth per capita, and laws and regulations. All four factors are based on HCFA estimates. The law did not specifically require that the factors be updated when actual data become available. Data from various measurement periods were used for the SGR calculation. Time lags between these measurement periods could lead to unevenness in conversion factor updates.

BBRA 99. The calculation of the update adjustment factor to the conversion factor is to be made on a calendar year basis, beginning in 2001. The formula for determining the update is modified to add a new component to measure variances from the allowed growth rate in the past year. The transition to the new system is made on a budget neutral basis.

By March 1 of each year, the Secretary is required to make available to MedPAC and the public an estimate of the SGR and the conversion factor that will apply in the following year and the data used in making such estimate. MedPac is required to include a review of the estimate in its June report. The Secretary is required to publish the conversion factor by November 1 (beginning in 2000) for the following year. The Secretary is required to publish, by November 1, 2000, the sustainable growth rate for 2000 and 2001. Beginning in 2001, the Secretary is required to publish the SGR for the following year and each of the two preceding years.

Calculation of the sustainable growth rate is to be made on a calendar year (CY) basis. The 2001 update to the conversion factor is to be based on the FY2000 SGR as well as the CY2000 and 2001 SGRs (using the best data available to the Secretary as of September 1, 2000). The 2002 update to the conversion factor will use the FY2000 SGR as well as the 2000, 2001, and 2002 SGRs (using the best data available to the Secretary as of September 1, 2001). For 2003 and succeeding years, the SGR for that year and the two preceding 2 years would be determined on the basis of the best data available to the Secretary as of September 1 of the preceding year.

The Secretary, acting through the Administrator of the Agency for Health Care Policy and Research (renamed Agency for Healthcare Research and Quality) is to conduct a study of

the following issues: (1) the various methods for accurately estimating the economic impact on Medicare fee-for-service expenditures of improvements in medical capabilities, advancements in scientific technology, demographic changes, and geographic changes in locations where beneficiaries receive services; (2) the rate of usage of physicians' services under fee-for-service by various age cohorts; and (3) other factors which may be reliable predictors of beneficiary utilization of such services. The Secretary, within 3 years of enactment, is required to report to Congress on the results of the study, together with any recommendations deemed appropriate. MedPAC is required to submit its own report to Congress within 180 days of the report's submission. MedPAC's report is to include an analysis and evaluation of the Secretary's report as well as any recommendations determined appropriate.

Effective Date. The changes apply to calculations made to determine the conversion factor for years beginning with 2001. They do not apply to or affect any update (or any update adjustment factor) for any year before 2001.

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

Prior Law. The fee schedule assigns relative values to services. The relative values reflect physician work, practice expenses, and malpractice costs. When the fee schedule went into effect in 1992, practice expense relative value units were based on historical charges. 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. In 1998, certain practice expense relative value units were reduced. The new resource-based system is being phased-in beginning in CY1999. In 1999, 75% of the payment was based on the 1998 charge-based relative value unit and 25% on the resource-based relative value. In 2000, the percentages are 50% charge-based and 50% resource-based. For 2001, the percentages will be 25% charge-based and 75% resource-based. Beginning in 2002, the values will be totally resource-based.

BBRA 99. The Secretary is required to establish by regulation (after notice and public comment) a process (including data collection standards) for determining practice expense relative values. Under this process, the Secretary will accept for use and will use to the maximum extent practicable and consistent with sound data practices, data collected or developed outside HHS. These outside data are to supplement data normally developed by HHS for determining the practice expense component. The Secretary would first promulgate the regulation on an interim basis in a manner that permits submission and use of outside data in the computation of relative value units for 2001.

The Secretary is required, when publishing the estimated and final updates for 2001 and 2002, to include a description of the process established for using external data. The Secretary is also required to provide information on the extent to which such data have been used in making adjustments in practice expenses, particularly in cases in which the data are otherwise inadequate because the data are not based on a large enough sample size to be statistically reliable.

Effective Date. Enactment.

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

Prior Law. No provision.

BBRA 99. GAO is required 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 payment rates for such services. In making this determination 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 required to submit a report to Congress on this study. The report is to include recommendations regarding practice expense adjustments, including the development and inclusion of adequate work units to assure the adequacy of payment amounts for safe outpatient cancer therapy services. The study is to include cost estimates for the recommendations.

Effective Date. Enactment.

Subtitle C — Other Services

Section 221. Revision of Provisions Relating to Therapy Services

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

There were two per beneficiary limits. The first was a $1,500 per beneficiary annual cap for all outpatient physical therapy services and speech language pathology services. The second was a $1,500 per beneficiary annual cap for all outpatient occupational therapy services. Beginning in 2002, the amount would increase by the MEI, rounded to the nearest multiple of $10.

BBA 97 also required the Secretary to report to Congress by January 1, 2001, on recommendations for establishing a revised coverage policy based on diagnostic groups.

Persons receiving outpatient physical therapy must be under the care of a physician. For this purpose, a physician is defined as a doctor of medicine, osteopathy, or podiatry.

BBRA 99. The law suspends application of the therapy limits in 2000 and 2001. (In the absence of additional legislation, the caps would be imposed again beginning in 2002.) During this time, the Secretary is required to conduct focused medical reviews of therapy claims with emphasis on claims for services provided to residents of SNFs.

The law also modifies the current required report to Congress to specify that the study is to establish an alternate payment policy and to include functional status in the calculation. The report must include recommendations for establishment of a mechanism to assure appropriate utilization of covered therapy services.

The Secretary is also required to study utilization patterns in 2000 compared to those in 1998 and 1999. The study (which must be based on a statistically significant number of claims) will look at nationwide patterns as well as patterns by region, types of setting, and diagnosis or condition. The Secretary is required to report the results of this study to Congress by June 30, 2001, together with any legislative recommendations deemed appropriate.

The provision further includes optometrists within the definition of those physicians under whose care a beneficiary must be in order to receive covered therapy services.

Effective Date. Generally, enactment, except that the revision to the report requirements is effective as if it had been incorporated in BBA 97. The physician supervision provision is effective January 1, 2000.

Section 222. Update in Renal Dialysis Composite Rate

Prior Law. Dialysis facilities providing care to beneficiaries with end-stage renal disease (ESRD) receive a fixed prospective payment amount for each dialysis treatment. In 1999, the base composite rate was $126 for hospital-based providers and $122 for free-standing facilities.

BBRA 99. The composite rate is updated by 1.2% for dialysis services furnished during 2000 and an additional 1.2% for services furnished in 2001. MedPAC is required to study the appropriateness of the payment differential between services furnished in a facility and those furnished at home. Within 18 months of enactment, it is required to submit a report on the study to Congress, including recommendations regarding changes in payment policy.

Effective Date. Enactment.

Section 223. Implementation of Inherent Reasonableness Authority

Prior Law. The Secretary has the authority to determine whether payment methodologies for certain Part B services, such as purchase of durable medical equipment and items paid according to a fee schedule, result in payments that are inherently unreasonable. The Secretary is required, by regulation, to describe the factors used in making this determination. Regulations were issued January 7, 1998.

BBRA 99. The Secretary is prohibited from exercising inherent reasonableness authority until after: (1) the GAO releases a report (requested March 1, 1999) regarding the impact of the use of such authority by the Secretary, carriers, and intermediaries; and (2) the Secretary has published final regulations that respond to both such report and comments received in response to the Secretary's interim final regulations published January 7, 1998. The Secretary is required to reevaluate the appropriateness of the criteria included in the interim final regulations and take appropriate steps to ensure the use of valid and reliable data when exercising inherent reasonableness authority.

Effective Date. Enactment.

Section 224. Increase in Reimbursement for PAP Smears

Prior Law. Payments for PAP smears are made under the clinical laboratory fee schedule.

BBRA 99. The Secretary is required to establish a national minimum payment amount for PAP smears at $14.60 for tests furnished in 2000. The payment amount is to be adjusted annually by the increase otherwise applicable for clinical lab tests. The minimum payment amount applies to both diagnostic and screening PAP smears including all cervical cancer screening technologies that have been approved by the FDA as a primary screening mechanism for the detection of cervical cancer.

The section also includes language expressing the sense of the Congress that HCFA should institute an appropriate increase for new cervical cancer screening technologies approved by the FDA.

Effective Date. Enactment.

Section 225. Refinement of Ambulance Services Demonstration Project

Prior Law. BBA 97 authorized up to three demonstration projects under which a unit of local government could enter into a contract with the Secretary to furnish, on a capitated basis, ambulance services for individuals living in the local government unit. The Secretary could not enter into such a contract unless the contract covered at least 80% of Medicare Part B enrollees (not including Medicare+Choice enrollees) residing in the area. Capitated payments in the first year are to equal 95% of the amounts which would otherwise be payable; in subsequent years they are updated by changes in the consumer price index.

BBRA 99. The provision requires the Secretary to publish a request for proposals by July 1, 2000. It also specifies that in the first year the capitation rate is to be based on the most current data and that the aggregate payments can not exceed what would otherwise be paid in the jurisdiction. The payment amount is updated in subsequent years by an appropriate inflation adjustment factor.

Effective Date. Effective as if included in the enactment of BBA 97.

Section 226. Phase-in of PPS for Ambulatory Surgical Centers

Prior Law. Medicare payments for ambulatory surgical centers (ASCs) have been based on a fee schedule since such services were first covered by the program in 1982. ASC services that are similar clinically and in terms of resource utilization are arranged into groups according to an "ambulatory payment classification" (APC) system. A payment amount is established for each group and is the same for each service in the group. The payments cover facility and nonphysician personnel costs with adjustments for geographic location of the facility and area wages. (Medicare pays physicians and surgeons providing care in ASCs according to the physician fee schedule.) BBA 97 mandated annual updates of ASC payments by the CPI-U minus 2 percentage points in 1998-2002. In June, 1998, HCFA proposed a major revision of the APC groups and rules, including regrouping and revising the rates based on a survey of ASC costs in 1994.

BBRA 99. BBRA 99 requires any new ASC rates based on data from pre-1999 cost surveys to be phased-in over 3 years, one-third in the first year; two-thirds in the second year, and fully implemented in the third year.

Effective Date. Enactment.

Section 227. Extension of Medicare Benefits for Immunosuppressive Drugs

Prior Law. In general, Medicare does not pay for outpatient prescription drugs. One exception is for immunosuppressive drugs. Medicare will pay for drugs used in immunosuppressive therapy during the first 36 months following a Medicare covered organ transplant.

BBRA 99. The law provides for a temporary extension of the current 36-month limit on immunosuppressive drugs *for persons otherwise exhausting their coverage in 2000-2004*. In each calendar year, there will be an extension specified by the Secretary (as the number of months or partial months), applicable to persons who exhaust their benefits in that calendar year. The increase for persons exhausting their benefits in 2000 is 8 months. The minimum increase for persons exhausting their benefits in 2001 is 8 months.

By May 1 of 2001, the Secretary may increase the number of months for the cohort exhausting their benefits in 2001. At the same time, the Secretary is also required to announce the additional months of benefits that will be available for the cohort exhausting their benefits in 2002. Similarly, by May 1 of 2002 and 2003, the Secretary is required to announce the number of months that will apply to the cohort exhausting their benefits in the following year.

Total expenditures over the 5-year period are limited to $150 million. The Secretary, in making the specification of the number of additional months for 2002-2004 is required to make the computation so that expenditures do not exceed this limit. Further, the Secretary is directed to seek to provide a level number of months for each cohort exhausting benefits in 2001-2004. The Secretary may adjust the amount of additional months from the prior year to the extent necessary to take into account differences between actual and estimated expenditures for previous years.

By March 1, 2003, the Secretary is required to submit a report to Congress on the operation of the temporary extension. The report is to include an analysis of the impact and recommendations regarding an appropriate cost-effective method for providing coverage on a permanent basis. In making the recommendations, the Secretary is required to identify potential modifications to the benefit that would best promote the following objectives: 1) improving health outcomes by decreasing transplant rejection rates attributable to failure to comply with immunosuppressive drug regimens; (2) achieving cost savings to the Medicare program by decreasing the need for secondary transplants and other care related to post-transplant complications; and (3) meeting the needs of those beneficiaries who because of low income or other factors, would be less likely to maintain a drug regimen in the absence of the modifications.

Effective Date. Enactment.

Section 228. Temporary Increase in Payment Rates for Durable Medical Equipment and Oxygen

Prior Law. Payments for durable medical equipment are determined on the basis of fee schedules for five different classifications of items. In general, the fee schedules establish national payment limits for DME, and the limits have floors and ceilings. The fee schedule amounts are updated annually based on the increase in the CPI-U, although in past years Congress required that the updates be less than the full CPI-U increase. In BBA 97, Congress eliminated altogether the updates for 1998-2002, but, for subsequent years, specified that the update would be the CPI-U increase as measured over a 12-month period ending in June of the previous year.

BBRA 99. DME payment amounts in effect for covered items furnished during 2001 and 2002 are increased by 0.3% and 0.6% respectively. These extra amounts are not included the base when updates are made in future years.

Effective Date. Enactment.

Section 229. Studies and Reports

Prior Law. No provision.

BBRA. This section requires several studies.

MedPAC is required to conduct a study on the cost-effectiveness and efficacy of covering services of a post-surgical care recovery center (which provides an intermediate level of recovery care following surgery). In conducting the study, MedPAC is to consider data gathered on these centers in demonstration projects. A report on the study is due to Congress within 1 year of enactment. The report is to include recommendations on the feasibility, costs, and savings of covering such services under Medicare.

The Agency for Health Care Policy and Research (renamed Agency for Healthcare Research and Quality) is required to conduct a study comparing the differences in the quality of ultrasound and other imaging services provided by credentialed individuals versus those provided by non-credentialed individuals. The study is to compare the differences in error rates, resulting complications, and patient outcomes. The Administrator of the Agency is required to consult with organizations nationally recognized for their expertise in ultrasound. The report is due to Congress within 2 years of enactment.

MedPac is required to undertake a comprehensive study reviewing the regulatory burdens placed on health care providers under Medicare. The study is to determine the cost of these burdens on the nation's health care system. The study is also to examine the complexity of the current regulatory system and its impact on providers. MedPAC is required to submit one or more reports on the study to Congress by December 31, 2001. The report is to include recommendations on: (1) how HCFA can reduce the regulatory burden; and (2) legislation that may be appropriate to reduce the complexity of the Medicare program.

The section also requires GAO to continue monitoring the compliance of the Department of Justice (DOJ) and U.S. attorneys with the DOJ "Guidelines on the Use of the False Claims

Act in Civil Health Care Matters." GAO is required to report on such compliance to the appropriate committees of Congress by April 1 of 2000, 2001, and 2002.

Effective Date. Enactment.

Title III — Provisions Relating to Parts A and B

Subtitle A — Home Health Services

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

Prior Law. Home health agencies are required to administer the Outcome and Assessment Information Set (OASIS), a data collection instrument which includes information regarding home health patient demographics, health history, living arrangements, supportive assistance, clinical situation, ability to carry out activities of daily living, medications, etc. The cost of a home health worker's time to collect these data are factored into the new home health PPS system.

BBRA 99. Home health agencies would receive a special payment of $10 per beneficiary for administration of the OASIS questionnaire for new home health patients for whom services are furnished during cost reporting periods in FY 2000. One-half of the payment is made in April 2000 and the remainder at cost report settlement. The GAO is required to study the cost of collecting OASIS data and to report to Congress by April 1, 2000.

Effective Date. Enactment.

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

Prior Law. The BBA 97 required that a PPS be implemented for home health care beginning in 1999. It required that the PPS be designed to reduce aggregate home health payments by 15% from what Medicare would have spent for home health care in that year had the PPS not been implemented; it specified that the 15% reduction was to go into effect even if the PPS were not ready for implementation in 1999. In P.L. 105-277 (the Omnibus Consolidated and Emergency Supplemental Appropriations Act for Fiscal Year 1999), Congress delayed implementation of the PPS until October 1, 2000, and moved the 15% reduction to coincide with commencement of the PPS.

BBRA 99. BBRA 99 postponed the 15% reduction to 12 months after implementation of the PPS.

Effective Date. Enactment.

Section 303. Increase in Per Beneficiary Limits

Prior Law. Under the home health care interim payment system established in BBA 97, aggregate payments to home health agencies were computed as the least of (a) reasonable costs, (b) payments based on per visit limits (applied in the aggregate), or (c) payments based on an average payment per beneficiary in FY1994, updated to the applicable year, with that amount multiplied by an agency's Medicare caseload in the applicable year (to achieve an aggregate payment limit).

BBRA 99. For cost reporting periods starting in FY2000, agency per beneficiary limits below the national median per beneficiary limit are increased by 2%. This increase is not included in the pre-PPS base to which PPS payment levels are benchmarked.

Effective Date. Enactment.

Section 304. Clarification of Surety Bond Requirements

Prior 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.

BBRA 99. Home health agencies are required to have a surety bond equal to the lesser of $50,000 or 10% of the agency's Medicare payments in the previous year. The bond must be in effect for 4 years, or longer if agency ownership changes; prior periods covered by a bond may be counted. Medicare and Medicaid surety bonds are to be coordinated.

Effective Date. Enactment.

Section 305. Refinement of Home Health Agency Consolidated Billing

Prior Law. Simultaneous with implementation of the home health PPS, home health agencies will be responsible for billing Medicare and paying all providers for goods, equipment, or services supplied to home health patients during an episode of care.

BBRA 99. Durable medical equipment (including oxygen and oxygen supplies), are excluded from the consolidated billing requirement.

Section 306. Technical Amendment Clarifying Applicable Market Basket Increase for PPS

This provision corrects drafting errors in the BBA 97.

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

Prior Law. All home health agencies are included in the home health PPS regardless of location.

BBRA 99. MedPCA is required to report to Congress within 2 years of enactment on the feasibility and advisability of exempting rural home health agencies, or service to individual residing in rural areas, from the home health PPS.

Effective Date. Enactment.

Subtitle B — Direct Graduate Medical Education

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

Prior Law. Medicare pays hospitals for its share of direct graduate medical education (DME) costs in approved programs using a count of the hospital's number of full-time equivalent residents and a hospital-specific historic cost per resident, updated for inflation.

BBRA 99. Medicare's methodology for calculating DME payments to teaching hospitals will incorporate a national average amount based on FY1997 hospital specific per resident amounts updated annually by the CPI-U. In FY2001, hospitals would receive no less than 70% of a geographically adjusted national average amount. Hospitals with per resident amounts above 140% of the geographically adjusted national average amount would have payments frozen at current levels for FY2001 and FY2002, and in FY2003-FY2005 they would receive an update equal to the Consumer Price Index (CPI) increase minus two percentage points. Hospitals with per resident amounts between 70% and 140% of the geographically adjusted national average would continue to receive payments based on their hospital-specific per resident amounts updated for inflation.

Effective Date. Enactment.

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

Prior Law. For the purposes of Medicare's reimbursement of graduate medical education, each full-time intern and resident is counted as 1.0 full-time equivalent (FTE) during their initial residency period. After the initial residency period, a full-time resident can be counted only as .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 AMA's Graduate Medical Education Directory. When there is a combined primary care and 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 1 additional year. However, when a combined program does not include primary care, the initial residency period is based on the minimum years to qualify for the longer of the composite programs.

BBRA 99. The period of initial residency counted by Medicare for individuals enrolled in child neurology training programs will be the period of initial residency for pediatrics plus 2 years. MedPAC is required to report to Congress on the appropriateness of extending this policy to other combined residencies by March 2001.

Effective Date. Enactment.

Subtitle C — Technical Corrections

Section 321. BBA Technical Corrections

This provision corrects drafting errors in the BBA 97.

Title IV — Rural Provider Provisions

Subtitle A — Rural Hospitals

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

Prior Law. Medicare's payments to an acute hospital will vary depending upon the geographic location of the hospital.

BBRA 99. The Secretary is required 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 most recent Goldsmith Modification, originally 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; (3) would otherwise qualify as a referral center or sole community hospital; (4) would meet other criteria as the Secretary specifies.

Effective Date. Enactment.

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

Prior Law. The Secretary is required 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 of 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.

BBRA 99. The existing criteria used to designate outlying rural counties as part of MSAs is updated.

Effective Date. Enactment.

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

Prior law. BBA 97 established the criteria for a small, rural, limited service hospital to be designated as a CAH. These hospitals are required to be a rural nonprofit or public hospital either located more that 35 miles away (or given geographic constraints, 15 miles away) from another hospital and certified by the state as a necessary provider. The CAHs provide 24-hour emergency services, have up to 15 acute care inpatient beds (or up to 25 beds if CAH is also a swing bed provider also offering nursing home care under Medicare or Medicaid) and have hospital stays of no more than 96 hours except under certain circumstances. For instance, a longer inpatient stay is permitted if inclement weather or other emergency circumstances prevent the transfer of a patient to another hospital; alternatively, a peer review organization or comparable entity may waive the 96-hour restriction on a case-by-case basis.

BBRA 99. The 96-hour length of stay limitation for CAHs is applied on an average annual basis rather than on a per case basis. Eligible for-profit hospitals, state-designated hospitals that have closed within the past 10 years, and downsized facilities that are state-licensed health centers or health clinics will be able to qualify as CAHs. CAHs will be able to elect payment methods for outpatient services. As drafted, CAHs will be reimbursed using the clinical diagnostic laboratory fee schedule, and Medicare beneficiaries may be liable for coinsurance for those services.

Effective Date. Enactment.

Section 404. 5-year Extension of Medicare Dependent Hospital (MDH) Program

Prior Law. MDHs are small rural hospitals that are not classified as sole community hospitals but that treat relatively high proportions of Medicare patients. From April 1, 1990, to April 1, 1993, MDHs had been reimbursed as sole community hospitals. This special payment status was phased out as of September 30, 1994. BBA 97 reinstated and extended the MDH classification, starting on October 1, 1997, through October, 2001.

BBRA 99. The Medicare Dependent Hospital program is extended through FY2006.

Effective Date. Enactment.

Section 405. Rebasing for Certain Sole Community Hospitals

Prior Law. Sole community hospitals (SCH) are paid based on whichever of the following target amounts yields the greatest Medicare reimbursement: (1) a hospital- specific amount based on its updated FY1982 costs; (2) a hospital-specific amount based on its updated FY1987 costs; or (3) the federal amount (which is the basis of the DRG payment calculation in a "typical" acute care hospital).

BBRA 99. As drafted, SCHs that are paid on the basis of either FY1982 or FY1987 hospital-specific amounts would be permitted to transition over time to Medicare payment based on their FY1996 costs.

Effective Date. Enactment.

Section 406. One Year Sole Community Hospital Payment Increase

Prior Law. SCHs are paid based on whichever of the following target amounts yields the greatest Medicare reimbursement: (1) a hospital-specific amount based on its updated FY1982 costs; (2) a hospital-specific amount based on its updated FY1987 costs; or (3) the federal amount. Each year these amounts are increased annually using an update factor which is determined in part by the projected increase in the hospital market basket index (MBI). BBA 97 included a 0% update for FY1998; the MBI minus 1.9 percentage points for FY1999; the MBI minus 1.8 percentage points for FY2000; the MBI minus 1.1 percentage points for FY2001 and FY2002; and for FY2003 and each subsequent year, the MBI percentage increase.

BBRA 99. A SCH's FY2000 target amount will be increased by the market basket for discharges occurring in FY2001.

Effective Date. Enactment.

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

Prior Law. BBA 97 limited the number of residents that a hospital may count for Medicare reimbursement of graduate medical education to the number of full time equivalent residents recognized by the hospital in its cost reporting period ending on or before December 31, 1996.

BBRA 99. A teaching hospital may increase the number of primary care residents that it counts in the "base year limit" by up to three full-time equivalent residents if those individuals were on maternity, disability, or a similar approved leave of absence. Hospitals located in rural areas are permitted to increase their resident limits by 30% for direct and indirect medical education payments. In addition, non-rural facilities that operate separately accredited rural training programs in rural areas, or that operate accredited training programs with integrated rural tracks, may receive direct graduate medical education and indirect medical education payments for cost reporting periods beginning on April 1, 2000, and for discharges occurring on or after April 1, 2000, respectively. The hospital that received residents who were transferred from a Veterans Affairs (VA) facility that lost its accreditation will not have those individuals count toward its resident cap.

Effective Date. Enactment.

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

Prior Law. In general, "swing beds" are inpatient hospital beds that may, under some circumstances, be used to provide skilled nursing facility-type of services like those Medicare covers for beneficiaries in skilled nursing facilities. Certain rural hospitals with fewer than 100 beds, and that have a certificate of need (CON) for such beds from the state health planning and development agency, may receive payment from Medicare for Medicare-covered services for beneficiaries who are swing bed patients and thus are no longer considered hospital inpatients and are not paid for under Medicare's inpatient rules. Restrictions apply to Medicare coverage of swing beds for inpatient hospitals with more than 49 (but less than 100) beds, including limitation to 5 working days for Medicare swing bed coverage if a skilled nursing facility bed (other than one affiliated with a hospital) becomes available in the area, unless a physician determines that transferring the patient would not be medically appropriate. A hospital may designate no more that 15% of its total bed days as swing beds.

BBRA 99. Hospitals with swing beds are no longer required to have a state-issued CON in order to operate a swing bed program with Medicare coverage, and restrictions on coverage for hospitals with 50 to 100 swing beds are removed, including the requirement for transfer of the patient to a freestanding skilled nursing facility after 5 days in a swing bed and the limitation on the number of swing beds to 15% of the hospital's bed days.

Effective Date. Effective on the first day after the end of the 3-year period during which Medicare payments to skilled nursing facilities changes to a federal per diem payment under the new SNF prospective payment system. In general, this effective date is the first cost

reporting period starting during or after July 2001, at which time Medicare will pay for swing bed care under the SNF prospective payment system.

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

Prior Law. BBA 97 replaced and modified the existing Essential Access Community Hospital (EACH) program with the Medicare Rural Flexibility Program. As part of this program, the Secretary was authorized to award grants to States that applied for grants for development or approval of a rural health plan, for purposes of engaging in activities related to planning and implementing a rural health care plan or rural health network, as well as for activities related to designating facilities as critical access hospitals.

BBRA 99. Rural hospitals with fewer than 50 beds may apply for grants not to exceed $50,000 to pay for data systems required to meet BBA 97 amendments, including the costs associated with purchase of computer software and hardware, education and training of hospital staff, and costs related to the implementation of PPS systems.

Effective Date. Enactment.

Section 410. GAO Study on Geographic Reclassification

Prior Law. No provision.

BBRA 99. GAO is required 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.

Effective Date. Enactment.

Subtitle B — Other Rural Provisions

Section 411. MedPAC Study of Rural Providers

Prior Law. No provision.

BBRA 99. MedPAC is required to conduct a study of rural providers. The report, which shall be submitted to Congress no later than 18 months of enactment, will evaluate the adequacy and appropriateness of the categories of special Medicare payments (and payment methodologies) for rural hospitals and address the impact of special payments on beneficiary access and quality of health services.

Effective Date. Enactment.

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

Prior Law. BBA 97 authorized Medicare coverage of advanced life support (ALS) services provided by a paramedic intercept service provider in a rural area when such service is medically necessary for the individual being transported and is provided under contract with one or more qualified volunteer ambulance services. The qualified volunteer ambulance service is certified, provides only basic life support services, and is prohibited by state law from

billing for any of these services. The entity supplying the advanced life support service is Medicare-certified and bills all recipients who receive ALS services, regardless of whether the recipients are Medicare-eligible.

BBRA 99. The coverage of medically necessary ALS services provided by a paramedic intercept service provider in a rural area is expanded to include areas 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 most recent Goldsmith Modification, originally published in the *Federal Register* on February 27, 1992).

Effective Date. Enactment.

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

Prior Law. BBA 97 authorized a telehealth demonstration project for beneficiaries with diabetes mellitus in medically under served rural or inner city areas.

BBRA 99. The Secretary is required to award funding for the diabetes mellitus telemedicine demonstration project no later than 3 months after enactment to the best technical proposal that had been submitted as of the bill's enactment date; the Secretary may not require additional review of the proposal or require resubmission of the proposal. Qualified medically under served areas are those that are federally designated as such at the time of a beneficiary's enrollment in this project. The project's data requirements are changed. Cost sharing requirements cannot be imposed on beneficiaries who enroll in the demonstration project.

Effective Date. Enactment.

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

Section 501. Changes in Medicare+Choice Enrollment Rules

Prior Law. Beneficiaries enrolled in an Medicare+Choice (M+C) plan that terminates its contract with HCFA are guaranteed access to certain Medicare supplemental insurance (i.e., Medigap) policies offered in their area of residence if they sign up within 63 days of their Medicare+Choice plan termination. (Terminations generally occur at the end of the year.)

There is an annual election period during November of each year for the following year when beneficiaries may enroll or disenroll from an M+C plan offered in their area. Currently, beneficiaries, at their option, may enroll or disenroll at any time during the year. Beginning in 2002, beneficiaries may change their election only once during the first 6 months of the year. In 2003 and subsequent years they can change elections only once during the first 3 months of the year. However, beginning in 2002, special election periods apply in case an M+C plan terminates coverage.

BBRA 99. The provision specifies that, if an M+C plan announces its intention to withdraw from the program, beneficiaries may elect to obtain a Medigap policy within 63 days of such notification (rather than within 63 days of the termination date). Coverage under Medigap becomes effective upon termination of coverage under the M+C plan. The provision also clarifies that the special election periods which begin in 2002 apply to announcements of impending terminations.

The provision further authorizes, after 2001, continuous open enrollment for institutionalized persons. Under this provision, individuals may enroll in a M+C plan or change their M+C plan enrollment.

Under certain conditions, a plan leaving an M+C payment area (typically a county) may choose to offer enrollees in that county the option of continuing enrollment in the plan if it is continuing as an M+C plan but in a different service area. The enrollees must agree to obtain all basic services (excluding emergency and urgently needed care) exclusively at facilities designated by the organization within the plan's service area. Further, at the time of the organization's decision to offer such coverage, there can be no other M+C plans in the enrollees' area.

Effective Date. Generally applies with respect to notices and elections made on or after enactment.

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

Prior Law. Changes in elections during continuous open enrollment periods were effective on the first day of the first calendar month following the election.

BBRA 99. If elections or changes in elections are made after the 10th day of the month, the effective date would be the second calendar month following the election.

Effective Date. January 1, 2000.

Section 503. Two-Year Extension of Medicare Cost Contracts

Prior Law. Prior to enactment of BBA 97, beneficiaries could enroll in health maintenance organizations with cost contracts as well as those with risk contracts. Under cost contracts, HMOs are paid on the basis of costs incurred in providing services. BBA 97 specified that cost contracts could not be renewed after December 31, 2002.

BBRA 99. The cost contract program is extended through 2004.

Effective Date. Enactment.

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

Section 511. Phase-In of New Risk Adjustment Methodology

Prior Law. 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 the Secretary of Health and Human Services (HHS) to develop and then implement a risk-adjustment payment methodology based on health status, effective January 1, 2000. The Secretary developed a method based on 15 principal inpatient diagnostic cost groups (PIP-DCGs), along with a phase-in schedule. The Secretary also plans to develop a new risk adjustment system for 2004 and beyond that would incorporate both inpatient and outpatient diagnosis.

BBRA 99. The phase-in schedule proposed by the Secretary of HHS is modified. In 2000 and 2001, 10% of payments will include risk adjustment for health-status and demographics and 90% will be based solely on demographic characteristics. In 2002, up to 20% of the payments will be adjusted under the new risk system, with the remainder of the payment based on adjustments for demographic characteristics. The BBRA provides for a Medicare Payment Advisory Commission (MedPAC) study and report on the new risk adjustment procedure, as well as a study and report by the Secretary of HHS regarding reporting of encounter data.

Effective Date. Enactment.

Section 512. Encourage Offering of M+C Plans in Areas Without Plans

Prior Law. An M+C plan receives the 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. These rates are subject to a budget neutrality provision.

BBRA 99. A bonus payment is established to encourage new M+C plans to enter counties that would otherwise not have a participating plan. The first plan to enter a previously unserved county (or an area where all organizations announced their withdrawal from the area as of October 13, 1999) will receive a 5% added payment during their first year and a 3% added payment during their second year. The bonus will be available to plans which are first offered during the 2-year period beginning on January 1, 2000.

Effective Date. Enactment.

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

Prior Law. The Secretary could not enter into an M+C contract if, within the preceding 5 years, that organization had an M+C contract which it did not renew. Exceptions could be made in circumstances which warrant special consideration, as determined by the Secretary. On October 6, 1999, the Secretary issued Operational Policy Letter #99.103. It specified that special services exceptions would generally be granted when: (1) the organization is proposing to introduce an M+C plan(s) in a geographic area(s) currently served by two or fewer M+C plans; (2) the organization is proposing to introduce M+C plans in counties other than the counties they had previously withdrawn from; or (3) the organization proposes to offer a different M+C plan type than they had previously offered (for example a preferred provider organization instead of an HMO).

BBRA 99. The provision reduces the general exclusion period to 2 years. A specific exception is authorized where, during a 6-month period beginning on the date the organization notifies the Secretary of its intent to terminate their M+C plan, there is a legislative change enacted (or a regulatory change adopted) that has the effect of increasing the payment rates for the area. The provision further specifies that nothing in this amendment is to be construed to affect the authority of the Secretary to provide for additional exceptions, including those provided in OPL99.103.

Effective Date. Applies to contract terminations occurring before, on, or after enactment.

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

Prior 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 used in adjusting those payments. The Secretary is not required to publish adjusted annual per capita cost (AAPCC) data.

BBRA 99. Beginning in 2001, the Secretary must provide county-level data for the original Medicare fee-for-service program under Parts A and B for each M+C payment area.

Effective Date. Enactment.

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

Prior Law. Premiums, benefits, and cost-sharing may not be segmented among individuals enrolled in the plan.

BBRA 99. Organizations may vary premiums, benefits, and cost-sharing across individuals enrolled in the plan, so long as these are uniform within segments of a service area. A segment is defined as one or more counties within the plan's service area.

Effective Date. Contract years beginning on or after January 1, 2001.

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

Prior Law. BBA 97 required M+C plans to submit adjusted community rate (ACR) proposals by May 1 of the previous calendar year.

BBRA 99. The deadline is changed to July 1.

Effective Date. The provision applies to information submitted by M+C organizations for years beginning with 1999.

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

Prior Law. The calculation of the national per capita M+C growth percentage included a negative adjustment of -0.5 percentage points annually from 1999-2002. The national per capita M+C growth percentage is used to calculate blended M+C payment rates and the floor payment rates.

BBRA 99. The adjustment for 2002 is -0.3 percentage points rather than -0.5 percentage points.

Effective Date. Enactment.

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

Prior 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 specified in law and regulations.

BBRA 99. The law requires the Secretary to recognize M+C accreditation standards relating to quality assurance, anti-discrimination, access to services, confidentiality and accuracy of enrollee records, information on advance directives, and provider participation rules.

Within 210 days of receiving an application from a private accrediting organization, the Secretary is required to determine whether such entity's accreditation process meets the requirements. The determination is to be made with respect to compliance with one or more of the specified standards as detailed in the application. Nothing in this section is to be

construed as limiting the Secretary's authority under Section 1857 (relating to contracts with M+C organizations) including the authority to terminate contracts.

Effective Date. Enactment.

Section 519. Timing of Medicare+Choice Health Information Fairs

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

BBRA 99. The campaign period is changed to the fall season.

Effective Date. Applies to campaigns conducted beginning in 2000.

Section 520. Quality Assurance Requirements for Preferred Provider Organization Plans

Prior Law. M+C plans may be coordinated care plans including HMOs, provider sponsored organizations, and preferred provider organizations (PPOs); they may also be private fee-for-service plans or medical savings accounts. The M+C program requires that participating plans maintain ongoing quality assurance programs. Quality assurance program requirements have been more extensive for coordinated care plans (which rely on a network of providers) than they are for private fee-for-service plans and medical savings accounts.

BBRA 99. PPOs are exempted from the requirements for a quality assurance program. A PPO plan is defined as an M+C plan that: (1) has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan; (2) provides for reimbursement for all covered benefits regardless of whether such benefits are provided within such network of providers; and (3) is offered by an organization that is not licensed or organized under state law as an HMO.

MedPAC is required to conduct a study on the appropriate quality improvement standards that should apply to each type of M+C plan (including each type of coordinated care plan) and the original fee-for-service program. The study is to examine the effects, costs, and feasibility of requiring entities, physicians, and other health care providers to comply with quality standards and related reporting requirements that are comparable to those applicable to M+C organizations. Within 2 years of enactment, MedPac is required to submit a report on the study, together with legislative recommendations, to the Congress.

Effective Date. The PPO exemption applies to contract years beginning on or after January 1, 2000. The MedPAC requirement is effective on enactment.

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

Prior Law. A hospital discharge planning evaluation must include an evaluation of a patient's need for appropriate post-hospital services including the availability of home health

services through individuals and entities that serve both the area where the patient resides and request to be listed by the hospital as available.

BBRA 99. The discharge planning process for beneficiaries enrolled in a M+C plan 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 providers of post-hospital services under the plan.

Effective Date. Enactment.

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

Prior Law. The Secretary is required to collect a user fee from each M+C organization for use in carrying out both the enrollment activities for the M+C program and the health insurance and counseling assistance program. The user fee has been equal to the organization's pro rata share of the aggregate amount of the fees collected from M+C organizations. Collection of fees was contingent on enactment of appropriations.

BBRA 99. An M+C organization's share of total user fees is the same proportion as their proportion of the total Medicare population; thus if a plan enrolls 1% of the Medicare population it would be responsible for 1% of the costs. Up to $100 million is authorized each year with the amount collected in user fees subtracted from the total. No further appropriation is required.

Effective Date. Applies to fees charged on or after January 1, 2001. The Secretary may not increase the fees for the 3-month period beginning October 1, 2000 over the level in effect for the preceding 9 months.

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

Prior Law. The law permits religious fraternal benefit societies to restrict enrollment in M+C plans to their members. This restriction has applied only to coordinated care plans.

BBRA 99. The authority is extended to all M+C plans.

Effective Date. Enactment.

Section 524. Rules Regarding Physician Referrals for Medicare+Choice Organizations

Prior Law. It is unlawful for physicians who bill Medicare to refer patients to certain entities if they have an ownership interest in or a compensation arrangement with the entity to which the patient is referred. An exception to this prohibition is authorized for referrals to certain specified health plans that agree to provide care on a prepaid basis.

BBRA 99. The exception is extended to M+C coordinated care plans.

Effective Date. Applies to services furnished on or after the date of enactment.

Subtitle C — Demonstration Projects and Special Medicare Populations

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

Prior Law. The Deficit Reduction Act of 1984 required the Secretary of HHS to grant 3-year waivers for demonstrations of SHMOs which provide integrated health and long-term care services on a prepaid capitation basis. The waivers have been extended on several occasions since then, and a second generation of projects was authorized by the Omnibus Budget Reconciliation Act of 1990. BBA 97 extended waivers for SHMOs through December 31, 2000, and expanded the number of persons who can be served per site to 36,000 (the prior limit was 12,000). The Secretary is required to submit to Congress by January 1, 999, a report with a plan for integration and transition of SHMOs into an option under Medicare+Choice.

BBRA 99. The provision extends the Medicare waivers for SHMOs until 18 months after the Secretary submits a report with a plan for integration and transition of SHMOs into an option under Medicare+Choice. It requires the Secretary to submit a final report 21 months after the integration and transition report. Six months after the Secretary's final report, MedPAC is required to submit a report with recommendations.

Effective Date. Enactment.

Section 532. Extension of Medicare Community Nursing Organization Demonstration Project

Prior Law. The Community Nursing Organization (CNO) demonstration project was established as a social experiment to evaluate the ability of community nursing organizations to deliver coordinated community nursing and ambulatory care services to Medicare Part B beneficiaries for fixed capitated payments. Originally authorized in OBRA 87, the project began operation in 1994 and was scheduled to operate in four sites through 1997.

BBRA 99. The CNO demonstration is extended for 2 years, but the total federal expenditures for it are required to be budget neutral; that is, the capitation payments must be set at a level such that the expenditures per beneficiary are the same as would be expended per beneficiary in regular Part B Medicare. The Secretary is required to report to Congress on the results of the demonstration by July 1, 2001.

Section 533. Medicare +Choice Competitive Bidding Demonstration Project

Prior 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 by BBA 97.

BBRA 99. The implementation of the Medicare+Choice Competitive Bidding Demonstration project is delayed until January 1, 2002, or, if later, 6 months after the Competitive Pricing Advisory Committee (CPAC) submits reports on (a) incorporating original fee-for-service Medicare into the demonstration; (b) quality assurance 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.

Effective Date. Enactment.

Section 534. Extension of Medicare Municipal Health Services Demonstration Projects

Prior Law. The municipal health services demonstration program is a multisite demonstration intended to improve access to primary care services in underserved urban areas and to reduce the cost of health care. BBA 97 authorized the Secretary to extend the project through December 31, 2000, but only with respect to persons who had received at least one service for the period January 1, 1996 - August 7, 1997 (enactment of BBA 97). Sites wishing the extension were required to submit plans for the orderly transition of participants to a non-demonstration health care delivery system.

BBRA 99. The project is extended through December 31, 2002.

Effective Date. Enactment.

Section 535. Medicare Coordinated Care Demonstration Project

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

BBRA 99. The law provides for the transfer of funds from the Medicare trust funds of such funds as are necessary to cover the costs of the project including the costs for information infrastructure and recurring costs of case management services, flexible benefits, and program management.

Effective Date. Enactment.

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

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

Prior Law. Medicare calculation of managed care rates includes the additional payments to teaching hospitals operating 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.

BBRA 99. Hospitals with approved nursing and allied health professional training programs would receive additional Medicare payments to reflect utilization of Medicare+Choice enrollees. In no case would the total payment under this section exceed $60 million.

Effective Date. Enactment.

Subtitle E — Studies and Reports

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

Prior Law. No provision.

BBRA 99. The Secretaries of HHS, DOD, and VA are required to submit to Congress a report no later than April 1, 2001, on the use of health services furnished by DOD and VA to Medicare beneficiaries, including both Medicare+Choice enrollees and Medicare fee-for-service beneficiaries.

Effective Date. Enactment.

Section 552. Medicare Payment Advisory Commission Studies and Reports

Prior Law. No provision.

BBRA 99. MedPAC is required to conduct a study on the development of a M+C payment methodology for the frail elderly enrolled under a special program for the frail elderly. The methodology is to: (1) account for the prevalence, mix, and severity of chronic conditions among these beneficiaries; (2) include medical diagnostic factors from all provider settings (including hospital and nursing facilty settings); and (3) include functional indicators of health status and such other factors as may be necessary to achieve appropriate payments for plans serving these beneficiaries. MedPac is required to submit a report on the study to Congress, within 1 year of enactment, together with any legislative recommendations deemed appropriate.

MedPAC is also required to submit a report to Congress, within 1 year of enactment, on specific legislative changes that should be made to make medical savings accounts a viable option under M+C.

Effective Dates. Enactment.

Section 553. GAO Studies, Audits, and Reports

Prior Law. No provision.

BBRA 99. GAO is required to conduct a study on the following issues related to Medigap policies: (1) the level of coverage provided by each type of policy; (2) the current

enrollment levels in each type of policy; (3) the availability of each type of policy to beneficiaries over age 65½; (4) the number and type of Medigap policies offered in each state; and (5) the average out-of-pocket costs (including premiums) per beneficiary under each type of Medigap policy. GAO is required to report to Congress, by July 31, 2001, on the study together with any legislative recommendation deemed appropriate.

Beginning in 2000, GAO is required to conduct an annual audit of the expenditures made by HHS during the preceding year in providing information on the M+C program to Medicare beneficiaries. GAO is to submit a report to Congress on the results of the audit for the preceding three years together with an evaluation of the effectiveness of the means used by the Secretary in providing the information. Reports on the audit are due not later than March 31 of 2001, 2004, 2007, and 2010.

Effective Date. Enactment.

Other Medicare-Related Provisions in P.L. 106-113

P.L. 106-113 included a few Medicare provisions which were not part of the Medicare section.

Section 211 of General Provisions in Title II, Department of Health and Human Services (HHS) (Medicare+Choice abortion language — No section title)

Prior Law. Medicare does not pay for abortions except in the case of rape or incest or where the life of the mother is in danger. The FY1999 appropriations language for HHS prohibited the Secretary from denying an eligible organization from participating in the M+C program because it has indicated it will not provide, pay for, or provide referrals for abortion services. Participating M+C organizations are responsible for informing enrollees where to obtain information about all covered Medicare services.

Section 211 of Title II of HHS. Section 211 includes similar language for FY2000.

Effective Date. Enactment.

Section 217 of General Provisions in Title II, HHS. Study and Report on the Geographic Adjustment Factors Under the Medicare Program

Prior Law. Payments for physicians' services are made on the basis of a fee schedule. The fee schedule assigns relative values to services. The relative values reflect physician work, practice expenses and malpractice costs. The relative values are adjusted for geographic variations in costs. The adjusted relative values are then converted into a dollar payment amount by a conversion factor.

Section 217 of Title II, HHS. The section requires the Secretary to conduct a study on the reasons why, and the appropriateness of the fact that the geographic adjustment factor is lower for physicians services provided in New Mexico than for such services provided in Arizona, Colorado and Texas. The study is also to consider the effect that the level of the geographic adjustment factor has on the recruitment and retention of physicians in small rural

states including New Mexico, Iowa, Louisiana, and Arkansas. The Secretary is required to report to Congress, within 3 months of enactment, on the study together with any recommendations for legislative changes determined appropriate.

Effective Date. Enactment.

Section 219 of General Provisions in Title II, HHS. (Medicare drug provision. No section title)

Prior Law. In general, Medicare does not cover outpatient prescription drugs. It does, however, cover drugs that can not be self-administered. On August 13, 1997, HCFA issued a memorandum to Medicare carriers stating that the inability to self-administer is to be based on the typical means of administration of the drug, not on the individual patient's ability to administer the drug.

Section 219 of Title II, HHS. The provision prohibits the use of any funds to carry out the transmittal or to promulgate any regulation or other transmittal or policy directive that has the effect of imposing (or clarifying the imposition of) a restriction on the coverage of injectable drugs beyond those applied on the day before issuance of the transmittal. The prohibition is effective for FY2000.

Effective Date. Enactment.