

106TH CONGRESS
1ST SESSION

S. 1582

To modify the provisions of the Balanced Budget Act of 1997 relating to the Medicare program under title XVIII of the Social Security Act.

IN THE SENATE OF THE UNITED STATES

SEPTEMBER 14, 1999

Mr. DURBIN introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To modify the provisions of the Balanced Budget Act of 1997 relating to the Medicare program under title XVIII of the Social Security Act.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECU-**
4 **RITY ACT; TABLE OF CONTENTS.**

5 (a) SHORT TITLE.—This Act may be cited as the
6 “Health Care Preservation Act of 1999”.

7 (b) AMENDMENTS TO SOCIAL SECURITY ACT.—Ex-
8 cept as otherwise specifically provided, whenever in this
9 Act an amendment is expressed in terms of an amendment
10 to or repeal of a section or other provision, the reference

1 shall be considered to be made to that section or other
 2 provision of the Social Security Act.

3 (c) TABLE OF CONTENTS.—The table of contents for
 4 this Act is as follows:

Sec. 1. Short title; amendments to Social Security Act; table of contents.

TITLE I—TEACHING HOSPITALS

Sec. 101. Termination of multiyear reduction of indirect graduate medical education payments.

Sec. 102. Exclusion of nursing and allied health education costs in calculating Medicare+Choice payment rate.

TITLE II—RURAL HOSPITALS

Sec. 201. Revision of criteria for designation as a critical access hospital.

Sec. 202. Authority to establish a prospective payment system for RHC services.

Sec. 203. Requirement to consider rural issues in establishing fee schedule for ambulance services.

Sec. 204. Stop-loss protection for rural hospital OPD services.

TITLE III—SAFETY NET PROVIDERS

Sec. 301. New prospective payment system for Federally-qualified health centers and rural health clinics under the Medicaid program.

Sec. 302. Carving out DSH payments from payments to Medicare+Choice organizations and paying the amounts directly to DSH hospitals enrolling Medicare+Choice enrollees.

Sec. 303. Limitation in reduction of payments to disproportionate share hospitals.

TITLE IV—OTHER HOSPITAL PROVISIONS

Sec. 401. Delay of financial limitation on rehabilitation services.

Sec. 402. Multiyear transition to prospective payment system for hospital outpatient department services.

TITLE V—SKILLED NURSING FACILITIES

Sec. 501. Modification of case mix categories for certain conditions.

Sec. 502. Exclusion of ambulance services to and from dialysis treatments and prosthetic services from the PPS for SNFs.

Sec. 503. Waiver of 3-day prior hospitalization requirement for coverage of skilled nursing facility services.

Sec. 504. Extension of certain Medicare community nursing organization demonstration projects.

TITLE VI—COST-EFFICIENT HOME HEALTH PROVIDERS

Sec. 601. Delay in contingency reduction.

Sec. 602. Elimination of 15-minute reporting requirement.

Sec. 603. Recoupment of overpayments.

Sec. 604. Increase in per visit limit.

TITLE VII—MEDICARE+CHOICE AND MEDIGAP PROTECTIONS
FOR SENIORS AND THE DISABLED

- Sec. 701. Two-year Medicare+Choice trial period.
 Sec. 702. Permitting enrollment in alternative plans upon receipt of notice of Medicare+Choice plan termination.
 Sec. 703. Guaranteed issuance of certain Medigap policies in cases of a substantial change in benefits under a Medicare+Choice plan.
 Sec. 704. Guaranteed issuance of certain Medigap policies to disabled Medicare+Choice disenrollees.
 Sec. 705. Issuance of same Medigap benefit package guaranteed for certain Medicare+Choice disenrollees.
 Sec. 706. Prohibition of attained-age rating of premiums for Medigap policies.

TITLE VIII—MEDICARE PRESERVATION THROUGH FRAUD
PREVENTION

- Sec. 801. Site inspections and background checks.
 Sec. 802. Registration of billing agencies.
 Sec. 803. Expanded access to the health integrity protection database (HIPDB).
 Sec. 804. Liability of Medicare carriers and fiscal intermediaries for claims submitted by excluded providers.
 Sec. 805. Community mental health centers.
 Sec. 806. Limiting the discharge of debts in bankruptcy proceedings in cases where a health care provider or a supplier engages in fraudulent activity.
 Sec. 807. Illegal distribution of a Medicare or Medicaid beneficiary identification or provider number.
 Sec. 808. Treatment of certain Social Security Act crimes as Federal health care offenses.
 Sec. 809. Authority of Office of Inspector General of the Department of Health and Human Services.
 Sec. 810. Universal product numbers on claims forms for reimbursement under the Medicare program.

1 TITLE I—TEACHING HOSPITALS

2 SEC. 101. TERMINATION OF MULTIYEAR REDUCTION OF IN-
3 DIRECT GRADUATE MEDICAL EDUCATION
4 PAYMENTS.

5 Section 1886(d)(5)(B)(ii) (42 U.S.C.
6 1395ww(d)(5)(B)(ii)) is amended—
7 (1) by adding “and” at the end of subclause
8 (II); and

1 (2) by striking subclauses (III), (IV), and (V)
2 and inserting the following:

3 “(III) on or after October 1,
4 1998, ‘c’ is equal to 1.6.”.

5 **SEC. 102. EXCLUSION OF NURSING AND ALLIED HEALTH**
6 **EDUCATION COSTS IN CALCULATING**
7 **MEDICARE+CHOICE PAYMENT RATE.**

8 (a) EXCLUDING COSTS IN CALCULATING PAYMENT
9 RATE.—

10 (1) IN GENERAL.—Section 1853(c)(3)(C)(i) (42
11 U.S.C. 1395w-23(c)(3)(C)(i)) is amended—

12 (A) by striking “and” at the end of sub-
13 clause (I);

14 (B) by striking the period at the end of
15 subclause (II) and inserting “, and”; and

16 (C) by adding at the end the following:

17 “(III) for costs attributable to
18 approved nursing and allied health
19 education programs under section
20 1861(v).”.

21 (2) EFFECTIVE DATE.—The amendments made
22 by paragraph (1) apply in determining the annual
23 per capita rate of payment for years beginning with
24 2001.

1 (b) PAYMENT TO HOSPITALS OF NURSING AND AL-
 2 LIED HEALTH EDUCATION PROGRAM COSTS FOR
 3 MEDICARE+CHOICE ENROLLEES.—Section 1861(v)(1) of
 4 such Act (42 U.S.C. 1395x(v)(1)) is amended by adding
 5 at the end the following:

6 “(V) In determining the amount of payment to a hos-
 7 pital for cost reporting periods (or portions thereof) occur-
 8 ring on or after January 1, 2001, with respect to the rea-
 9 sonable costs for approved nursing and allied health edu-
 10 cation programs, individuals who are enrolled with a
 11 Medicare+Choice organization under part C shall be
 12 treated as if they were not so enrolled.”

13 **TITLE II—RURAL HOSPITALS**

14 **SEC. 201. REVISION OF CRITERIA FOR DESIGNATION AS A** 15 **CRITICAL ACCESS HOSPITAL.**

16 (a) CONVERSION OF DOWNSIZED OR RECENTLY
 17 CLOSED HOSPITALS TO CRITICAL ACCESS HOSPITALS.—
 18 Section 1820(c)(2) (42 U.S.C. 1395i–4(c)(2)) is
 19 amended—

20 (1) in subparagraph (A), by striking “subpara-
 21 graph (B)” and inserting “subparagraphs (B), (C),
 22 (D), and (E)”; and

23 (2) by adding at the end the following:

1 “(C) RECENTLY CLOSED FACILITIES.—A
2 State may designate a facility as a critical ac-
3 cess hospital if the facility—

4 “(i) was a nonprofit or public hospital
5 that ceased operations within the 3-year
6 period ending on the date of enactment of
7 the Health Care Preservation Act of 1999;
8 and

9 “(ii) as of the effective date of such
10 designation, meets the criteria for designa-
11 tion under subparagraph (B).

12 “(D) DOWNSIZED FACILITIES.—A State
13 may designate a health clinic or a health center
14 (as defined by the State) as a critical access
15 hospital if such clinic or center—

16 “(i) is licensed by the State as a
17 health clinic or a health center if the State
18 requires such licensure in order to operate
19 as a health clinic or health center;

20 “(ii) was a nonprofit or public hos-
21 pital that was downsized to a health clinic
22 or health center; and

23 “(iii) as of the effective date of such
24 designation, meets the criteria for designa-
25 tion under subparagraph (B).

1 “(E) FEDERALLY-QUALIFIED HEALTH
2 CENTER.—A State may designate a Federally-
3 qualified health center (as defined in section
4 1905(l)(2)(B)) as a critical access hospital if
5 such center—

6 “(i) operates a laboratory that has in
7 effect a certificate issued under section
8 353 of the Public Health Service Act that
9 permits such laboratory to perform tests
10 categorized as high complexity;

11 “(ii) operates a radiology department;
12 and

13 “(iii) as of the effective date of such
14 designation, meets the criteria for designa-
15 tion under subparagraph (B).”.

16 (b) REVISION OF CRITERIA FOR DESIGNATION AS A
17 CRITICAL ACCESS HOSPITAL.—Section 1820(c)(2)(B)(iii)
18 (42 U.S.C. 1395i–4(c)(2)(B)(iii)) is amended by striking
19 “not to exceed 96 hours” and all that follows to the semi-
20 colon and inserting “not to exceed, on average, 96 hours
21 per patient”.

22 (c) EFFECTIVE DATE.—The amendments made by
23 this section take effect on the date of enactment of this
24 Act.

1 **SEC. 202. AUTHORITY TO ESTABLISH A PROSPECTIVE PAY-**
2 **MENT SYSTEM FOR RHC SERVICES.**

3 (a) ESTABLISHMENT OF SYSTEM.—Section 1833 (42
4 U.S.C. 1395l) is amended by adding at the end the fol-
5 lowing:

6 “(u) AUTHORITY TO ESTABLISH PROSPECTIVE PAY-
7 MENT SYSTEM FOR RURAL HEALTH CLINIC SERVICES.—

8 “(1) IN GENERAL.—Notwithstanding sub-
9 sections (a)(3) and (f), the Secretary may establish
10 by regulation a prospective payment system for rural
11 health clinic services (except for such services pro-
12 vided by a rural health clinic located in a rural hos-
13 pital with less than 50 beds).

14 “(2) BUDGET NEUTRAL PAYMENTS.—If the
15 Secretary establishes a prospective payment system
16 pursuant to paragraph (1), the Secretary shall es-
17 tablish the initial payment levels under such system
18 in a manner that results in aggregate payments (in-
19 cluding payments by individuals to whom services
20 are provided) for the first year, as estimated by the
21 Secretary, approximately equal to the aggregate pay-
22 ments that would have otherwise been made under
23 this part.”.

24 (b) CONFORMING AMENDMENTS.—

1 (1) PAYMENT.—Section 1833(a)(3) (42 U.S.C.
2 1395l(a)(3)) is amended by inserting “subject to
3 subsection (u),” before “in the case”.

4 (2) LIMITS.—Section 1833(f) (42 U.S.C.
5 1395l(f)) is amended by striking “In establishing”
6 and inserting “Subject to subsection (u), in estab-
7 lishing”.

8 (3) REQUIREMENT FOR RURAL HEALTH CLIN-
9 ICS.—Clause (ii) of the second sentence of section
10 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) is amended
11 by inserting “(and section 1833(u) if the Secretary
12 implements a prospective payment system under
13 that section)” after “section 1833”.

14 **SEC. 203. REQUIREMENT TO CONSIDER RURAL ISSUES IN**
15 **ESTABLISHING FEE SCHEDULE FOR AMBU-**
16 **LANCE SERVICES.**

17 (a) IN GENERAL.—Section 1834(l)(2)(C) (42 U.S.C.
18 1395m(l)(2)(C)) is amended by inserting “, including dif-
19 ferences in rural and non-rural areas” after “differences”.

20 (b) EFFECTIVE DATE.—The amendment made by
21 subsection (a) takes effect as if included in the enactment
22 of the Balanced Budget Act of 1997 (Public Law 105–
23 33; 111 Stat. 251).

1 **SEC. 204. STOP-LOSS PROTECTION FOR RURAL HOSPITAL**
 2 **OPD SERVICES.**

3 (a) IN GENERAL.—Section 1833(t)(10)(D)(i) (42
 4 U.S.C. 1395l(t)(10)(D)(i)) (as added by section 402) is
 5 amended by adding at the end the following:

6 “The applicable percentage shall be 100
 7 percent with respect to covered OPD serv-
 8 ices furnished during a transition year in
 9 a rural hospital.”.

10 (b) EFFECTIVE DATE.—The amendments made by
 11 subsection (a) take effect as if included in the amendments
 12 made by section 4523 of the Balanced Budget Act of 1997
 13 (Public Law 105–33; 111 Stat. 445).

14 **TITLE III—SAFETY NET**
 15 **PROVIDERS**

16 **SEC. 301. NEW PROSPECTIVE PAYMENT SYSTEM FOR FED-**
 17 **ERALLY-QUALIFIED HEALTH CENTERS AND**
 18 **RURAL HEALTH CLINICS UNDER THE MED-**
 19 **ICAID PROGRAM.**

20 (a) IN GENERAL.—Section 1902(a)(13) (42 U.S.C.
 21 1396a(a)(13)) is amended—

22 (1) in subparagraph (A), by adding “and” at
 23 the end;

24 (2) in subparagraph (B), by striking “and” at
 25 the end; and

26 (3) by striking subparagraph (C).

1 (b) NEW PROSPECTIVE PAYMENT SYSTEM.—Section
2 1902 (42 U.S.C. 1396a) is amended by adding at the end
3 the following:

4 “(aa) PAYMENT FOR SERVICES PROVIDED BY FED-
5 ERALLY-QUALIFIED HEALTH CENTERS AND RURAL
6 HEALTH CLINICS.—

7 “(1) IN GENERAL.—Beginning with fiscal year
8 2000 and each succeeding fiscal year, the State plan
9 shall provide for payment for services described in
10 section 1905(a)(2)(C) furnished by a Federally-
11 qualified health center and services described in sec-
12 tion 1905(a)(2)(B) furnished by a rural health clinic
13 in accordance with the provisions of this subsection.

14 “(2) FISCAL YEAR 2000.—For fiscal year 2000,
15 the State plan shall provide for payment for such
16 services in an amount (calculated on a per visit
17 basis) that is equal to 100 percent of the costs in-
18 curred by the center or clinic in furnishing such
19 services during fiscal year 1999 which are reason-
20 able and related to the cost of furnishing such serv-
21 ices, or based on such other tests of reasonableness
22 as the Secretary prescribes in regulations under sec-
23 tion 1833(a)(3), or in the case of services to which
24 such regulations do not apply, the same methodology
25 used under section 1833(a)(3), adjusted to take into

1 account any increase in the scope of such services
2 furnished by the center or clinic during fiscal year
3 2000.

4 “(3) FISCAL YEAR 2001 AND SUCCEEDING
5 YEARS.—For fiscal year 2001 and each succeeding
6 fiscal year, the State plan shall provide for payment
7 for such services in an amount (calculated on a per
8 visit basis) that is equal to the amount calculated for
9 such services under this subsection for the preceding
10 fiscal year—

11 “(A) increased by the percentage increase
12 in the MEI (Medicare economic index) (as de-
13 fined in section 1842(i)(3)) applicable to pri-
14 mary care services (as defined in section
15 1842(i)(4)) for that fiscal year; and

16 “(B) adjusted to take into account any in-
17 crease in the scope of such services furnished by
18 the center or clinic during that fiscal year.

19 “(4) ESTABLISHMENT OF INITIAL YEAR PAY-
20 MENT AMOUNT FOR NEW CENTERS OR CLINICS.—In
21 any case in which an entity first qualifies as a Fed-
22 erally-qualified health center or rural health clinic
23 after October 1, 2000, the State plan shall provide
24 for payment for services described in section
25 1905(a)(2)(C) furnished by the center or services

1 described in section 1905(a)(2)(B) furnished by the
2 clinic in the first fiscal year in which the center or
3 clinic qualifies in an amount (calculated on a per
4 visit basis) that is equal to 100 percent of the costs
5 of furnishing such services during such fiscal year in
6 accordance with the regulations and methodology re-
7 ferred to in paragraph (2). For each fiscal year fol-
8 lowing the fiscal year in which the entity first quali-
9 fies as a Federally-qualified health center or rural
10 health clinic, the State plan shall provide for the
11 payment amount to be calculated in accordance with
12 paragraph (3) of this subsection.

13 “(5) ADMINISTRATION IN THE CASE OF MAN-
14 AGED CARE.—In the case of services furnished by a
15 Federally-qualified health center or rural health clin-
16 ic pursuant to a contract between the center or clinic
17 and a managed care entity (as defined in section
18 1932(a)(1)(B)), the State plan shall provide for pay-
19 ment to the center or clinic (at least quarterly) by
20 the State of a supplemental payment equal to the
21 amount (if any) by which the amount determined
22 under paragraphs (2), (3), and (4) of this subsection
23 exceeds the amount of the payments provided under
24 the contract.

1 “(6) ALTERNATIVE PAYMENT SYSTEM.—Not-
2 withstanding any other provision of this section, the
3 State plan may provide for payment in any fiscal
4 year to a Federally-qualified health center (as de-
5 fined in section 1905(l)(2)(B)) for services described
6 in section 1905(a)(2)(C) or to a rural health clinic
7 for services described in section 1905(a)(2)(B) in an
8 amount that is in excess of the amount otherwise re-
9 quired to be paid to the center or clinic under this
10 subsection.”.

11 (c) CONFORMING AMENDMENTS.—

12 (1) Section 4712 of the Balanced Budget Act
13 of 1997 (Public Law 105–33; 111 Stat. 508) is
14 amended by striking subsection (c).

15 (2) Section 1915(b) (42 U.S.C. 1396n(b)) is
16 amended by striking “1902(a)(13)(E)” and insert-
17 ing “1902(aa)”.

18 (d) EFFECTIVE DATE.—The amendments made by
19 this section take effect on October 1, 1999.

1 **SEC. 302. CARVING OUT DSH PAYMENTS FROM PAYMENTS**
2 **TO MEDICARE+CHOICE ORGANIZATIONS AND**
3 **PAYING THE AMOUNTS DIRECTLY TO DSH**
4 **HOSPITALS ENROLLING MEDICARE+CHOICE**
5 **ENROLLEES.**

6 (a) IN GENERAL.—Section 1853(c)(3) (42 U.S.C.
7 1395w–23(c)(3)) is amended—

8 (1) in subparagraph (A), by striking “subpara-
9 graph (B)” and inserting “subparagraphs (B) and
10 (D)”;

11 (2) by redesignating subparagraph (D) as sub-
12 paragraph (E); and

13 (3) by inserting after subparagraph (C) the fol-
14 lowing:

15 “(D) REMOVAL OF PAYMENTS ATTRIB-
16 UTABLE TO DISPROPORTIONATE SHARE PAY-
17 MENTS FROM CALCULATION OF ADJUSTED AV-
18 ERAGE PER CAPITA COST.—

19 “(i) IN GENERAL.—In determining
20 the area-specific Medicare+Choice capita-
21 tion rate under subparagraph (A) for a
22 year (beginning with 2001), the annual per
23 capita rate of payment for 1997 deter-
24 mined under section 1876(a)(1)(C) shall be
25 adjusted, subject to clause (ii), to exclude
26 from the rate the additional payments that

1 the Secretary estimates were made during
2 1997 for additional payments described in
3 section 1886(d)(5)(F).

4 “(ii) TREATMENT OF PAYMENTS COV-
5 ERED UNDER STATE HOSPITAL REIM-
6 BURSEMENT SYSTEM.—To the extent that
7 the Secretary estimates that an annual per
8 capita rate of payment for 1997 described
9 in clause (i) reflects payments to hospitals
10 reimbursed under section 1814(b)(3), the
11 Secretary shall estimate a payment adjust-
12 ment that is comparable to the payment
13 adjustment that would have been made
14 under clause (i) if the hospitals had not
15 been reimbursed under such section.”.

16 (b) ADDITIONAL PAYMENTS FOR MANAGED CARE
17 ENROLLEES.—Section 1886(d)(5)(F) (42 U.S.C.
18 1395ww(d)(5)(F)) is amended—

19 (1) in clause (ii), by striking “clause (ix)” and
20 inserting “clauses (ix) and (x)”; and

21 (2) by adding at the end the following:

22 “(x)(I) For cost reporting periods (or portions there-
23 of) occurring on or after January 1, 2001, the Secretary
24 shall provide for an additional payment amount for each
25 applicable discharge of any subsection (d) hospital that is

1 a disproportionate share hospital (as described in clause
2 (i)).

3 “(II) For purposes of this clause, the term ‘applicable
4 discharge’ means the discharge of any individual who is
5 enrolled with a Medicare+Choice organization under part
6 C.

7 “(III) The amount of the payment under this clause
8 with respect to any applicable discharge shall be equal to
9 the estimated average per discharge amount (as deter-
10 mined by the Secretary) that would otherwise have been
11 paid under this subparagraph if the individual had not
12 been enrolled as described in subclause (II).

13 “(IV) The Secretary shall establish rules for an addi-
14 tional payment amount for any hospital reimbursed under
15 a reimbursement system authorized under section
16 1814(b)(3) if such hospital would qualify as a dispropor-
17 tionate share hospital under clause (i) were it not so reim-
18 bursed. Such payment shall be determined in the same
19 manner as the amount of payment is determined under
20 this clause for disproportionate share hospitals.”.

21 **SEC. 303. LIMITATION IN REDUCTION OF PAYMENTS TO**
22 **DISPROPORTIONATE SHARE HOSPITALS.**

23 (a) IN GENERAL.—Section 1886(d)(5)(F)(ix) (42
24 U.S.C. 1395ww(d)(5)(F)(ix)) is amended—

1 (1) in subclause (IV), by striking “4” and in-
 2 serting “3”; and

3 (2) in subclause (V), by striking “5” and in-
 4 serting “3”.

5 (b) EFFECTIVE DATE.—The amendment made by
 6 subsection (a) takes effect as if included in the amend-
 7 ments made by section 4403 of the Balanced Budget Act
 8 of 1997 (Public Law 105–33; 111 Stat. 398).

9 **TITLE IV—OTHER HOSPITAL**
 10 **PROVISIONS**

11 **SEC. 401. DELAY OF FINANCIAL LIMITATION ON REHABILI-**
 12 **TATION SERVICES.**

13 (a) IN GENERAL.—Section 1833(g) (42 U.S.C.
 14 1395l(g)) is amended by adding at the end the following:

15 “(4) Notwithstanding the preceding provisions of this
 16 subsection, for outpatient physical therapy services, out-
 17 patient occupational therapy services, and outpatient
 18 speech-language pathology services covered under this title
 19 and furnished on or after January 1, 2000, and before
 20 January 1, 2002, the Secretary shall implement a pay-
 21 ment methodology based on the classification of individ-
 22 uals by diagnostic category, functional status, and prior
 23 use of services in both inpatient and outpatient settings.”.

24 (b) BUDGET NEUTRALITY IN IMPLEMENTATION.—
 25 The payment methodology implemented under section

1 1833(g)(4) (42 U.S.C. 1395l(g)(4)), as added by sub-
 2 section (a), shall be designed so that the methodology, tak-
 3 ing into account the increased expenditures resulting from
 4 the implementation of such methodology, does not result
 5 in any increase or decrease in the expenditures under title
 6 XVIII of the Social Security Act on a fiscal year basis.

7 **SEC. 402. MULTIYEAR TRANSITION TO PROSPECTIVE PAY-**
 8 **MENT SYSTEM FOR HOSPITAL OUTPATIENT**
 9 **DEPARTMENT SERVICES.**

10 (a) IN GENERAL.—Section 1833(t) (42 U.S.C.
 11 1395l(t)) is amended by adding at the end the following:

12 “(10) MULTIYEAR TRANSITION.—

13 “(A) IN GENERAL.—In the case of covered
 14 OPD services furnished by a hospital during a
 15 transition year, the Secretary shall increase the
 16 payments for such services under the prospec-
 17 tive payment system established under this sub-
 18 section by the amount (if any) which the Sec-
 19 retary determines necessary to ensure that the
 20 payment to cost ratio of the hospital for the
 21 transition year equals a ratio equal to the appli-
 22 cable percentage of the payment to cost ratio of
 23 the hospital for 1996.

24 “(B) PAYMENT TO COST RATIO.—

1 “(i) IN GENERAL.—The payment to
2 cost ratio of a hospital for any year is the
3 ratio which—

4 “(I) the hospital’s reimbursement
5 under this title for covered OPD serv-
6 ices furnished during the year, includ-
7 ing through cost-sharing described in
8 subparagraph (D)(ii), bears to

9 “(II) the cost of such services.

10 “(ii) CALCULATION OF 1996 PAYMENT
11 TO COST RATIO.—The Secretary shall de-
12 termine each hospital’s payment to cost
13 ratio for 1996 as if the amendments made
14 to this title by the provisions of section
15 4521 of the Balanced Budget Act of 1997
16 were in effect in 1996.

17 “(iii) TRANSITION YEARS.—The Sec-
18 retary shall estimate each payment to cost
19 ratio of a hospital for any transition year
20 before the beginning of such year.

21 “(C) INTERIM PAYMENTS.—

22 “(i) IN GENERAL.—The Secretary
23 shall make interim payments to a hospital
24 during any transition year for which the

1 Secretary estimates a payment is required
2 under subparagraph (A).

3 “(ii) ADJUSTMENTS.—If the Secretary
4 makes payments under clause (i) for any
5 transition year, the Secretary shall make
6 retrospective adjustments to each hospital
7 based on its settled cost report so that the
8 amount of any additional payment to a
9 hospital for such year equals the amount
10 described in subparagraph (A).

11 “(D) DEFINITIONS.—In this paragraph:

12 “(i) APPLICABLE PERCENTAGE.—The
13 term ‘applicable percentage’ means, with
14 respect to covered OPD services furnished
15 during—

16 “(I) the first full year (and any
17 portion of the immediately preceding
18 year) for which the prospective pay-
19 ment system under this subsection is
20 in effect, 95 percent;

21 “(II) the second full calendar
22 year for which such system is in ef-
23 fect, 90 percent; and

1 “(III) the third full calendar year
2 for which such system is in effect, 85
3 percent.

4 “(ii) COST-SHARING.—The term ‘cost-
5 sharing’ includes—

6 “(I) copayment amounts de-
7 scribed in paragraph (5);

8 “(II) coinsurance described in
9 section 1866(a)(2)(A)(ii); and

10 “(III) the deductible described
11 under section 1833(b).

12 “(iii) TRANSITION YEAR.—The term
13 ‘transition year’ means any year (or por-
14 tion thereof) described in clause (i).

15 “(E) EFFECT ON COPAYMENTS.—Nothing
16 in this paragraph shall be construed as affect-
17 ing the unadjusted copayment amount de-
18 scribed in paragraph (3)(B).

19 “(F) APPLICATION WITHOUT REGARD TO
20 BUDGET NEUTRALITY.—The transitional pay-
21 ments made under this paragraph—

22 “(i) shall not be considered an adjust-
23 ment under paragraph (2)(E); and

24 “(ii) shall not be implemented in a
25 budget neutral manner.”.

1 (b) EFFECTIVE DATE.—The amendments made by
 2 this section take effect as if included in the amendments
 3 made by section 4523 of the Balanced Budget Act of 1997
 4 (Public Law 105–33; 111 Stat. 445).

5 **TITLE V—SKILLED NURSING**
 6 **FACILITIES**

7 **SEC. 501. MODIFICATION OF CASE MIX CATEGORIES FOR**
 8 **CERTAIN CONDITIONS.**

9 (a) IN GENERAL.—For purposes of applying any for-
 10 mula under paragraph (1) of section 1888(e) of the Social
 11 Security Act (42 U.S.C. 1395yy(e)), for services provided
 12 on or after October 1, 1999, and before the earlier of Oc-
 13 tober 1, 2001, or the date described in subsection (c), the
 14 Secretary of Health and Human Services shall increase
 15 the adjusted Federal per diem rate otherwise determined
 16 under paragraph (4) of such section for services provided
 17 to any individual during the period in which such indi-
 18 vidual is in a RUG III category by the applicable payment
 19 add-on as determined in accordance with the following
 20 table:

| RUG III category | Applicable payment add-on |
|-------------------------|----------------------------------|
| SE3 | \$75.87 |
| SE2 | \$65.70 |
| SE1 | \$58.46 |
| SSC | \$57.15 |
| SSB | \$54.52 |
| SSA | \$53.21 |
| CC2 | \$56.82 |
| CC1 | \$52.55 |
| CB2 | \$49.93 |
| CB1 | \$47.62 |

| RUG III category | Applicable payment add-on |
|-------------------------|----------------------------------|
| CA2 | \$47.30 |
| CA1 | \$44.67. |

1 (b) UPDATE.—The Secretary shall adjust the applica-
2 ble payment add-on under subsection (a) for fiscal year
3 2001 by the skilled nursing facility market basket percent-
4 age change (as defined under section 1888(e)(5)(B) of the
5 Social Security Act (42 U.S.C. 1395yy(e)(5)(B))) applica-
6 ble to such fiscal year.

7 (c) DATE DESCRIBED.—The date described in this
8 subsection is the date on which the Secretary of Health
9 and Human Services implements a case mix methodology
10 under section 1888(e)(4)(G)(i) of the Social Security Act
11 (42 U.S.C. 1395yy(e)(4)(G)(i)) that takes into account
12 adjustments for the provision of nontherapy ancillary serv-
13 ices and supplies such as drugs and respiratory therapy.

14 **SEC. 502. EXCLUSION OF AMBULANCE SERVICES TO AND**
15 **FROM DIALYSIS TREATMENTS AND PROS-**
16 **THETIC SERVICES FROM THE PPS FOR SNFs.**

17 (a) IN GENERAL.—The first sentence of section
18 1888(e)(2)(A)(ii) (42 U.S.C. 1395yy(e)(2)(A)(ii)) is
19 amended by inserting “ambulance services furnished an
20 individual in conjunction with a renal dialysis service,
21 prosthetic and orthotic devices, including testing, fitting,
22 or training in the use of prosthetic and orthotic devices,”
23 after “subparagraphs (F) and (O) of section 1861(s)(2),”.

1 (b) EFFECTIVE DATE.—The amendment made by
 2 this section applies to services furnished on or after the
 3 date of enactment of this Act.

4 **SEC. 503. WAIVER OF 3-DAY PRIOR HOSPITALIZATION RE-**
 5 **QUIREMENT FOR COVERAGE OF SKILLED**
 6 **NURSING FACILITY SERVICES.**

7 (a) IN GENERAL.—Not later than October 1, 2000,
 8 the Secretary of Health and Human Services (in this sec-
 9 tion referred to as the “Secretary”) shall provide for cov-
 10 erage under section 1812(f) of the Social Security Act (42
 11 U.S.C. 1395d(f)) of extended care services (as defined in
 12 section 1861(h) of such Act (42 U.S.C. 1395x(h))) for in-
 13 dividuals with a condition that is classifiable within a diag-
 14 nosis-related group identified under subsection (b).

15 (b) IDENTIFICATION OF DRGS.—For purposes of
 16 subsection (a) and subject to subsections (f) through (h),
 17 the diagnosis-related groups identified under this sub-
 18 section are—

19 (1) diagnosis-related group code 410 (relating
 20 to chemotherapy without acute leukemia as sec-
 21 ondary diagnosis); and

22 (2) the diagnosis-related groups described in
 23 subsections (c) through (e).

24 (c) IDENTIFICATION OF DRGS THROUGH A MEDI-
 25 CARE SELECT STUDY AND REPORT.—

1 (1) IN GENERAL.—The diagnosis related groups
2 described in this subsection are those diagnosis-re-
3 lated groups identified in the report submitted under
4 paragraph (3) and determined to reduce the total of
5 payments made under the Medicare program under
6 title XVIII of the Social Security Act (42 U.S.C.
7 1395 et seq.) (in this section referred to as the
8 “Medicare program”).

9 (2) STUDY.—

10 (A) IN GENERAL.—The Secretary shall
11 conduct a study of extended care services pro-
12 vided in skilled nursing facilities for which cov-
13 erage is provided under the Medicare select pro-
14 gram under section 1882(t) of the Social Secu-
15 rity Act (42 U.S.C. 1395ss(t)) to obtain data
16 concerning—

17 (i) the length of stay of individuals in
18 hospitals; and

19 (ii) extended care services provided to
20 individuals in skilled nursing facilities.

21 (B) DRGS IDENTIFIED.—The study con-
22 ducted under subparagraph (A) shall include
23 the identification of those diagnosis-related
24 groups that are generally treated with less than
25 a 3-day hospital stay under such program.

1 (3) REPORT.—Not later than January 1, 2001,
2 the Secretary shall submit to the appropriate com-
3 mittees of Congress a report on the study conducted
4 under paragraph (2) that shall include—

5 (A) a description of each diagnosis-related
6 group identified under subparagraph (B) of
7 such paragraph; and

8 (B) a determination as to whether waiving
9 the 3-day hospitalization stay requirement with
10 respect to each diagnosis-related group would
11 reduce the total of payments made under the
12 Medicare program.

13 (d) IDENTIFICATION OF DRGs THROUGH DEM-
14 ONSTRATION PROGRAMS.—

15 (1) IN GENERAL.—The diagnosis related groups
16 described in this subsection are those diagnosis-re-
17 lated groups identified in the report submitted under
18 paragraph (3) and determined to reduce the total of
19 payments made under the Medicare program.

20 (2) DEMONSTRATION PROGRAMS.—

21 (A) ESTABLISHMENT.—The Secretary
22 shall—

23 (i) establish demonstration programs
24 under which the Secretary provides for
25 coverage under section 1812(f) of the So-

1 cial Security Act (42 U.S.C. 1395d(f)) of
2 extended care services for individuals with
3 a condition that is classifiable within a di-
4 agnosis-related group identified by the Sec-
5 retary under subparagraph (B) in the geo-
6 graphic areas selected under subparagraph
7 (C); and

8 (ii) collect the data described in sub-
9 paragraph (D).

10 (B) DRGS IDENTIFIED.—The Secretary
11 shall identify those diagnosis-related groups for
12 which waiver of the 3-day hospitalization stay
13 requirement is likely to reduce the total of pay-
14 ments made under the Medicare program.

15 (C) SELECTION OF GEOGRAPHIC AREAS.—
16 The geographic areas selected under this sub-
17 paragraph are those geographic areas that the
18 Secretary expects—

19 (i) to maximize the provision of appro-
20 priate statistically relevant data on the
21 cost of—

22 (I) extended care services pro-
23 vided in skilled nursing facilities; and

24 (II) inpatient hospital services
25 (as defined in section 1861(b) of the

1 Social Security Act (42 U.S.C.
2 1395x(b)); and

3 (ii) to minimize regional differences in
4 the practice of medicine.

5 (D) COLLECTION OF DATA.—The Sec-
6 retary shall collect appropriate statistically rel-
7 evant data on the cost of extended care services
8 and inpatient hospital services provided—

9 (i) in the geographic areas selected
10 under subparagraph (C)—

11 (I) before the implementation of
12 the demonstration programs under
13 this subsection; and

14 (II) after the implementation of
15 such programs; and

16 (ii) in the geographic areas not se-
17 lected under such subparagraph for the pe-
18 riods described in subclauses (I) and (II)
19 of clause (i).

20 (3) REPORT.—

21 (A) IN GENERAL.—Not later than January
22 1, 2002, the Secretary shall submit to the ap-
23 propriate committees of Congress a report—

24 (i) on the demonstration programs
25 conducted under paragraph (2); and

1 (ii) comparing the effect of the waiver
2 of 3-day prior hospitalization requirement
3 for coverage of extended care services—

4 (I) among geographic areas; and

5 (II) before and after the imple-
6 mentation of the programs established
7 under paragraph (2).

8 (B) CONTENTS.—The report submitted
9 under subparagraph (A) shall contain—

10 (i) a description of each diagnosis-re-
11 lated group for which a demonstration pro-
12 gram is implemented under paragraph (2);
13 and

14 (ii) a determination as to whether
15 waiving the 3-day hospitalization stay re-
16 quirement with respect to each diagnosis-
17 related group would reduce the total of
18 payments made under the Medicare pro-
19 gram.

20 (C) CONSIDERATION OF DATA.—In pre-
21 paring such report, the Secretary shall consider
22 the data collected under paragraph (2)(D).

23 (e) IDENTIFICATION OF ADDITIONAL DRGs.—The
24 diagnosis related groups described in this subsection are
25 those diagnosis-related groups not otherwise identified

1 under this section that the Secretary determines would re-
2 duce the total of payments made under the Medicare pro-
3 gram if such diagnosis-related group were identified under
4 subsection (b).

5 (f) REQUIREMENT OF HOSPITAL DEDUCTIBLES AND
6 COINSURANCE.—

7 (1) IN GENERAL.—For purposes of this section,
8 when the requirement for a 3-day hospitalization
9 stay has been waived under this section, the Sec-
10 retary shall require the application of any
11 deductibles and coinsurance under section 1813 of
12 the Social Security Act (42 U.S.C. 1395e) beginning
13 with the first day of extended care services provided
14 in a skilled nursing facility.

15 (2) REDUCTION OF AMOUNT.—The Secretary
16 shall reduce the amount of any deductible or coin-
17 surance applied under this subsection based on the
18 best estimate of the Secretary of the difference be-
19 tween the average cost of hospital inpatient services
20 for the individual involved and the average cost of
21 services provided to that individual in a skilled nurs-
22 ing facility.

23 (g) RECOVERY OF INCREASED PAYMENTS.—If the
24 Secretary determines that the application of this section
25 in a fiscal year has resulted in any increase in the total

1 of payments made under the Medicare program for the
2 fiscal year above the total of such payments that would
3 have been made in the fiscal year if this section did not
4 apply (taking into account any reduction in the total of
5 payments made under such program as a result of the
6 elimination of or a reduction in the length of hospitaliza-
7 tion), the Secretary—

8 (1) shall, notwithstanding any other provision
9 of law, provide for a reduction in the amounts other-
10 wise payable under part A of such title (42 U.S.C.
11 1395 et seq.) for post-hospital extended care services
12 (as defined in section 1861(i) of the Social Security
13 Act (42 U.S.C. 1395x(i))) in the following fiscal
14 year by such proportion as will reduce the total of
15 payments made in such fiscal year under such part
16 by the total amount of such an increase in the pre-
17 vious fiscal year; and

18 (2) may rescind the selection of any diagnosis-
19 related group identified under subsection (b) if the
20 application of this section with respect to such group
21 has resulted in an increase in the total of payments
22 made under the Medicare program.

23 (h) SPECIAL RULE FOR DUAL ELIGIBLES.—In the
24 case of an individual eligible for assistance for nursing fa-
25 cility services under title XIX of the Social Security Act

1 (42 U.S.C. 1396 et seq.), the provisions of such title shall
 2 apply as if this section had not been enacted.

3 **SEC. 504. EXTENSION OF CERTAIN MEDICARE COMMUNITY**
 4 **NURSING ORGANIZATION DEMONSTRATION**
 5 **PROJECTS.**

6 Notwithstanding any other provision of law, dem-
 7 onstration projects conducted under section 4079 of the
 8 Omnibus Budget Reconciliation Act of 1987 may be con-
 9 ducted for an additional period of 5 years, and the dead-
 10 line for any report required relating to the results of such
 11 projects shall be not later than 6 months before the end
 12 of such additional period.

13 **TITLE VI—COST-EFFICIENT**
 14 **HOME HEALTH PROVIDERS**

15 **SEC. 601. DELAY IN CONTINGENCY REDUCTION.**

16 (a) IN GENERAL.—Section 4603(e) of the Balanced
 17 Budget Act of 1997 (42 U.S.C. 1395fff note), as amended
 18 by section 5101(c)(3) of the Tax and Trade Relief Exten-
 19 sion Act of 1998 (contained in division J of Public Law
 20 105–277), is amended—

21 (1) by striking “described in subsection (d),”
 22 and inserting “beginning on or after September 30,
 23 2001”; and

24 (2) by striking “September 30, 2000” and in-
 25 serting “September 30, 2001”.

1 (b) EFFECTIVE DATE.—The amendments made by
2 this section take effect as if included in the enactment of
3 the Balanced Budget Act of 1997 (Public Law 105–33;
4 111 Stat. 251).

5 **SEC. 602. ELIMINATION OF 15-MINUTE REPORTING RE-**
6 **QUIREMENT.**

7 (a) IN GENERAL.—Section 1895(c)(2) (42 U.S.C.
8 1395fff(c)(2)) is amended by striking “, as measured in
9 15 minute increments”.

10 (b) EFFECTIVE DATE.—The amendment made by
11 subsection (a) takes effect as if included in the amend-
12 ments made by section 4603 of the Balanced Budget Act
13 of 1997 (Public Law 105–33; 111 Stat. 467).

14 **SEC. 603. RECOUPMENT OF OVERPAYMENTS.**

15 (a) 36-MONTH REPAYMENT PERIOD.—

16 (1) IN GENERAL.—Except as provided in para-
17 graph (2), in the case of an overpayment by the Sec-
18 retary of Health and Human Services to a home
19 health agency for home health services furnished
20 during a cost reporting period beginning on or after
21 October 1, 1997, as a result of payment limitations
22 provided for under clause (v), (vi), or (viii) of section
23 1861(v)(1)(L) of the Social Security Act (42 U.S.C.
24 1395x(v)(1)(L)), the home health agency may elect
25 to repay the amount of such overpayment over a 36-

1 month period beginning on the date of notification
2 of such overpayment.

3 (2) EXCEPTION.—No home health agency may
4 make an election under paragraph (1) if any final
5 adverse action (as defined in section 1128E(g)(1) of
6 such Act (42 U.S.C. 1320a–7e(g)(1))) has been
7 taken against such agency.

8 (b) NO INTEREST ON OVERPAYMENT AMOUNTS.—In
9 the case of an agency that makes an election under sub-
10 section (a), no interest shall accrue on the outstanding
11 balance of the amount of overpayment during such 36-
12 month period.

13 (c) TERMINATION.—No election under subsection (a)
14 may be made for cost reporting periods (or portions there-
15 of) beginning on or after the date of implementation of
16 the prospective payment system for home health services
17 under section 1895 of the Social Security Act (42 U.S.C.
18 1395fff).

19 (d) EFFECTIVE DATE.—The provisions of subsection
20 (a) take effect as if included in the enactment of the Bal-
21 anced Budget Act of 1997 (Public Law 105–33; 111 Stat.
22 251).

23 **SEC. 604. INCREASE IN PER VISIT LIMIT.**

24 Section 1861(v)(1)(L)(i) (42 U.S.C.
25 1395x(v)(1)(L)(i)), as amended by section 5101(b) of the

1 Tax and Trade Relief Extension Act of 1998 (contained
2 in division J of Public Law 105–277), is amended—

3 (1) in subclause (IV), by striking “or”;

4 (2) in subclause (V)—

5 (A) by inserting “and before October 1,
6 1999,” after “October 1, 1998,”; and

7 (B) by striking the period and inserting “,
8 or”; and

9 (3) by adding at the end the following:

10 “(VI) October 1, 1999, 112 percent of such me-
11 dian.”.

12 **TITLE VII—MEDICARE+CHOICE**
13 **AND MEDIGAP PROTECTIONS**
14 **FOR SENIORS AND THE DIS-**
15 **ABLED**

16 **SEC. 701. TWO-YEAR MEDICARE+CHOICE TRIAL PERIOD.**

17 (a) IN GENERAL.—Section 1882(s)(3)(B) (42 U.S.C.
18 1395ss(s)(3)(B)) is amended—

19 (1) in clause (v)(III), by striking “12” and in-
20 serting “24”; and

21 (2) in clause (vi), by striking “12” and insert-
22 ing “24”.

23 (b) EFFECTIVE DATE.—The amendment made by
24 subsection (a) applies to terminations and

1 discontinuations occurring on or after the date of enact-
2 ment of this Act.

3 **SEC. 702. PERMITTING ENROLLMENT IN ALTERNATIVE**
4 **PLANS UPON RECEIPT OF NOTICE OF**
5 **MEDICARE+CHOICE PLAN TERMINATION.**

6 (a) **MEDICARE+CHOICE PLANS.**—Section 1851(e)(4)
7 (42 U.S.C. 1395w–21(e)(4)) is amended by striking sub-
8 paragraph (A) and inserting the following:

9 “(A)(i) the certification of the organization
10 or plan under this part has been terminated, or
11 the organization or plan has notified the indi-
12 vidual of an impending termination of such cer-
13 tification; or

14 “(ii) the organization has terminated or
15 otherwise discontinued providing the plan in the
16 area in which the individual resides, or has no-
17 tified the individual of an impending termi-
18 nation or discontinuation of such plan;”.

19 (b) **MEDIGAP PLANS.**—

20 (1) **IN GENERAL.**—Section 1882(s)(3)(A) (42
21 U.S.C. 1395ss(s)(3)(A)) is amended in the matter
22 following clause (iii)—

23 (A) by inserting “(92 days in the case of
24 a termination or discontinuation of coverage

1 under the types of circumstances described in
 2 section 1851(e)(4)(A))” after “63 days”;

3 (B) by inserting “(or, if elected by the in-
 4 dividual, the date of notification of the indi-
 5 vidual by the plan or organization of the im-
 6 pending termination or discontinuance of the
 7 plan in the area in which the individual re-
 8 sides)” after “the date of the termination of en-
 9 rollment described in such subparagraph”; and

10 (C) by inserting “(or date of such notifica-
 11 tion)” after “the date of termination or
 12 disenrollment”.

13 (2) EFFECTIVE DATE.—The amendments made
 14 by this subsection apply to notices of intended termi-
 15 nation made by group health plans and
 16 Medicare+Choice organizations after the date of en-
 17 actment of this Act.

18 **SEC. 703. GUARANTEED ISSUANCE OF CERTAIN MEDIGAP**
 19 **POLICIES IN CASES OF A SUBSTANTIAL**
 20 **CHANGE IN BENEFITS UNDER A**
 21 **MEDICARE+CHOICE PLAN.**

22 (a) IN GENERAL.—Section 1851(e)(4)(C) (42 U.S.C.
 23 1395w-21(e)(4)(C)) is amended—

24 (1) in clause (i), by striking “or” at the end;
 25 and

1 (2) by adding at the end the following:

2 “(iii) the organization offering the
3 plan substantially changed the benefits of-
4 fered under the plan in which the indi-
5 vidual enrolled; or”.

6 (b) EFFECTIVE DATE.—The amendment made by
7 subsection (a) applies to terminations and
8 discontinuations occurring on or after the date of enact-
9 ment of this Act.

10 **SEC. 704. GUARANTEED ISSUANCE OF CERTAIN MEDIGAP**
11 **POLICIES TO DISABLED MEDICARE+CHOICE**
12 **DISENROLLEES.**

13 (a) IN GENERAL.—Section 1882(s)(3)(C) (42 U.S.C.
14 1395ss(s)(3)(C)) is amended by adding at the end the fol-
15 lowing:

16 “(E) For purposes of this paragraph, in the case of
17 an individual otherwise described in subparagraph (B)(v)
18 except that such individual is under age 65, such indi-
19 vidual shall be deemed to be an individual described in
20 such subparagraph”.

21 (b) EFFECTIVE DATE.—The amendment made by
22 subsection (a) applies to terminations and
23 discontinuations occurring on or after the date of enact-
24 ment of this Act.

1 **SEC. 705. ISSUANCE OF SAME MEDIGAP BENEFIT PACKAGE**
2 **GUARANTEED FOR CERTAIN**
3 **MEDICARE+CHOICE DISENROLLEES.**

4 (a) **IN GENERAL.**—Section 1882(s)(3)(C)(ii) (42
5 U.S.C. 1395ss(s)(3)(C)(ii)) is amended by striking “, if
6 available from the same issuer, or, if not so available,”
7 and inserting “or, if not available,”.

8 (b) **EFFECTIVE DATE.**—The amendment made by
9 subsection (a) applies to terminations and
10 discontinuations occurring on or after the date of enact-
11 ment of this Act.

12 **SEC. 706. PROHIBITION OF ATTAINED-AGE RATING OF PRE-**
13 **MIUMS FOR MEDIGAP POLICIES.**

14 Section 1882 (42 U.S.C. 1395ss) is amended by add-
15 ing at the end the following:

16 “(v)(1) A Medicare supplemental policy may not be
17 issued or renewed (or otherwise provide coverage after the
18 deadline established under paragraph (2)) in any State
19 unless the premiums for the policy do not increase for an
20 individual under the policy based on the aging of the indi-
21 vidual.

22 “(2) The requirement of paragraph (1) shall apply
23 to premiums for policies under a timetable, recognized by
24 the Secretary, that provides for an appropriate phase-in
25 of such requirement. The Secretary shall recognize as the
26 timetable such timetable as the National Association of

1 Insurance Commissioners may recommend to the Sec-
 2 retary within 9 months after the date of enactment of this
 3 subsection.”.

4 **TITLE VIII—MEDICARE PRESER-**
 5 **VATION THROUGH FRAUD**
 6 **PREVENTION**

7 **SEC. 801. SITE INSPECTIONS AND BACKGROUND CHECKS.**

8 (a) SITE INSPECTIONS FOR DME SUPPLIERS, COM-
 9 MUNITY MENTAL HEALTH CENTERS, AND OTHER PRO-
 10 VIDER GROUPS.—Title XVIII (42 U.S.C. 1395 et seq.) is
 11 amended by adding at the end the following:

12 “SITE INSPECTIONS FOR DME SUPPLIERS, COMMUNITY
 13 MENTAL HEALTH CENTERS, AND OTHER PROVIDER
 14 GROUPS

15 “SEC. 1897. (a) SITE INSPECTIONS.—

16 “(1) IN GENERAL.—The Secretary shall con-
 17 duct a site inspection for each applicable provider
 18 (as defined in paragraph (2)) that applies for a pro-
 19 vider number in order to provide items or services
 20 under this title. Such site inspection shall be in addi-
 21 tion to any other site inspection that the Secretary
 22 would otherwise conduct with regard to an applica-
 23 ble provider.

24 “(2) APPLICABLE PROVIDER DEFINED.—

1 “(A) IN GENERAL.—Except as provided in
2 subparagraph (B), in this section, the term ‘ap-
3 plicable provider’ means—

4 “(i) a supplier of durable medical
5 equipment (including items described in
6 section 1834(a)(13));

7 “(ii) a supplier of prosthetics,
8 orthotics, or supplies (including items de-
9 scribed in paragraphs (8) and (9) of sec-
10 tion 1861(s));

11 “(iii) a community mental health cen-
12 ter; or

13 “(iv) any other provider group, as de-
14 termined by the Secretary.

15 “(B) EXCEPTION.—In this section, the
16 term ‘applicable provider’ does not include—

17 “(i) a physician that provides durable
18 medical equipment (as so described) or
19 prosthetics, orthotics, or supplies (as so de-
20 scribed) to an individual as incident to an
21 office visit by such individual; or

22 “(ii) a hospital that provides durable
23 medical equipment (as described in sub-
24 paragraph (A)(i)) or prosthetics, orthotics,
25 or supplies (as described in subparagraph

1 (A)(ii) to an individual as incident to an
2 emergency room visit by such individual.

3 “(b) STANDARDS AND REQUIREMENTS.—In con-
4 ducting the site inspection pursuant to subsection (a), the
5 Secretary shall ensure that the site being inspected is in
6 full compliance with all the conditions and standards of
7 participation and requirements for obtaining Medicare
8 billing privileges under this title.

9 “(c) TIME.—The Secretary shall conduct the site in-
10 spection for an applicable provider prior to the issuance
11 of a provider number to such provider.

12 “(d) TIMELY REVIEW.—The Secretary shall provide
13 for procedures to ensure that the site inspection required
14 under this section does not unreasonably delay the
15 issuance of a provider number to an applicable provider.”.

16 (b) BACKGROUND CHECKS.—Title XVIII (42 U.S.C.
17 1395 et seq.) (as amended by subsection (a)) is amended
18 by adding at the end the following:

19 “BACKGROUND CHECKS

20 “SEC. 1898. (a) BACKGROUND CHECK REQUIRED.—
21 Except as provided in subsection (b), the Secretary shall
22 conduct a background check on any individual or entity
23 that applies to the Secretary for a provider number for
24 the purpose of furnishing any item or service under this
25 title. In performing the background check, the Secretary
26 shall—

1 “(1) conduct the background check before
2 issuing a provider number to an individual or entity;

3 “(2) include a search of criminal records in the
4 background check; and

5 “(3) provide for procedures that ensure the
6 background check does not unreasonably delay the
7 issuance of a provider number to an eligible indi-
8 vidual or entity.

9 “(b) USE OF STATE LICENSING PROCEDURE.—The
10 Secretary may use the results of a State licensing proce-
11 dure as a background check under subsection (a) if the
12 State licensing procedure meets the requirements of sub-
13 section (a).

14 “(c) ATTORNEY GENERAL REQUIRED TO PROVIDE
15 INFORMATION.—

16 “(1) IN GENERAL.—Upon request of the Sec-
17 retary, the Attorney General shall provide the crimi-
18 nal background check information referred to in sub-
19 section (a)(2) to the Secretary.

20 “(2) RESTRICTION ON USE OF DISCLOSED IN-
21 FORMATION.—The Secretary may only use the infor-
22 mation disclosed under subsection (a) for the pur-
23 pose of carrying out the Secretary’s responsibilities
24 under this title.

25 “(d) REFUSAL TO ISSUE PROVIDER NUMBER.—

1 “(1) AUTHORITY.—In addition to any other
2 remedy available to the Secretary, the Secretary may
3 refuse to issue a provider number to an individual
4 or entity if the Secretary determines, after a back-
5 ground check conducted under this section, that
6 such individual or entity has a history of acts that
7 indicate issuance of a provider number to such indi-
8 vidual or entity would be detrimental to the best in-
9 terests of the program or program beneficiaries.
10 Such acts may include, but are not limited to—

11 “(A) any bankruptcy;

12 “(B) any act resulting in a civil judgment
13 against such individual or entity; or

14 “(C) any felony conviction under Federal
15 or State law.

16 “(2) REPORTING OF REFUSAL TO ISSUE PRO-
17 VIDER NUMBER TO THE HEALTH INTEGRITY PRO-
18 TECTION DATABASE (HIPDB).—A determination to
19 refuse to issue a provider number to an individual
20 or entity as a result of a background check con-
21 ducted under this section shall be reported to the
22 health integrity protection database established
23 under section 1128E in accordance with the proce-
24 dures for reporting final adverse actions taken

1 against a health care provider, supplier, or practi-
2 tioner under that section.”.

3 (c) REGULATIONS; EFFECTIVE DATE.—

4 (1) REGULATIONS.—Not later than 1 year after
5 the date of enactment of this Act, the Secretary of
6 Health and Human Services shall promulgate such
7 regulations as are necessary to implement the
8 amendments made by subsections (a) and (b).

9 (2) EFFECTIVE DATE.—The amendments made
10 by subsections (a) and (b) apply to applications re-
11 ceived by the Secretary of Health and Human Serv-
12 ices on or after January 1, 2000.

13 (d) USE OF MEDICARE INTEGRITY PROGRAM
14 FUNDS.—The Secretary of Health and Human Services
15 may use funds appropriated or transferred for purposes
16 of carrying out the Medicare integrity program established
17 under section 1893 of the Social Security Act (42 U.S.C.
18 1395ddd) to carry out the provisions of sections 1897 and
19 1898 of that Act (as added by subsections (a) and (b)).

20 **SEC. 802. REGISTRATION OF BILLING AGENCIES.**

21 (a) REGISTRATION OF BILLING AGENCIES AND INDI-
22 VIDUALS.—Title XVIII (42 U.S.C. 1395 et seq.) (as
23 amended by section 801(b)) is amended by adding at the
24 end the following:

1 “REGISTRATION OF BILLING AGENCIES AND INDIVIDUALS

2 “SEC. 1899. (a) REGISTRATION.—The Secretary
3 shall establish procedures for the registration of all appli-
4 cable persons.

5 “(b) REQUIRED APPLICATION.—Each applicable per-
6 son shall submit a registration application to the Secretary
7 at such time, in such manner, and accompanied by such
8 information as the Secretary may require.

9 “(c) IDENTIFICATION NUMBER.—If the Secretary ap-
10 proves an application submitted under subsection (b), the
11 Secretary shall assign a unique identification number to
12 the applicable person.

13 “(d) REQUIREMENT.—Every claim for reimburse-
14 ment under this title that is compiled and submitted by
15 an applicable person shall contain the identification num-
16 ber that is assigned to the applicable person pursuant to
17 subsection (c).

18 “(e) TIMELY REVIEW.—The Secretary shall provide
19 for procedures that ensure the timely consideration and
20 determination regarding approval of applications under
21 this section.

22 “(f) DEFINITION OF APPLICABLE PERSON.—In this
23 section, the term ‘applicable person’ means an individual
24 or an entity that compiles and submits claims for reim-

1 bursement under this title to the Secretary on behalf of
2 any individual or entity.”.

3 (b) PERMISSIVE EXCLUSION.—Section 1128(b) (42
4 U.S.C. 1320a–7(b)) is amended by adding at the end the
5 following:

6 “(16) FRAUD BY APPLICABLE PERSON.—An ap-
7 plicable person (as defined in section 1899(f)) that
8 the Secretary determines knowingly submitted or
9 caused to be submitted a claim for reimbursement
10 under title XVIII that the applicable person knows
11 or should know is false or fraudulent.”.

12 (c) REGULATIONS; EFFECTIVE DATE.—

13 (1) REGULATIONS.—Not later than 1 year after
14 the date of enactment of this Act, the Secretary of
15 Health and Human Services shall promulgate such
16 regulations as are necessary to implement the
17 amendments made by subsections (a) and (b).

18 (2) EFFECTIVE DATE.—The amendments made
19 by subsections (a) and (b) take effect on January 1,
20 2000.

21 **SEC. 803. EXPANDED ACCESS TO THE HEALTH INTEGRITY**

22 **PROTECTION DATABASE (HIPDB).**

23 (a) IN GENERAL.—Section 1128E(d)(1) (42 U.S.C.
24 1320a–7e(d)(1)) is amended to read as follows:

1 “(1) AVAILABILITY.—The information in the
2 database maintained under this section shall be
3 available to—

4 “(A) Federal and State government agen-
5 cies and health plans, and any health care pro-
6 vider, supplier, or practitioner entering an em-
7 ployment or contractual relationship with an in-
8 dividual or entity who could potentially be the
9 subject of a final adverse action, in any case in
10 which the contract involves the furnishing of
11 items or services reimbursed by 1 or more Fed-
12 eral health care programs (regardless of wheth-
13 er the individual or entity is paid by the pro-
14 grams directly, or whether the items or services
15 are reimbursed directly or indirectly through
16 the claims of a direct provider); and

17 “(B) utilization and quality control peer
18 review organizations and accreditation entities
19 as defined by the Secretary, including but not
20 limited to organizations described in part B of
21 this title and in section 1154(a)(4)(C).”.

22 (b) CRIMINAL PENALTY FOR MISUSE OF INFORMA-
23 TION.—Section 1128B(b) (42 U.S.C. 1320a–7b(b)) is
24 amended by adding at the end the following:

1 “(4) Whoever knowingly uses information maintained
2 in the health integrity protection database maintained in
3 accordance with section 1128E for a purpose other than
4 a purpose authorized under that section shall be impris-
5 oned for not more than 3 years or fined under title 18,
6 United States Code, or both.”.

7 (c) EFFECTIVE DATES.—

8 (1) AVAILABILITY.—The amendment made by
9 subsection (a) takes effect on the date of enactment
10 of this Act.

11 (2) CRIMINAL PENALTY FOR MISUSE OF INFOR-
12 MATION.—The amendment made by subsection (b)
13 takes effect on the date of enactment of this Act and
14 applies to acts committed on or after the date of en-
15 actment of this Act.

16 **SEC. 804. LIABILITY OF MEDICARE CARRIERS AND FISCAL**
17 **INTERMEDIARIES FOR CLAIMS SUBMITTED**
18 **BY EXCLUDED PROVIDERS.**

19 (a) REIMBURSEMENT TO THE SECRETARY FOR
20 AMOUNTS PAID TO EXCLUDED PROVIDERS.—

21 (1) REQUIREMENTS FOR FISCAL INTER-
22 MEDIARIES.—

23 (A) IN GENERAL.—Section 1816 (42
24 U.S.C. 1395h) is amended by adding at the end
25 the following:

1 “(m) An agreement with an agency or organization
2 under this section shall require that such agency or orga-
3 nization reimburse the Secretary for any amounts paid by
4 the agency or organization for a service under this title
5 which is furnished by an individual or entity during any
6 period for which the individual or entity is excluded, pur-
7 suant to section 1128, 1128A, or 1156, from participation
8 in the health care program under this title if the amounts
9 are paid to the individual or entity excluded from
10 participation—

11 “(1) after the 60-day period beginning on the
12 date the Secretary provides notice of the exclusion to
13 the agency or organization, unless the payment was
14 made as a result of incorrect information provided
15 by the Secretary; or

16 “(2) which has concealed or altered their iden-
17 tity.”.

18 (B) CONFORMING AMENDMENT.—Section
19 1816(i) (42 U.S.C. 1395h(i)) is amended by
20 adding at the end the following:

21 “(4) Nothing in this subsection shall be con-
22 strued to prohibit reimbursement by an agency or
23 organization pursuant to subsection (m).”.

24 (2) REQUIREMENTS FOR CARRIERS.—Section
25 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended—

1 (A) by striking “and” at the end of sub-
2 paragraph (I); and

3 (B) by inserting after subparagraph (I) the
4 following:

5 “(J) will reimburse the Secretary for any
6 amounts paid by the carrier for an item or service
7 under this part which is furnished by an individual
8 or entity during any period for which the individual
9 or entity is excluded, pursuant to section 1128,
10 1128A, or 1156, from participation in the health
11 care program under this title if the amounts are
12 paid to the individual or entity excluded from
13 participation—

14 “(1) after the 60-day period beginning on the
15 date the Secretary provides notice of the exclusion to
16 the agency or organization, unless the payment was
17 made as a result of incorrect information provided
18 by the Secretary; or

19 “(2) which has concealed or altered their iden-
20 tity; and”.

21 (b) CONFORMING REPEAL OF MANDATORY PAYMENT
22 RULE.—Section 1862(e) (42 U.S.C. 1395y(e)) is
23 amended—

1 (1) in paragraph (1)(B), by striking “and when
2 the person” and all that follows through “person”;
3 and

4 (2) by amending paragraph (2) to read as fol-
5 lows:

6 “(2) No individual or entity may bill (or collect any
7 amount from) any individual for any item or service for
8 which payment is denied under paragraph (1). No indi-
9 vidual is liable for payment of any amounts billed for such
10 an item or service in violation of the preceding sentence.”.

11 (c) EFFECTIVE DATE.—

12 (1) IN GENERAL.—The amendments made by
13 this section apply to claims for payment submitted
14 on or after the date of enactment of this Act.

15 (2) CONTRACT MODIFICATION.—The Secretary
16 of Health and Human Services shall take such steps
17 as may be necessary to modify contracts and agree-
18 ments entered into, renewed, or extended prior to
19 the date of enactment of this Act to conform such
20 contracts or agreements to the provisions of this sec-
21 tion.

22 **SEC. 805. COMMUNITY MENTAL HEALTH CENTERS.**

23 (a) IN GENERAL.—Section 1861(ff)(3)(B) (42
24 U.S.C. 1395x(ff)(3)(B)) is amended by striking “entity”

1 and all that follows and inserting the following: “entity
2 that—

3 “(i) provides the community mental health serv-
4 ices specified in paragraph (1) of section 1913(c) of
5 the Public Health Service Act;

6 “(ii) meets applicable certification or licensing
7 requirements for community mental health centers
8 in the State in which it is located;

9 “(iii) provides a significant share of its services
10 to individuals who are not eligible for benefits under
11 this title; and

12 “(iv) meets such additional standards or re-
13 quirements for obtaining Medicare billing privileges
14 as the Secretary may specify to ensure—

15 “(I) the health and safety of beneficiaries
16 receiving such services; or

17 “(II) the furnishing of such services in an
18 effective and efficient manner.”.

19 (b) RESTRICTION.—Section 1861(ff)(3)(A) (42
20 U.S.C. 1395x(ff)(3)(A)) is amended by inserting “other
21 than in an individual’s home or in an inpatient or residen-
22 tial setting” before the period.

23 (c) EFFECTIVE DATE.—The amendments made by
24 this section apply to items and services furnished after the

1 sixth month that begins after the date of enactment of
2 this Act.

3 **SEC. 806. LIMITING THE DISCHARGE OF DEBTS IN BANK-**
4 **RUPTCY PROCEEDINGS IN CASES WHERE A**
5 **HEALTH CARE PROVIDER OR A SUPPLIER EN-**
6 **GAGES IN FRAUDULENT ACTIVITY.**

7 (a) IN GENERAL.—

8 (1) CIVIL MONETARY PENALTIES.—Section
9 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended by
10 adding at the end the following: “Notwithstanding
11 any other provision of law, amounts made payable
12 under this section are not dischargeable under sec-
13 tion 727, 1141, 1228 (a) or (b), or 1328 of title 11,
14 United States Code, or any other provision of such
15 title.”.

16 (2) RECOVERY OF OVERPAYMENT TO PRO-
17 VIDERS OF SERVICES UNDER PART A OF MEDI-
18 CARE.—Section 1815(d) (42 U.S.C. 1395g(d)) is
19 amended—

20 (A) by inserting “(1)” after “(d)”; and

21 (B) by adding at the end the following:

22 “(2) Notwithstanding any other provision of law,
23 amounts due to the Secretary under this section are not
24 dischargeable under section 727, 1141, 1228 (a) or (b),
25 or 1328 of title 11, United States Code, or any other pro-

1 vision of such title if the overpayment was the result of
2 fraudulent activity, as may be defined by the Secretary.”.

3 (3) RECOVERY OF OVERPAYMENT OF BENEFITS
4 UNDER PART B OF MEDICARE.—Section 1833(j) (42
5 U.S.C. 1395l(j)) is amended—

6 (A) by inserting “(1)” after “(j)”; and

7 (B) by adding at the end the following:

8 “(2) Notwithstanding any other provision of law,
9 amounts due to the Secretary under this section are not
10 dischargeable under section 727, 1141, 1228 (a) or (b),
11 or 1328 of title 11, United States Code, or any other pro-
12 vision of such title if the overpayment was the result of
13 fraudulent activity, as may be defined by the Secretary.”.

14 (4) COLLECTION OF PAST-DUE OBLIGATIONS
15 ARISING FROM BREACH OF SCHOLARSHIP AND LOAN
16 CONTRACT.—Section 1892(a) (42 U.S.C.
17 1395ccc(a)) is amended by adding at the end the
18 following:

19 “(5) Notwithstanding any other provision of
20 law, amounts due to the Secretary under this section
21 are not dischargeable under section 727, 1141, 1228
22 (a) or (b), or 1328 of title 11, United States Code,
23 or any other provision of such title.”.

1 (b) EFFECTIVE DATE.—The amendments made by
2 subsection (a) apply to bankruptcy petitions filed after the
3 date of enactment of this Act.

4 **SEC. 807. ILLEGAL DISTRIBUTION OF A MEDICARE OR MED-**
5 **ICAID BENEFICIARY IDENTIFICATION OR**
6 **PROVIDER NUMBER.**

7 (a) IN GENERAL.—Section 1128B(b) (42 U.S.C.
8 1320a–7b(b)), as amended by section 803(b), is amended
9 by adding at the end the following:

10 “(5) Whoever knowingly, intentionally, and with the
11 intent to defraud purchases, sells or distributes, or ar-
12 ranges for the purchase, sale, or distribution of 2 or more
13 Medicare or Medicaid beneficiary identification numbers
14 or provider numbers shall be imprisoned for not more than
15 3 years or fined under title 18, United States Code (or,
16 if greater, an amount equal to the monetary loss to the
17 Federal and any State government as a result of such
18 acts), or both.”.

19 (b) EFFECTIVE DATE.—The amendment made by
20 subsection (a) takes effect on the date of enactment of
21 this Act and applies to acts committed on or after the date
22 of enactment of this Act.

1 **SEC. 808. TREATMENT OF CERTAIN SOCIAL SECURITY ACT**
2 **CRIMES AS FEDERAL HEALTH CARE OF-**
3 **FENSES.**

4 (a) **IN GENERAL.**—Section 24(a) of title 18, United
5 States Code, is amended—

6 (1) by striking the period at the end of para-
7 graph (2) and inserting “; or”; and

8 (2) by adding at the end the following:

9 “(3) section 1128B of the Social Security Act
10 (42 U.S.C. 1320a-7b).”.

11 (b) **EFFECTIVE DATE.**—The amendment made by
12 subsection (a) takes effect on the date of enactment of
13 this Act and applies to acts committed on or after the date
14 of enactment of this Act.

15 **SEC. 809. AUTHORITY OF OFFICE OF INSPECTOR GENERAL**
16 **OF THE DEPARTMENT OF HEALTH AND**
17 **HUMAN SERVICES.**

18 (a) **AUTHORITY.**—Notwithstanding any other provi-
19 sion of law, upon designation by the Inspector General of
20 the Department of Health and Human Services, any
21 criminal investigator of the Office of Inspector General of
22 such department may, in accordance with guidelines
23 issued by the Secretary of Health and Human Services
24 and approved by the Attorney General, while engaged in
25 activities within the lawful jurisdiction of such Inspector
26 General—

1 (1) obtain and execute any warrant or other
2 process issued under the authority of the United
3 States;

4 (2) make an arrest without a warrant for—

5 (A) any offense against the United States
6 committed in the presence of such investigator;
7 or

8 (B) any felony offense against the United
9 States, if such investigator has reasonable cause
10 to believe that the person to be arrested has
11 committed or is committing that felony offense;
12 and

13 (3) exercise any other authority necessary to
14 carry out the authority described in paragraphs (1)
15 and (2).

16 (b) FUNDS.—The Office of Inspector General of the
17 Department of Health and Human Services may receive
18 and expend funds that represent the equitable share from
19 the forfeiture of property in investigations in which the
20 Office of Inspector General participated, and that are
21 transferred to the Office of Inspector General by the De-
22 partment of Justice, the Department of the Treasury, or
23 the United States Postal Service. Such equitable sharing
24 funds shall be deposited in a separate account and shall
25 remain available until expended.

1 **SEC. 810. UNIVERSAL PRODUCT NUMBERS ON CLAIMS**
2 **FORMS FOR REIMBURSEMENT UNDER THE**
3 **MEDICARE PROGRAM.**

4 (a) UPNS ON CLAIMS FORMS FOR REIMBURSEMENT
5 UNDER THE MEDICARE PROGRAM.—

6 (1) ACCOMMODATION OF UPNS ON MEDICARE
7 CLAIMS FORMS.—Not later than February 1, 2001,
8 all claims forms developed or used by the Secretary
9 of Health and Human Services for reimbursement
10 under the Medicare program under title XVIII of
11 the Social Security Act (42 U.S.C. 1395 et seq.)
12 shall accommodate the use of universal product
13 numbers for a UPN covered item.

14 (2) REQUIREMENT FOR PAYMENT OF CLAIMS.—
15 Title XVIII (42 U.S.C. 1395 et seq.) (as amended
16 by section 802(a)) is amended by adding at the end
17 the following:

18 “USE OF UNIVERSAL PRODUCT NUMBERS
19 “SEC. 1899A. (a) IN GENERAL.—No payment shall
20 be made under this title for any claim for reimbursement
21 for any UPN covered item unless the claim contains the
22 universal product number of the UPN covered item.

23 “(b) DEFINITIONS.—In this section:

24 “(1) UPN COVERED ITEM.—

1 “(A) IN GENERAL.—Except as provided in
2 subparagraph (B), the term ‘UPN covered
3 item’ means—

4 “(i) a covered item (as defined in sec-
5 tion 1834(a)(13));

6 “(ii) an item described in paragraph
7 (8) or (9) of section 1861(s);

8 “(iii) an item described in paragraph
9 (5) of section 1861(s); and

10 “(iv) any other item for which pay-
11 ment is made under this title that the Sec-
12 retary determines to be appropriate.

13 “(B) EXCLUSION.—The term ‘UPN cov-
14 ered item’ does not include a customized item
15 for which payment is made under this title.

16 “(2) UNIVERSAL PRODUCT NUMBER.—The
17 term ‘universal product number’ means a number
18 that is—

19 “(A) affixed by the manufacturer to each
20 individual UPN covered item that uniquely
21 identifies the item at each packaging level; and

22 “(B) based on commercially acceptable
23 identification standards, such as standards es-
24 tablished by the Uniform Code Council-Inter-
25 national Article Numbering System or the

1 Health Industry Business Communication
2 Council.”.

3 (3) DEVELOPMENT AND IMPLEMENTATION OF
4 PROCEDURES.—

5 (A) INFORMATION INCLUDED IN UPN.—

6 The Secretary of Health and Human Services,
7 in consultation with manufacturers and entities
8 with appropriate expertise, shall determine the
9 relevant descriptive information appropriate for
10 inclusion in a universal product number for a
11 UPN covered item.

12 (B) REVIEW OF PROCEDURE.—From the
13 information obtained by the use of universal
14 product numbers on claims for reimbursement
15 under the Medicare program under title XVIII
16 of the Social Security Act (42 U.S.C. 1395 et
17 seq.), the Secretary of Health and Human
18 Services, in consultation with interested parties,
19 shall periodically review the UPN covered items
20 billed under the Health Care Financing Admin-
21 istration Common Procedure Coding System
22 and adjust such coding system to ensure that
23 functionally equivalent UPN covered items are
24 billed and reimbursed under the same codes.

1 (4) EFFECTIVE DATE.—The amendment made
2 by paragraph (2) applies to claims for reimburse-
3 ment submitted on and after February 1, 2002.

4 (b) STUDY AND REPORTS TO CONGRESS.—

5 (1) STUDY.—The Secretary of Health and
6 Human Services shall conduct a study on the results
7 of the implementation of the provisions in para-
8 graphs (1) and (3) of subsection (a) and the amend-
9 ment to the Social Security Act in paragraph (2) of
10 that subsection.

11 (2) REPORTS.—

12 (A) PROGRESS REPORT.—Not later than 6
13 months after the date of enactment of this Act,
14 the Secretary of Health and Human Services
15 shall submit a report to the appropriate com-
16 mittees of Congress that contains a detailed de-
17 scription of the progress of the matters studied
18 pursuant to paragraph (1).

19 (B) IMPLEMENTATION.—Not later than 18
20 months after the date of enactment of this Act,
21 and annually thereafter for 3 years, the Sec-
22 retary of Health and Human Services shall sub-
23 mit a report to the appropriate committees of
24 Congress that contains a detailed description of
25 the results of the study conducted pursuant to

1 paragraph (1), together with the Secretary's
2 recommendations regarding the use of universal
3 product numbers and the use of data obtained
4 from the use of such numbers.

5 (c) DEFINITIONS.—In this section:

6 (1) UPN COVERED ITEM.—The term “UPN
7 covered item” has the meaning given such term in
8 section 1899A(b)(1) of the Social Security Act (as
9 added by subsection (a)(2)).

10 (2) UNIVERSAL PRODUCT NUMBER.—The term
11 “universal product number” has the meaning given
12 such term in section 1899A(b)(2) of the Social Secu-
13 rity Act (as added by subsection (a)(2)).

14 (d) AUTHORIZATION OF APPROPRIATIONS.—There
15 are authorized to be appropriated such sums as may be
16 necessary for the purpose of carrying out the provisions
17 in paragraphs (1) and (3) of subsection (a), subsection
18 (b), and section 1899A of the Social Security Act (as
19 added by subsection (a)(2)).

○