II

105TH CONGRESS
1ST SESSION

S. 386

To amend title XVIII of the Social Security Act to protect and improve the medicare program, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MARCH 3, 1997

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

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A BILL

To amend title XVIII of the Social Security Act to protect and improve the medicare program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS; DEFINITION OF SECRETARY.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Modernization and Patient Protection Act of 1997''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

(c) DEFINITION OF SECRETARY.—As used in this Act, the term ''Secretary'' means the Secretary of Health and Human Services.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) It is in the interest of both taxpayers and beneficiaries under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) that the program provide those beneficiaries with a broad array of health plan choices and generally encourage competition between providers to promote lower costs and greater variety among plans offered by eligible organizations under section 1876 of that Act (42 U.S.C. 1395mm).

(2) Such competition and consumer choice is consistent with a guaranteed defined package of

basic health care service benefits, including ready access to physicians and other health care providers, hospitalization and home care services, and a comprehensive system of preventive care options.

(3) As the medicare program evolves into a program offering beneficiaries more choices, it is critical that those beneficiaries have more definitive and more easily comparable information about plans offered by eligible organizations under section 1876 of that Act, and that those beneficiaries are protected against adverse coverage decisions under the medicare program through a strengthened grievance and appeals process.

(4) Establishing stronger fiscal integrity in the medicare program will involve—

(A) eliminating unnecessary and wasteful geographic variability within the medicare program's national reimbursement system;

(B) establishing stronger antifraud provisions including enhanced criminal penalties for practitioners and entities involved in medicare billing abuses; and

(C) establishing ''smart shopper'' mandates that require the medicare program to demand competitive bidding and prospective payment on goods and services purchased by the program for beneficiaries.

(5) The medicare program must accommodate its reimbursement system to a variety of alternative and creative health care systems and providers such as telemedicine, hospice care, and medical care services from the nonphysician licensed professions, as it has been shown that such systems offer beneficiaries under the medicare program services which are as good or better than those offered by traditional practitioners and may save taxpayer dollars.

(6) The frail elderly eligible under both the medicare program and the medicaid program under title XIX of that Act (42 U.S.C. 1396 et seq.) are among the fastest growing and most costly segments of the medicare population. It is in the interest of both the taxpayer and these beneficiaries that the medicare program encourage and nurture the On-Lok program, Social Health Maintenance Organizations, and PACE (under title III of this Act) which

have been designed specifically to serve this population in a humane, effective, and cost-efficient manner.

TITLE I—PROMOTING COMPETITION, QUALITY, AND BENEFICIARY CHOICE IN MEDICARE

SEC. 101. ESTABLISHMENT OF PLAN IMPROVEMENT AND COMPETITION OFFICE.

(a) ESTABLISHMENT.—Not later than January 1, 1998, the Secretary shall establish the Office of Plan Improvement and Competition (in this title referred to as the ''Office'') within the Health Care Financing Administration.

(b) DUTIES.—The duties of the Office shall include the following:

(1) To collect data from the Social Security Administration's regional offices regarding the systematic coverage and procedural inconsistencies in the determination by intermediaries, carriers, and health maintenance organizations under the medicare program as to whether an item or service is covered or disallowed in full or in part.

(2) To supervise and monitor advertising and promotional materials distributed to individuals by

eligible organizations under section 1876 of the Social Security Act (42 U.S.C. 1395mm) and by organizations which provide medicare supplemental policies under section 1882 of that Act (42 U.S.C. 1395ss) in order to ensure that the information contained in such materials is accurate and enable the individuals receiving the materials to compare the organizations that the individuals are eligible to enroll with.

(3) To collect data regarding the results of research by organizations on improvement in health care quality and best-practice information.

(4) To distribute the data collected under paragraph (3) to eligible organizations under section 1876 of the Social Security Act (42 U.S.C. 1395mm) and by organizations which provide medicare supplemental policies under section 1882 of that Act (42 U.S.C. 1395ss), and to encourage such organizations to incorporate the results of that research in the plans offered by the organizations to individuals.

(5) To publish and distribute the quality report cards and the comparative reports developed by the Secretary under section 1805 of the Social Security Act, as added by section 202 of this Act.

SEC. 102. HMO COMPETITIVE PRICING DEMONSTRATION PROJECTS.

(a) DEMONSTRATION PROJECTS.—

(1) IN GENERAL.—The Secretary shall conduct demonstration projects in every applicable area, as defined in paragraph (2), for the purpose of establishing competitive pricing for eligible organizations with risk-sharing contracts under section 1876 of the Social Security Act (42 U.S.C. 1395mm).

(2) APPLICABLE AREA DEFINED.—

(A) IN GENERAL.—In paragraph (1), the term ''applicable area'' means a medicare payment area—

(i) that has an input-price-adjusted national adjusted average per capita cost that is at least 120 percent of the national standardized adjusted average per capita cost, determined under section 1876(a)(4)(D)(ii) of the Social Security Act (42 U.S.C. 1395mm(a)(4)(D)(ii)), as added by section 201 of this Act; or

(ii) where at least 50 percent of the eligible organizations under section 1876 of the Social Security Act (42 U.S.C. 1395mm) in that area offer health plans

under that section with monthly premiums that are less than $20.

If the Secretary determines that a medicare payment area is an applicable area under this section, that area shall continue to be an applicable area for the duration of the demonstration projects conducted under this section.

(B) LIMITATION.—A medicare payment area shall not be considered an applicable area if the Secretary determines before starting the demonstration project in that area that there are an insufficient number of eligible organizations with risk-sharing contracts under section 1876 of the Social Security Act (42 U.S.C. 1395mm) in that area to support a demonstration project under this section.

(C) MEDICARE PAYMENT AREA; ADJUSTED AVERAGE PER CAPITA COST; INPUT-PRICE-ADJUSTED NATIONAL ADJUSTED AVERAGE PER CAPITA COST.—In this section, the terms ''medicare payment area'', ''adjusted average per capita cost'', and ''input-price-adjusted national average per capita cost'' have the meaning

given those terms in section 1876(a) of the Social Security Act (42 U.S.C. 1395mm(a)), as added by section 201 of this Act.

(3) LIMITATION OF PAYMENT.—The Secretary shall not make a payment to an eligible organization under a demonstration project conducted under this section that is greater than the payment that would have been made to that organization under section 1876 of the Social Security Act (42 U.S.C. 1395mm) if not for the demonstration project.

(4) REQUIREMENT OF NUMBER OF BIDS.—The Secretary shall discontinue the demonstration project conducted under this section in a medicare payment area where only 1 eligible organization with risk-sharing contracts under section 1876 of the Social Security Act (42 U.S.C. 1395mm) submits a bid to the Secretary to provide items and services under the demonstration project.

(b) REPORT TO CONGRESS.—

(1) IN GENERAL.—Not later than January 1, 2002, the Secretary shall submit to Congress a report regarding the demonstration projects conducted under this section.

(2) CONTENTS OF REPORT.—The report described in paragraph (1) shall include the following:

(A) A description of the demonstration projects conducted under this section.

(B) Recommendations for establishing a new payment methodology for eligible organizations with risk-sharing contracts under section 1876 of the Social Security Act (42 U.S.C. 1395mm), based on the results of the demonstration projects conducted under this section.

(C) Any other information regarding the demonstration projects conducted under this section that the Secretary determines would assist Congress in revising a new payment methodology for eligible organizations with risk-sharing contracts under section 1876 of that Act (42 U.S.C. 1395mm).

(c) WAIVER OF MEDICARE REQUIREMENTS.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects under this section.

(d) NO ADDITIONAL FUNDING.—The Secretary shall conduct demonstration projects under this section with funds otherwise available to the Secretary.

SEC. 103. MEDIGAP AMENDMENTS.

(a) GUARANTEEING ISSUE WITHOUT PREEXISTING CONDITIONS FOR CONTINUOUSLY COVERED INDIVIDUALS.—Section 1882(s) of the Social Security Act (42 U.S.C. 1395ss(s)) is amended—

(1) in paragraph (3), by striking ''paragraphs (1) and (2)'' and inserting ''this subsection'',

(2) by redesignating paragraph (3) as paragraph (4), and

(3) by inserting after paragraph (2) the following:

''(3)(A) The issuer of a medicare supplemental policy—

''(i) may not deny or condition the issuance or effectiveness of a medicare supplemental policy described in subparagraph (C);

''(ii) may not discriminate in the pricing of the policy on the basis of the individual's health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), age, or disability; and

''(iii) may not impose an exclusion of benefits based on a pre-existing condition,

in the case of an individual described in subparagraph (B) who seeks to enroll under the policy not later than 63 days after the date of the termination of enrollment described in such subparagraph.

''(B) An individual described in this subparagraph is an individual described in any of the following clauses:

''(i) The individual is enrolled with an eligible organization under a contract under section 1876 or with an organization under an agreement under section 1833(a)(1)(A) and such enrollment ceases either because the individual moves outside the service area of the organization under the contract or agreement or because of the termination or nonrenewal of the contract or agreement.

''(ii) The individual is enrolled with an organization under a policy described in subsection (t) and such enrollment ceases either because the individual moves outside the service area of the organization under the policy, because of the bankruptcy or insolvency of the insurer, or because the insurer closes the block of business to new enrollment.

''(iii) The individual is covered under a medicare supplemental policy and such coverage is terminated because of the bankruptcy or insolvency of the insurer issuing the policy, because the insurer closes

the block of business to new enrollment, or because the individual changes residence so that the individual no longer resides in a State in which the issuer of the policy is licensed.

''(iv) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under this title and the plan terminates or ceases to provide (or significantly reduces) such supplemental health benefits to the individual.

''(v)(i) The individual is enrolled with an eligible organization under a contract under section 1876 or with an organization under an agreement under section 1833(a)(1)(A) and such enrollment is terminated by the enrollee during the first 12 months of such enrollment, but only if the individual never was previously enrolled with an eligible organization under a contract under section 1876 or with an organization under an agreement under section 1833(a)(1)(A).

''(ii) The individual is enrolled under a policy described in subsection (t) and such enrollment is

terminated during the first 12 months of such enrollment, but only if the individual never was previously enrolled under such a policy under such subsection.

''(C)(i) Subject to clause (ii), a medicare supplemental policy described in this subparagraph, with respect to an individual described in subparagraph (B), is a policy the benefits under which are comparable or lesser in relation to the benefits under the enrollment described in subparagraph (B) (or, in the case of an individual described in clause (ii), under the most recent medicare supplemental policy described in clause (ii)(II)).

''(ii) An individual described in this clause is an individual who—

''(I) is described in subparagraph (B)(v), and

''(II) was enrolled in a medicare supplemental policy within the 63-day period before the enrollment described in such subparagraph.

''(iii) As a condition for approval of a State regulatory program under subsection (b)(1) and for purposes of applying clause (i) to policies to be issued in the State, the regulatory program shall provide for the method of determining whether policy benefits are comparable or lesser in relation to other benefits. With respect to a State

without such an approved program, the Secretary shall establish such method.

''(D) At the time of an event described in subparagraph (B) because of which an individual ceases enrollment or loses coverage or benefits under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, the insurer offering the policy, or the administrator of the plan, respectively, shall notify the individual of the rights of the individual, and obligations of issuers of medicare supplemental policies, under subparagraph (A).''.

(b) LIMITATION ON IMPOSITION OF PREEXISTING CONDITION EXCLUSION DURING INITIAL OPEN ENROLLMENT PERIOD.—Section 1882(s)(2)(B) of the Social Security Act (42 U.S.C. 1395ss(s)(2)(B)) is amended to read as follows:

''(B) In the case of a policy issued during the 6-month period described in subparagraph (A), the policy may not exclude benefits based on a pre-existing condition.''.

(c) CLARIFYING THE NONDISCRIMINATION REQUIREMENTS DURING THE 6-MONTH INITIAL ENROLLMENT PERIOD.—Section 1882(s)(2)(A) of the Social Security Act (42 U.S.C. 1395ss(s)(2)(A)) is amended to read as follows:

''(2)(A)(i) In the case of an individual described in clause (ii), the issuer of a medicare supplemental policy—

''(I) may not deny or condition the issuance or effectiveness of a medicare supplemental policy, and

''(II) may not discriminate in the pricing of the policy on the basis of the individual's health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), age, or disability.

''(ii) An individual described in this clause is an individual for whom an application is submitted before the end of the 6-month period beginning with the first month as of the first day on which the individual is 65 years of age or older and is enrolled for benefits under part B.''.

(d) EXTENDING 6-MONTH INITIAL ENROLLMENT PERIOD TO NONELDERLY MEDICARE BENEFICIARIES.—Section 1882(s)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395ss(s)(2)(A)) (as amended by subsection (c) of this Act) is amended by striking ''is submitted'' and all that follows and inserting the following: ''is submitted—

''(I) before the end of the 6-month period beginning with the first month as of the first day on

which the individual is 65 years of age or older and is enrolled for benefits under part B; and

''(II) for each time the individual becomes eligible for benefits under part A pursuant to section 226(b) or 226A and is enrolled for benefits under part B, before the end of the 6-month period beginning with the first month as of the first day on which the individual is so eligible and so enrolled.''.

(e) EFFECTIVE DATES.—

(1) GUARANTEED ISSUE.—The amendment made by subsection (a) shall take effect on July 1, 1998.

(2) LIMIT ON PREEXISTING CONDITION EXCLUSIONS.—The amendment made by subsection (b) shall apply to policies issued on or after July 1, 1998.

(3) CLARIFICATION OF NONDISCRIMINATION REQUIREMENTS.—The amendment made by subsection (c) shall apply to policies issued on or after July 1, 1998.

(4) EXTENSION OF ENROLLMENT PERIOD TO DISABLED INDIVIDUALS.—

(A) IN GENERAL.—The amendment made by subsection (d) shall take effect on July 1, 1998.

(B) TRANSITION RULE.—In the case of an individual who first became eligible for benefits under part A of title XVIII of the Social Security Act pursuant to section 226(b) or 226A of such Act and enrolled for benefits under part B of such title before July 1, 1998, the 6-month period described in section 1882(s)(2)(A) of such Act shall begin on July 1, 1998. Before July 1, 1998, the Secretary shall notify any individual described in the previous sentence of their rights in connection with medicare supplemental policies under section 1882 of such Act, by reason of the amendment made by subsection (d).

(f) TRANSITION PROVISIONS.—

(1) IN GENERAL.—If the Secretary identifies a State as requiring a change to its statutes or regulations to conform its regulatory program to the changes made by this section, the State regulatory program shall not be considered to be out of compliance with the requirements of section 1882 of the Social Security Act due solely to failure to make such change until the date specified in paragraph (4).

(2) NAIC STANDARDS.—If, within 9 months after the date of enactment of this Act, the National Association of Insurance Commissioners (in this subsection referred to as the ''NAIC'') modifies its NAIC Model Regulation relating to section 1882 of the Social Security Act (referred to in such section as the 1991 NAIC Model Regulation, as modified pursuant to section 171(m)(2) of the Social Security Act Amendments of 1994 (Public Law 103–432) and as modified pursuant to section 1882(d)(3)(A)(vi)(IV) of the Social Security Act, as added by section 271(a) of the Health Care Portability and Accountability Act of 1996 (Public Law 104–191) to conform to the amendments made by this section, such revised regulation incorporating the modifications shall be considered to be the applicable NAIC model regulation (including the revised NAIC model regulation and the 1991 NAIC Model Regulation) for the purposes of such section.

(3) SECRETARY STANDARDS.—If the NAIC does not make the modifications described in paragraph (2) within the period specified in such paragraph, the Secretary shall make the modifications

described in such paragraph and such revised regulation incorporating the modifications shall be considered to be the appropriate regulation for the purposes of such section.

(4) DATE SPECIFIED.—

(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

(i) the date the State changes its statutes or regulations to conform its regulatory program to the changes made by this section, or

(ii) 1 year after the date the NAIC or the Secretary first makes the modifications under paragraph (2) or (3), respectively.

(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies as—

(i) requiring State legislation (other than legislation appropriating funds) to conform its regulatory program to the changes made in this section, but

(ii) having a legislature which is not scheduled to meet in 1999 in a legislative

session in which such legislation may be considered,

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after July 1, 1999. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

TITLE II—INCREASING MEDICARE COVERAGE OPTIONS

Subtitle A—Risk Plan Improvements

SEC. 201. FINANCING AND QUALITY MODERNIZATION AND REFORM.

(a) PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS.—

(1) IN GENERAL.—Section 1876(a) of the Social Security Act (42 U.S.C. 1395mm(a)) is amended to read as follows:

''(a)(1)(A) The Secretary shall annually determine, and shall announce (in a manner intended to provide notice to interested parties) not later than October 1 before the calendar year concerned—

''(i) a per capita rate of payment for individuals who are enrolled under this section with an eligible organization which has entered into a risk-sharing contract and who are entitled to benefits under part A and enrolled under part B, and

''(ii) a per capita rate of payment for individuals who are so enrolled with such an organization and who are enrolled under part B only.

For purposes of this section, the term 'risk-sharing contract' means a contract entered into under subsection (g) and the term 'reasonable cost reimbursement contract' means a contract entered into under subsection (h).

''(B)(i) The annual per capita rate of payment for each medicare payment area (as defined in paragraph (5)) shall be equal to 95 percent of the adjusted average per capita cost (as defined in paragraph (4)), adjusted by the Secretary for—

''(I) individuals who are enrolled under this section with an eligible organization which has entered into a risk-sharing contract and who are enrolled under part B only; and

''(II) such risk factors as age, disability status, gender, institutional status, and such other factors as the Secretary determines to be appropriate so as to ensure actuarial equivalence.

The Secretary may add to, modify, or substitute for such factors, if such changes will improve the determination of actuarial equivalence.

''(ii) The Secretary shall reduce the annual per capita rate of payment by a uniform percentage (determined by the Secretary for a year, subject to adjustment under subparagraph (G)(v)) so that the total reduction is estimated to equal the amount to be paid under subparagraph (G).

''(C) In the case of an eligible organization with a risk-sharing contract, the Secretary shall make monthly payments in advance and in accordance with the rate determined under subparagraph (B) and except as provided in subsection (g)(2), to the organization for each individual enrolled with the organization under this section.

''(D) The Secretary shall establish a separate rate of payment to an eligible organization with respect to any individual determined to have end-stage renal disease and enrolled with the organization. Such rate of payment shall be actuarially equivalent to rates paid to other enrollees in the payment area (or such other area as specified by the Secretary).

''(E)(i) The amount of payment under this paragraph may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled in the plan under this section and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

''(ii)(I) Subject to subclause (II), the Secretary may make retroactive adjustments under clause (i) to take into account individuals enrolled during the period beginning on the date on that the individual enrolls with an eligible organization (that has a risk-sharing contract under this section) under a health benefit plan operated, sponsored, or contributed to by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the plan under this section, except that for purposes of making such retroactive adjustments under this clause, such period may not exceed 90 days.

''(II) No adjustment may be made under subclause (I) with respect to any individual who does not certify that the organization provided the individual with the explanation described in subsection (c)(3)(E) at the time the individual enrolled with the organization.

''(F)(i) At least 45 days before making the announcement under subparagraph (A) for a year, the Secretary

shall provide for notice to eligible organizations of proposed changes to be made in the methodology or benefit coverage assumptions from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity to comment on such proposed changes.

''(ii) In each announcement made under subparagraph (A), the Secretary shall include an explanation of the assumptions (including any benefit coverage assumptions) and changes in methodology used in the announcement in sufficient detail so that eligible organizations can compute per capita rates of payment for individuals located in each county (or equivalent medicare payment area) which is in whole or in part within the service area of such an organization.

''(2) With respect to any eligible organization that has entered into a reasonable cost reimbursement contract, payments shall be made to such plan in accordance with subsection (h)(2) rather than paragraph (1).

''(3) Subject to subsection (c) (2)(B)(ii) and (7), payments under a contract to an eligible organization under paragraph (1) or (2) shall be instead of the amounts that

(in the absence of the contract) would be otherwise payable, pursuant to sections 1814(b) and 1833(a), for services furnished by or through the organization to individuals enrolled with the organization under this section.

''(4)(A) For purposes of this section, the 'adjusted average per capita cost' for a medicare payment area (as defined in paragraph (5)) is equal to the greatest of the following:

''(i) The sum of—

''(I) the area-specific percentage for the year (as specified under subparagraph (B) for the year) of the area-specific adjusted average per capita cost for the year for the medicare payment area, as determined under subparagraph (C), and

''(II) the national percentage (as specified under subparagraph (B) for the year) of the input-price-adjusted national adjusted average per capita cost for the year, as determined under subparagraph (D),

multiplied by a budget neutrality adjustment factor determined under subparagraph (E).

''(ii) An amount equal to—

"(I) in the case of 1998, 80 percent of the average annual per capita cost under parts A and B of this title for 1997;

"(II) in the case of 1999, 80 percent of the average annual per capita cost under parts A and B of this title for 1998; and

"(III) in the case of a succeeding year, the amount specified in this clause for the preceding year increased by the national average per capita growth percentage specified under subparagraph (F) for that succeeding year.

"(iii) An amount equal to—

"(I) in the case of 1998, 102 percent of the annual per capita rate of payment for 1997 for the medicare payment area (determined under this subsection, as in effect on the day before the date of enactment of the Medicare Modernization and Patient Protection Act of 1997; and

"(II) in the case of a subsequent year, 102 percent of the adjusted average per capita cost under this subsection for the area for the previous year.

"(B) For purposes of subparagraph (A)(i)—

''(i) for 1998, the 'area-specific percentage' is 80 percent and the 'national percentage' is 20 percent,

''(ii) for 1999, the 'area-specific percentage' is 75 percent and the 'national percentage' is 25 percent,

''(iii) for 2000, the 'area-specific percentage' is 70 percent and the 'national percentage' is 30 percent,

''(iv) for 2001, the 'area-specific percentage' is 65 percent and the 'national percentage' is 35 percent, and

''(v) for 2002 and each subsequent year, the 'area-specific percentage' is 60 percent and the 'national percentage' is 40 percent.

''(C) For purposes of subparagraph (A)(i), the area-specific adjusted average per capita cost for a medicare payment area—

''(i) for 1998, is the annual per capita rate of payment for 1997 for the medicare payment area (determined under this subsection, as in effect the day before the date of enactment of the Medicare Modernization and Patient Protection Act of 1997), increased by the national average per capita growth

percentage for 1998 (as defined in subparagraph (F)); or

''(ii) for a subsequent year, is the area-specific adjusted average per capita cost for the previous year determined under this subparagraph for the medicare payment area, increased by the national average per capita growth percentage for such subsequent year.

''(D)(i) For purposes of subparagraph (A)(i), the input-price-adjusted national adjusted average per capita cost for a medicare payment area for a year is equal to the sum, for all the types of medicare services (as classified by the Secretary), of the product (for each such type of service) of—

''(I) the national standardized adjusted average per capita cost (determined under clause (ii)) for the year,

''(II) the proportion of such rate for the year which is attributable to such type of services, and

''(III) an index that reflects (for that year and that type of services) the relative input price of such services in the area compared to the national average input price of such services.

In applying subclause (III), the Secretary shall, subject to clause (iii), apply those indices under this title that are

used in applying (or updating) national payment rates for specific areas and localities.

''(ii) In clause (i)(I), the 'national standardized adjusted average per capita cost' for a year is equal to—

''(I) the sum (for all medicare payment areas) of the product of (aa) the area-specific adjusted average per capita cost for that year for the area under subparagraph (C), and (bb) the average number of medicare beneficiaries residing in that area in the year; divided by

''(II) the total average number of medicare beneficiaries residing in all the medicare payment areas for that year.

''(iii) In applying this subparagraph for 1998—

''(I) medicare services shall be divided into 2 types of services: part A services and part B services;

''(II) the proportions described in clause (i)(II) for such types of services shall be—

''(aa) for part A services, the ratio (expressed as a percentage) of the average annual per capita rate of payment for the area for part A for 1997 to the total average annual per capita rate of payment for the area for parts A and B for 1997, and

"(bb) for part B services, 100 percent minus the ratio described in item (aa);

"(III) for part A services, 70 percent of payments attributable to such services shall be adjusted by the index used under section 1886(d)(3)(E) to adjust payment rates for relative hospital wage levels for hospitals located in the payment area involved;

"(IV) for part B services—

"(aa) 66 percent of payments attributable to such services shall be adjusted by the index of the geographic area factors under section 1848(e) used to adjust payment rates for physicians' services furnished in the payment area, and

"(bb) of the remaining 34 percent of the amount of such payments, 70 percent shall be adjusted by the index described in subclause (III); and

"(V) the index values shall be computed based only on the beneficiary population who are 65 years of age or older and are not determined to have end-stage renal disease.

The Secretary may continue to apply the rules described in this clause (or similar rules) for 1999.

''(E) For each year, the Secretary shall compute a budget neutrality adjustment factor so that the aggregate of the payments under this section shall not exceed the aggregate payments that would have been made under this section if the area-specific percentage for the year had been 100 percent and the national percentage had been 0 percent.

''(F) In this section, the 'national average per capita growth percentage' for a year is equal to the Secretary's estimate (after consultation with the Secretary of the Treasury) of the 3-year average (ending with the year involved) of the annual rate of growth in the national average wage index (as defined in section 209(k)(1)) for each year in the period.

''(5)(A) In this section the term 'medicare payment area' means a county, or equivalent area specified by the Secretary.

''(B) In the case of individuals who are determined to have end-stage renal disease, the medicare payment area shall be each State.

''(6) The payment to an eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A and enrolled under part B shall be made from the Federal

Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The portion of that payment to the organization for a month to be paid by each trust fund shall be determined as follows:

''(A) In regard to expenditures by eligible organizations having risk-sharing contracts, the allocation shall be determined each year by the Secretary based on the relative weight that benefits from each fund contribute to the adjusted average per capita cost.

''(B) In regard to expenditures by eligible organizations operating under a reasonable cost reimbursement contract, the initial allocation shall be based on the plan's most recent budget, such allocation to be adjusted, as needed, after cost settlement to reflect the distribution of actual expenditures.

The remainder of that payment shall be paid by the former trust fund.

''(7) Subject to paragraphs (2)(B)(ii) and (7) of subsection (c), if an individual is enrolled under this section with an eligible organization having a risk-sharing contract, only the eligible organization shall be entitled to receive payments from the Secretary under this title for services furnished to the individual.''.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall take effect on October 1, 1997.

(b) QUALITY STANDARDS.—

(1) REVISION OF CURRENT REQUIREMENTS; DEEMED STATUS OF ACCREDITED ORGANIZATIONS.—Section 1876(c)(6) of the Social Security Act (42 U.S.C. 1395mm(c)(6)) is amended to read as follows:

''(6)(A) The organization must meet quality standards established by the Secretary in consultation with appropriate private quality accreditation entities. Such standards shall include a requirement that the organization have arrangements for an ongoing quality assurance program for health care services it provides to such individuals, which (i) stresses health outcomes, and (ii) provides review by physicians and other health care professionals of the process followed in the provision of such health care services.

''(B) If the Secretary finds that accreditation of an organization by the National Committee on Quality Assurance or any other national accreditation body provides reasonable assurance that the organization meets quality standards at least as stringent as those established under subparagraph (A), then any organization so accredited is

deemed to have met the quality standards established under such subparagraph.''.

(2) WAIVER OF ''50/50'' RULE FOR CERTAIN ORGANIZATIONS.—Section 1876(f) of the Social Security Act (42 U.S.C. 1395mm(f)) is amended by adding at the end the following:

''(4) The requirement of paragraph (1) shall not apply in the case of an organization that either—

''(A) is (and has been for a minimum period specified by the Secretary and not longer than 3 years) accredited by an accreditation body described in subsection (c)(6)(B), or

''(B) the Secretary determines has met (or has been deemed to have met) the quality standards described in subsection (c)(6)(A) over a minimum period specified by the Secretary.''.

(c) ENROLLMENT AND DISENROLLMENT PERIODS.—

(1) MONTHLY ENROLLMENT PERIOD.—Section 1876(c)(3) of the Social Security Act (42 U.S.C. 1395mm(c)(3)) is amended by striking subparagraph (A) and inserting the following:

''(A) Each eligible organization shall have a monthly enrollment period for the enrollment of individuals under this section, and shall provide that at any time during

which enrollments are accepted, the organization will accept up to the limits of its capacity (as determined by the Secretary) and without restrictions, except as may be authorized in regulations, individuals who are eligible to enroll under subsection (d) in the order in which they apply for enrollment, unless to do so would result in failure to meet the requirements of subsection (f) or would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the population in the geographic area served by the organization.''.

(2) DISENROLLMENT PERIOD.—The first sentence of section 1876(c)(3)(B) of the Social Security Act (42 U.S.C. 1395mm(c)(3)(B)) is amended to read as follows:

''(B) An individual may enroll under this section with an eligible organization in such manner as may be prescribed in regulations and may terminate that enrollment with that eligible organization as of the first day of every month if the request for termination is made during the first year that the individual is enrolled with that organization and as of the first day of every sixth month following such request thereafter.''.

(d) REQUIREMENTS FOR SERVICE AREAS.—

(1) IN GENERAL.—Section 1876 of the Social Security Act (42 U.S.C. 1395mm) is amended by adding at the end the following:

''(k)(1) Except as provided in paragraph (2), for purposes of this section, if an eligible organization's service area includes any part of a metropolitan statistical area, the service area shall include the entire metropolitan statistical area (including any area designated by the Secretary as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act within such metropolitan statistical area).

''(2) The Secretary may permit an organization's service area to exclude any portion of a metropolitan statistical area (other than the central county of such metropolitan statistical area) if—

''(A) the organization demonstrates that it lacks the financial or administrative capacity to serve the entire metropolitan statistical area; and

''(B) the Secretary finds that the composition of the organization's service area does not reduce the financial risk to the organization of providing services to enrollees because of the health status or other demographic characteristics of individuals residing in the service area (as compared to the health status or demographic characteristics of individuals

residing in the portion of the metropolitan statistical area not included in the organization's service area).''.

(2) CONFORMING AMENDMENT.—Section 1876(c)(4)(A)(i) of the Social Security Act (42 U.S.C. 1395mm(c)(4)(A)(i)) is amended by striking ''the area served by the organization'' and inserting ''the organization's service area''.

(e) OTHER ENROLLEE PROTECTIONS.—

(1) CLARIFICATION OF RESTRICTIONS ON CHARGES FOR OUT-OF-PLAN SERVICES.—

(A) INPATIENT HOSPITAL AND EXTENDED CARE SERVICES.—Section 1866(a)(1)(O) of the Social Security Act (42 U.S.C. 1395cc(a)(1)(O)) is amended in the matter preceding clause (i) by inserting after ''this title'' the following: ''(without regard to whether or not the services are furnished on an emergency basis)''.

(B) PHYSICIANS' SERVICES AND RENAL DIALYSIS SERVICES.—Section 1876(j)(1)(A) of the Social Security Act (42 U.S.C. 1395mm(j)(1)(A)) is amended by striking ''this

section'' and inserting ''this section (without regard to whether or not the services are furnished on an emergency basis)''.

(2) ARRANGEMENTS FOR DIALYSIS SERVICES.—Section 1876(c) of the Social Security Act (42 U.S.C. 1395mm(c)) is amended by adding at the end the following:

''(9) Each eligible organization shall assure that enrollees requiring renal dialysis services who are temporarily outside of the organization's service area (within the United States) have reasonable access to such services by—

''(A) making such arrangements with providers of services or renal dialysis facilities outside the service area for the coverage of and payment for such services furnished to enrollees as the Secretary determines necessary to assure reasonable access; or

''(B) providing for the reimbursement of any provider of services or renal dialysis facility outside the service area for the furnishing of such services to enrollees.''.

(3) STUDY AND REPORT.—

(A) STUDY.—The Secretary shall conduct a study of how to provide increased portability

of items and services provided under a plan offered by an eligible organization with a risk-sharing contract under section 1876 of the Social Security Act (42 U.S.C. 1395mm).

(B) REPORT TO CONGRESS.—Not later than 18 months after the date of enactment of this Act, the Secretary shall submit a report to Congress which shall contain a detailed statement of the findings and conclusions of the Secretary with respect to the study conducted under subparagraph (A), together with the Secretary's recommendations for such legislation and administrative actions as the Secretary considers appropriate.

(f) OUTLIER PAYMENTS.— Section 1876(a)(1) of the Social Security Act (42 U.S.C. 1395mm(a)(1)) (as amended by subsection (a) of this section) is amended by adding at the end the following:

''(G)(i) In the case of an eligible organization with a risk-sharing contract, the Secretary may make additional payments to the organization equal to not more than 50 percent of the imputed reasonable cost (or, if so requested by the organization, the reasonable cost) above the threshold amount of services covered under parts A

and B and provided (or paid for) in a year by the organization to any individual enrolled with the organization under this section.

''(ii) For purposes of clause (i), the 'imputed reasonable cost' is an amount determined by the Secretary on a national, regional, or other basis that is related to the reasonable cost of services.

''(iii) For purposes of clause (i), the 'threshold amount' is an amount determined by the Secretary from time to time, adjusted by the geographic factor utilized in determining payments to the organization under subparagraph (B) and rounded to the nearest multiple of $100, such that the total amount to be paid under this subparagraph for a year is estimated to be 5 percent or less of the total amount to be paid under risk-sharing contracts for services furnished for that year.

''(iv) An eligible organization shall submit a claim for additional payments under subsection (i) within such time as the Secretary may specify.

''(v) To the extent that total payments under clause (i) in a year—

''(I) exceed the payment set aside as a result of the reduction under subparagraph (B) for the year, the Secretary shall increase the percentage reduction under such subparagraph for the following year by

such percentage as will result in an increase in the reduction equal to such excess in previous payments, or

''(II) are less than the payment set aside as a result of the reduction under subparagraph (B) for the year, the amount of such difference shall remain available in the succeeding years for additional payments under this subparagraph and the Secretary may take such difference into account in establishing the percentage reduction under subparagraph (B) for the following year.''.

(g) APPLICATION OF INTERMEDIATE SANCTIONS FOR ANY PROGRAM VIOLATIONS.—

(1) IN GENERAL.—Section 1876(i)(1) of the Social Security Act (42 U.S.C. 1395mm(i)(1)) is amended by striking ''the Secretary may terminate'' and all that follows and inserting the following: ''in accordance with procedures established under paragraph (9), the Secretary may at any time terminate any such contract or impose the intermediate sanctions described in subparagraph (B) or (C) of paragraph (6) (whichever is applicable) on the eligible organization if the Secretary determines that the organization—

''(A) has failed substantially to carry out the contract;

''(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this section;

''(C) is operating in a manner that is not in the best interests of the individuals covered under the contract; or

''(D) no longer substantially meets the applicable conditions of subsections (b), (c), (e), and (f).''.

(2) OTHER INTERMEDIATE SANCTIONS FOR MISCELLANEOUS PROGRAM VIOLATIONS.—Section 1876(i)(6) (42 U.S.C. 1395mm(i)(6)) is amended by adding at the end the following:

''(C) In the case of an eligible organization for which the Secretary makes a determination under paragraph (1) the basis of which is not described in subparagraph (A), the Secretary may apply the following intermediate sanctions:

''(i) Civil money penalties of not more than $25,000 for each determination under paragraph (1) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract.

''(ii) Civil money penalties of not more than $10,000 for each week beginning after the initiation of procedures by the Secretary under paragraph (9) during which the deficiency that is the basis of a determination under paragraph (1) exists.

''(iii) Suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.''.

(3) PROCEDURES FOR IMPOSING SANCTIONS.—Section 1876(i) (42 U.S.C. 1395mm(i)) is amended by adding at the end the following:

''(9) The Secretary may terminate a contract with an eligible organization under this section or may impose the intermediate sanctions described in paragraph (6) on the organization in accordance with formal investigation and compliance procedures established by the Secretary under which—

''(A) the Secretary provides the organization with the opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under paragraph (1);

''(B) the Secretary imposes more severe sanctions on organizations that have a history of deficiencies or that have not taken steps to correct deficiencies the Secretary has brought to their attention;

''(C) there are no unreasonable or unnecessary delays between the finding of a deficiency and the imposition of sanctions; and

''(D) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before imposing any sanction or terminating the contract.''.

(4) CONFORMING AMENDMENTS.—

(A) Section 1876(i)(6)(B) of the Social Security Act (42 U.S.C. 1395mm(i)(6)(B)) is amended by striking the second sentence.

(B) Section 1876(i)(6) of the Social Security Act (42 U.S.C. 1395mm(i)(6)) is further amended by adding at the end the following:

''(D) The provisions of section 1128A (other than subsections (a), (b), and (m)) shall apply to a civil money penalty under subparagraph (A) or (B) in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).''.

(h) AGREEMENTS WITH PEER REVIEW ORGANIZATIONS.—

(1) REQUIREMENT FOR WRITTEN AGREEMENT.—Section 1876(i)(7)(A) of the Social Security Act (42 U.S.C. 1395mm(i)(7)(A)) is amended by striking ''an agreement'' and inserting ''a written agreement''.

(2) DEVELOPMENT OF MODEL AGREEMENT.—Not later than July 1, 1998, the Secretary shall develop a model of the agreement that an eligible organization with a risk-sharing contract under section 1876 of the Social Security Act (42 U.S.C. 1395mm) must enter into with an entity providing peer review services with respect to services provided by the organization under section 1876(i)(7)(A) of that Act.

(3) REPORT BY GAO.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study of the costs incurred by eligible organizations with risk-sharing contracts under section 1876 of the Social Security Act (42 U.S.C. 1395mm) of complying with the requirement of entering into a written agreement with an entity providing

peer review services with respect to services provided by the organization, together with an analysis of how information generated by such entities is used by the Secretary to assess the quality of services provided by such eligible organizations.

(B) REPORT TO CONGRESS.—Not later than July 1, 1998, the Comptroller General of the United States shall submit a report to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate on the study conducted under subparagraph (A).

(i) ELIMINATION OF GAG CLAUSES.—

(1) IN GENERAL.—Section 1876(i) of the Social Security Act (42 U.S.C. 1395mm(i)) (as amended by subsection (g)) is amended by adding at the end the following:

''(10)(A) Each contract with an eligible organization under this section shall provide that the organization may not prohibit an applicable individual from openly communicating, within the scope of such individual's license (or such individual's group license), with any patient of such

individual who is covered under this section with respect to such patients'—

''(i) physical or mental condition;

''(ii) medical care; or

''(iii) appropriate treatment options.

''(B) As used in this paragraph, the term 'applicable individual' means a health care provider who—

''(i) provides items and services under this section; and

''(ii) is licensed or certified by the State in which such items and services are provided.''.

(2) ENFORCEMENT.—Section 1876(i)(6)(A)(vi) of the Social Security Act (42 U.S.C. 1395mm(i)(6)(A)(iv)) is amended by striking ''paragraph (8)'' and inserting ''paragraph (8) or (10)''.

(j) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall apply to contract years beginning with 1998.

SEC. 202. QUALITY REPORT CARDS AND COMPARATIVE REPORTS.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by inserting after section 1804 the following:

''QUALITY REPORT CARDS AND COMPARATIVE REPORTS

''SEC. 1805. (a) DISTRIBUTION OF QUALITY REPORT CARDS AND COMPARATIVE REPORTS.—Beginning with

calendar year 1998, the Secretary shall include with the notice distributed under section 1804 a quality report card and a comparative report. The quality report card and comparative report shall contain information designed to assist medicare beneficiaries in choosing eligible organizations including a comparison of benefits, costs, and the quality indicators developed under subsection (b).

''(b) QUALITY REPORT CARDS.—

''(1) IN GENERAL.—The Secretary shall develop quality indicators for eligible organizations that will assist medicare beneficiaries' decisionmaking regarding health care and treatment by allowing the beneficiaries to compare quality information.

''(2) QUALITY INDICATORS DESCRIBED.—The quality indicators developed under paragraph (1) may include the following:

''(A) Information on the number of members of an eligible organization who disenroll from the organization.

''(B) Outcomes of care.

''(C) Population health status.

''(D) Appropriateness of care.

''(E) Consumer satisfaction for general and subgroup populations.

''(F) Access to care, including access to emergency care, waiting time for scheduled appointments, and provider location convenience.

''(G) Prevention of diseases, disorders, disabilities, injuries, and other health conditions.

''(3) ONGOING BASIS.—Development of quality indicators shall be done on an ongoing basis.

''(c) COMPARATIVE REPORTS.—

''(1) IN GENERAL.—The Secretary shall develop an understandable standardized comparative report on the plans offered by eligible organizations, that will assist medicare beneficiaries' decisionmaking regarding health care and treatment by allowing the beneficiaries to compare the organizations that the beneficiaries are eligible to enroll with.

''(2) CONTENTS OF REPORT.—The report described in paragraph (1) shall include a comparison of the following:

''(A) The monthly premium.

''(B) The amount of any deductibles and coinsurance.

''(C) The choice of doctors.

''(D) The choice of hospitals.

''(E) The service area.

''(F) Emergency room care coverage.

''(G) Hospital charges.

''(H) Physician charges.

''(I) Coverage of prescription drugs.

''(J) Ambulance coverage.

''(K) Coverage of routine eye exams and eyeglasses.

''(L) Coverage of skilled nursing facilities and home health care.

''(M) Coverage of hearing exams and hearing aids.

''(N) Coverage of mental health therapy.

''(O) Any physician financial incentives.

''(P) The number of members in the plan.

''(Q) The number of individuals who voluntarily enrolled and disenrolled in the plan during the previous fiscal year.

''(R) The percentage of physicians in the plan who left the plan during the previous fiscal year.

''(S) Whether the plan offers a point of service option.

''(T) The number of applications during the previous fiscal year requesting that the plan cover certain out-of-network services and the number of such applications that were denied.

"(U) Any other materials that the Secretary determines would be helpful for beneficiaries to compare the organizations that the beneficiaries are eligible to enroll with.

"(d) FUNDING AND COMPLIANCE.—

"(1) IN GENERAL.—Each eligible organization shall—

"(A) disclose quality indicator data and the information necessary to complete the comparative report as requested, to the Secretary; and

"(B) pay to the Secretary the pro rata share, as determined by the Secretary, of the estimated costs to be incurred by the Secretary in carrying out the requirements of this section.

"(2) APPROPRIATION.—Any funds received in the Treasury as a result of payments made under paragraph (1)(B) are authorized to be appropriated and are appropriated to the Secretary, for the purposes described in such paragraph, and shall remain available until expended.

"(e) DEFINITIONS.—In this section—

"(1) the term 'eligible organization' means an organization with a risk-sharing contract under section 1876;

''(2) the term 'medicare beneficiary' means an individual entitled to benefits under part A or enrolled under part B; and

''(3) the term 'provider' means hospitals, physicians, nursing homes, and providers of ancillary services to medicare beneficiaries.''.

SEC. 203. PREEMPTION OF STATE LAWS RESTRICTING MANAGED CARE.

(a) PREEMPTION OF STATE BENEFIT MANDATES.—No State shall establish or enforce any law or regulation that requires the offering, as part of health insurance coverage to be offered to an individual entitled to benefits under the medicare program, of any services, category of care, or services of any class or type of provider.

(b) PREEMPTION OF STATE LAW RESTRICTIONS ON MANAGED CARE ARRANGEMENTS.—

(1) LIMITATION ON RESTRICTIONS ON NETWORK PLANS.—A State may not prohibit or limit—

(A) a carrier or group health plan providing health coverage from including incentives for enrollees to use the services of participating providers;

(B) such a carrier or plan from limiting coverage of services to those provided by a participating provider;

(C) the negotiation of rates and forms of payments for providers by such a carrier or plan with respect to health coverage;

(D) such a carrier or plan from limiting the number of participating providers;

(E) such a carrier or plan from requiring that services be provided (or authorized) by a practitioner selected by the enrollee from a list of available participating providers or from requiring enrollees to obtain referral in order to have coverage for treatment by a specialist or health institution; and

(F) the corporate practice of medicine.

(2) DEFINITIONS.—In this subsection:

(A) MANAGED CARE ARRANGEMENT.—The term ''managed care arrangement'' means, with respect to an arrangement under a group health plan or under health insurance coverage, providers who have entered into an agreement under the arrangement under which such providers are obligated to provide items and services covered under the arrangement to individuals covered under the plan or who have such coverage.

(B) MANAGED CARE COVERAGE.—The term ''managed care coverage'' means health coverage to the extent the coverage is provided through a managed care arrangement (as defined in subparagraph (A)).

(C) PARTICIPATING PROVIDER.—The term ''participating provider'' means an entity or individual that provides, sells, or leases health care services as part of a provider network (as defined in subparagraph (D)).

(D) PROVIDER NETWORK.—The term ''provider network'' means, with respect to a group health plan or health insurance coverage, providers who have entered into an agreement described in subparagraph (A) under a managed care arrangement.

(c) PREEMPTION OF STATE LAWS RESTRICTING UTILIZATION REVIEW PROGRAMS.—

(1) IN GENERAL.—No State law or regulation shall prohibit or regulate activities under a utilization review program (as defined in paragraph (2)).

(2) UTILIZATION REVIEW PROGRAM DEFINED.—In this subsection, the term ''utilization review program'' means a system of reviewing the medical necessity and appropriateness of patient

services (which may include inpatient and outpatient services) using specified guidelines. Such a system may include preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory procedures, and retrospective review.

(3) EXEMPTION OF LAWS PREVENTING DENIAL OF LIFESAVING MEDICAL TREATMENT PENDING TRANSFER TO ANOTHER HEALTH CARE PROVIDER.—Nothing in this section shall be construed to invalidate any State law that has the effect of preventing involuntary denial of life-preserving medical treatment when such denial would cause the involuntary death of the patient pending transfer of the patient to a health care provider willing to provide such treatment.

(d) EFFECTIVE DATE.—This section takes effect on January 1, 1998.

SEC. 204. APPEALS.

(a) OMBUDSMAN FOR MEDICARE HMO'S.—Section 1876(c) of the Social Security Act (42 U.S.C. 1395mm(c)) (as amended by section 201(e)(2) of this Act) is amended by adding at the end the following:

''(10) The organization shall designate an independent ombudsman to assist members enrolled with such organization with exercising such members' right to file grievances and appeals under paragraph (5).''.

(b) NOTICE BY MEDICARE HMO'S OF RIGHT TO FILE GRIEVANCES AND APPEALS.—Section 1876(c)(5) of the Social Security Act (42 U.S.C. 1395mm(c)(5)) is amended by adding at the end the following:

''(C)(i) The organization shall provide to a member enrolled with the organization a clear and understandable statement regarding such member's right to file grievances and appeals under paragraph (5).

''(ii) The statement described in clause (i) shall be provided to the member each time the member applies to the organization for items or services to be covered.''.

(c) EXPEDITING DETERMINATIONS AND APPEALS.—

(1) IN GENERAL.—Not later than 90 days after the date of enactment of this Act, the Secretary shall promulgate regulations that are intended to expedite determinations and appeals regarding covered items and services for individuals who are entitled to items and services under part A and eligible for items and services under part B of title XVIII of the Social Security Act.

(2) CONTENTS.—In promulgating the regulations required under paragraph (1), the Secretary shall consider whether to include a regulation that states that an individual need not partake in a fair hearing regarding a covered service if Health Care Financing Administration policy would require the fair hearing officer to rule against the individual.

SEC. 205. MEDICARE HMO ENROLLMENT FAIR.

(a) IN GENERAL.—Section 1876 of the Social Security Act (42 U.S.C. 1395mm) (as amended by section 201(d) of this Act) is amended by adding at the end the following:

''(l) In the month of November of each year, the Secretary shall coordinate an annual enrollment fair in each medicare payment area in order for eligible organizations to inform individuals eligible to enroll in the plans offered by those organizations under this section about the aspects of those plans, including the aspects described in section 1805(c)(2).''.

(b) REQUIREMENT FOR ELIGIBLE ORGANIZATIONS.—Section 1876(c) of the Social Security Act (42 U.S.C. 1395mm(c)) (as amended by section 204(a) of this Act) is amended by adding at the end the following:

''(11) The organization shall participate in the annual enrollment fair (coordinated by the Secretary under

subsection (l)) in each medicare payment area in which the organization offers a plan under this section.''.

Subtitle B—Maintaining Fee-for-Service Program

SEC. 211. FAILSAFE BUDGET MECHANISM.

(a) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following:

''FAILSAFE BUDGET MECHANISM

''SEC. 1894. (a) REQUIREMENT OF PAYMENT ADJUSTMENTS TO ACHIEVE MEDICARE BUDGET TARGETS.—

''(1) IN GENERAL.—If the Secretary determines under subsection (e)(3)(C) before a fiscal year (beginning with fiscal year 2000) that—

''(A) the fee-for-service expenditures (as defined in subsection (f)) for all sectors of medicare services (as defined in subsection (b)) for the fiscal year, will exceed

''(B) the sum of the allotments specified under subsection (c)(2) for such fiscal year (taking into account any adjustment in the allotment under subsection (g) for that fiscal year) for all sectors,

then, notwithstanding any other provision of this title, there shall be an adjustment (consistent with

subsection (d)) in applicable payment rates or payments for items and services included in each excess spending sector in the fiscal year. In this section, the term 'aggregate excess spending' means, for a fiscal year, the amount by which the amount described in subparagraph (A) (for the fiscal year) exceeds the amount described in subparagraph (B) for such year.

''(2) EXCESS SPENDING SECTOR.—In this section, the term 'excess spending sector' means, for a fiscal year, a sector of medicare services for which the Secretary determines under subsection (e)(3)(C)—

''(A) the fee-for-service expenditures (as defined in subsection (f)) for the fiscal year, will exceed

''(B) the allotment specified under subsection (c)(2) for such fiscal year (taking into account any adjustment in the allotment under subsection (g) for that fiscal year).

In this section, the term 'excess spending' means, for a fiscal year with respect to such a sector, the amount by which the amount described in subparagraph (A) (for the fiscal year and sector) exceeds

the amount described in subparagraph (B) for such year and sector.

''(b) SECTORS OF MEDICARE SERVICES DESCRIBED.—

''(1) IN GENERAL.—For purposes of this section, items and services included under each of the following subparagraphs shall be considered to be a separate 'sector' of medicare services:

''(A) Inpatient hospital services.

''(B) Home health services.

''(C) Extended care services (for inpatients of skilled nursing facilities).

''(D) Hospice care.

''(E) Physicians' services (including services and supplies described in section 1861(s)(2)(A)) and services of other health care professionals (including certified registered nurse anesthetists, nurse practitioners, physician assistants, and clinical psychologists) for which separate payment is made under this title.

''(F) Outpatient hospital services and ambulatory facility services.

''(G) Durable medical equipment and supplies, including prosthetic devices and orthotics.

''(H) Diagnostic tests (including clinical laboratory services and x-ray services).

''(I) Other items and services.

''(2) CLASSIFICATION OF ITEMS AND SERVICES.—The Secretary shall classify each type of item and service covered and paid for separately under this title into one of the sectors specified in paragraph (1). After publication of such classification under subsection (e)(1), the Secretary is not authorized to make substantive changes in such classification.

''(c) ALLOTMENT.—

''(1) ALLOTMENTS FOR EACH SECTOR.—For purposes of this section, subject to subsection (g)(1), the allotment for a sector of medicare services for a fiscal year is equal to the product of—

''(A) the total allotment for the fiscal year established under paragraph (2), and

''(B) the allotment proportion (specified under paragraph (3)) for the sector and fiscal year involved.

''(2) TOTAL ALLOTMENT.—

''(A) IN GENERAL.—For purposes of this section, the total allotment for a fiscal year is equal to—

"(i) the medicare benefit budget for the fiscal year (as specified under subparagraph (B)), reduced by

"(ii) the amount of payments the Secretary estimates will be made in the fiscal year under section 1876.

In making the estimate under clause (ii), the Secretary shall take into account estimated enrollment and demographic profile of individuals electing to enroll in section 1876.

"(B) MEDICARE BENEFIT BUDGET.—For purposes of this subsection, subject to subparagraph (C), the 'medicare benefit budget'—

"(i) for fiscal year 1998 is $225,070,000,000;

"(ii) for fiscal year 1999 is $239,590,000,000;

"(iii) for fiscal year 2000 is $252,490,000,000;

"(iv) for fiscal year 2001 is $271,890,000,000;

"(v) for fiscal year 2002 is $292,020,000,000; and

"(viii) for a subsequent fiscal year is equal to the medicare benefit budget under

this subparagraph for the preceding fiscal year multiplied by the product of (I) 1.05, and (II) 1 plus the annual percentage increase in the average number of medicare beneficiaries from the previous fiscal year to the fiscal year involved.

''(3) MEDICARE ALLOTMENT PROPORTION DEFINED.—

''(A) IN GENERAL.—For purposes of this section and with respect to a sector of medicare services for a fiscal year, the term 'medicare allotment proportion' means the ratio of—

''(i) the baseline-projected medicare expenditures (as determined under subparagraph (B)) for the sector for the fiscal year, to

''(ii) the sum of such baseline expenditures for all such sectors for the fiscal year.

''(B) BASELINE-PROJECTED MEDICARE EXPENDITURES.—In this paragraph, the 'baseline-projected medicare expenditures' for a sector of medicare services—

''(i) for fiscal year 1998 is equal to fee-for-service expenditures for such sector

during fiscal year 1997, increased by the baseline annual growth rate for such sector of medicare services for fiscal year 1998 (as specified in the table in subparagraph (C)); and

"(ii) for a subsequent fiscal year is equal to the baseline-projected medicare expenditures under this subparagraph for the sector for the previous fiscal year increased by the baseline annual growth rate for such sector for the fiscal year involved (as specified in such table).

"(C) BASELINE ANNUAL GROWTH RATES.—The following table specifies the baseline annual growth rates for each of the sectors for different fiscal years:

"For the following sector—	Baseline annual growth rates for fiscal year—				
	1998	1999	2000	2001	2002 and thereafter
(A) Inpatient hospital services	6.0%	6.1%	5.7%	5.5%	5.2%
(B) Home health services	11.7%	9.1%	8.4%	8.1%	7.9%
(C) Extended care services	9.3%	8.7%	8.6%	8.4%	8.0%
(D) Hospice care	18.0%	15.0%	12.0%	10.0%	9.0%
(E) Physicians' services	8.7%	9.0%	9.3%	9.6%	10.1%
(F) Outpatient hospital services	14.5%	15.0%	14.1%	13.9%	14.0%
(G) Durable medical equipment and supplies	13.7%	12.4%	13.2%	13.9%	14.5%
(H) Diagnostic tests	11.0%	11.4%	11.4%	11.5%	11.9%
(I) Other items and services	10.9%	12.0%	11.6%	11.6%	11.8%

"(d) MANNER OF PAYMENT ADJUSTMENT.—

"(1) PAYMENT REDUCTIONS.—

"(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall apply a payment reduction for each excess spending sector for a fiscal year in such a manner as to—

"(i) make a change in payment rates (to the maximum extent practicable) at the time payment rates are otherwise changed or subject to change for that fiscal year; and

"(ii) provide for the full appropriate adjustment so that the fee-for-service expenditures for the sector for the fiscal year will be reduced by 133⅓ percent of the amount of the sector reduction target for that sector.

"(B) SECTOR REDUCTION TARGET.—In paragraph (1), the 'sector reduction target' for an excess spending sector for a fiscal year is equal to the product of—

"(i) the amount of the excess spending for such sector and year (as defined in subsection (a)(2)); and

"(ii) the ratio of—

"(I) the aggregate excess spending for the year (as defined in subsection (a)(1)), to

"(II) the sum of the amounts of the excess spending for all excess spending sectors.

"(2) TAKING INTO ACCOUNT VOLUME AND CASH FLOW.—In providing for an adjustment in payments under this subsection for a sector for a fiscal year, the Secretary shall take into account (in a manner consistent with actuarial projections)—

"(A) the impact of such an adjustment on the volume or type of services provided in such sector (and other sectors), and

"(B) the fact that an adjustment may apply to items and services furnished in a fiscal year (payment for which may occur in a subsequent fiscal year),

in a manner that is consistent with assuring that total fee-for-services expenditures for each sector for the fiscal year will not exceed the allotment under subsection (c)(1) for such sector for such year.

"(3) PROPORTIONALITY OF REDUCTIONS WITHIN A SECTOR.—In making adjustments under this

subsection in payment for items and services included within a sector of medicare services for a fiscal year, the Secretary shall provide for such an adjustment that results (to the maximum extent feasible) in the same percentage reductions in aggregate Federal payments under parts A and B for the different classes of items and services included within the sector for the fiscal year.

''(4) APPLICATION TO PAYMENTS MADE BASED ON PROSPECTIVE PAYMENT RATES DETERMINED ON A FISCAL YEAR BASIS.—

''(A) IN GENERAL.—In applying subsection (a) with respect to items and services for which payment is made under part A or B on the basis of rates that are established on a prospective basis for (and in advance of) a fiscal year, the Secretary shall provide for the payment adjustment under such subsection through an appropriate reduction in such rates established for items and services furnished (or, in the case of payment for operating costs of inpatient hospital services of subsection (d) hospitals and subsection (d) Puerto Rico hospitals (as defined in paragraphs (1)(B) and (9)(A) of section

1886(d)), discharges occurring) during such year.

''(B) DESCRIPTION OF APPLICATION TO SPECIFIC SERVICES.—The payment adjustment described in subparagraph (A) applies for a fiscal year to at least the following:

''(i) UPDATE FACTOR FOR PAYMENT FOR OPERATING COSTS OF INPATIENT HOSPITAL SERVICES OF PPS HOSPITALS.—To the computation of the applicable percentage increase specified in section 1886(d)(3)(B)(i) for discharges occurring in the fiscal year.

''(ii) HOME HEALTH SERVICES.—To the extent payment amounts for home health services are based on per visit payment rates under section 1895, to the computation of the increase in the national per visit payment rates established for the year under section 1895(b)(2)(B).

''(iii) HOSPICE CARE.—To the update of payment rates for hospice care under section 1814(i) for services furnished during the fiscal year.

"(iv) UPDATE FACTOR FOR PAYMENT OF OPERATING COSTS OF INPATIENT HOSPITAL SERVICES OF PPS-EXEMPT HOSPITALS.—To the computation of the target amount under section 1886(b)(3) for discharges occurring during the fiscal year.

"(5) APPLICATION TO PAYMENTS MADE BASED ON PROSPECTIVE PAYMENT RATES DETERMINED ON A CALENDAR YEAR BASIS.—

"(A) IN GENERAL.—In applying subsection (a) for a fiscal year with respect to items and services for which payment is made under part A or B on the basis of rates that are established on a prospective basis for (and in advance of) a calendar year, the Secretary shall provide for the payment adjustment under such subsection through an appropriate reduction in such rates established for items and services furnished at any time during such calendar year as follows:

"(i) For fiscal year 1999, the reduction shall be made for payment rates during calendar year 1999 in a manner so as to achieve the necessary payment reductions for such fiscal year for items and

services furnished during the first 3 quarters of calendar year 1999.

''(ii) For a subsequent fiscal year, the reduction shall be made for payment rates during the calendar year in which the fiscal year ends in a manner so as to achieve the necessary payment reductions for such fiscal year for items and services furnished during the first 3 quarters of the calendar year, but also taking into account the payment reductions made in the first quarter of the fiscal year resulting from payment reductions made under this paragraph for the previous calendar year.

''(iii) Payment rate reductions effected under this subparagraph for a calendar year and applicable to the last 3 quarters of the fiscal year in which the calendar year ends shall continue to apply during the first quarter of the succeeding fiscal year.

''(B) APPLICATION IN SPECIFIC CASES.—The payment adjustment described in subparagraph (A) applies for a fiscal year to at least the following:

"(i) UPDATE IN CONVERSION FACTOR FOR PHYSICIANS' SERVICES.—To the computation of the conversion factor under subsection (d) of section 1848 used in the fee schedule established under subsection (b) of such section, for items and services furnished during the calendar year in which the fiscal year ends.

"(ii) PAYMENT RATES FOR OTHER HEALTH CARE PROFESSIONALS.—To the computation of payments for professional services, furnished during the calendar year in which the fiscal year ends, of certified registered nurse anesthetists under section 1833(l), nurse midwives, physician assistants, nurse practitioners and clinical nurse specialists under section 1833(r), clinical psychologists, clinical social workers, physical or occupational therapists, and any other health professionals for which payment rates are based (in whole or in part) on payments for physicians' services.

"(iii) UPDATE IN LABORATORY FEE SCHEDULE.—To the computation of the

fee schedule amount under section 1833(h)(2) for clinical diagnostic laboratory services furnished during the calendar year in which the fiscal year ends.

''(iv) UPDATE IN REASONABLE CHARGES FOR VACCINES.—To the computation of the reasonable charge for vaccines described in section 1861(s)(10) for vaccines furnished during the calendar year in which the fiscal year ends.

''(v) DURABLE MEDICAL EQUIPMENT-RELATED ITEMS.—To the computation of the payment basis under section 1834(a)(1)(B) for covered items described in section 1834(a)(13), for items furnished during the calendar year in which the fiscal year ends.

''(vi) RADIOLOGIST SERVICES.—To the computation of conversion factors for radiologist services under section 1834(b), for services furnished during the calendar year in which the fiscal year ends.

''(vii) SCREENING MAMMOGRAPHY.—To the computation of payment rates for screening mammography under section

1834(c)(1)(C)(ii), for screening mammography performed during the calendar year in which the fiscal year ends.

''(viii) PROSTHETICS AND ORTHOTICS.—To the computation of the amount to be recognized under section 1834(h) for payment for prosthetic devices and orthotics and prosthetics, for items furnished during the calendar year in which the fiscal year ends.

''(ix) SURGICAL DRESSINGS.—To the computation of the payment amount referred to in section 1834(i)(1)(B) for surgical dressings, for items furnished during the calendar year in which the fiscal year ends.

''(x) PARENTERAL AND ENTERAL NUTRITION.—To the computation of reasonable charge screens for payment for parenteral and enteral nutrition under section 1834(h), for nutrients furnished during the calendar year in which the fiscal year ends.

''(xi) AMBULANCE SERVICES.—To the computation of limits on reasonable charges for ambulance services, for services

furnished during the calendar year in which the fiscal year ends.

''(6) APPLICATION TO PAYMENTS MADE BASED ON COSTS DURING A COST REPORTING PERIOD.—

''(A) IN GENERAL.—In applying subsection (a) for a fiscal year with respect to items and services for which payment is made under part A or B on the basis of costs incurred for items and services in a cost reporting period, the Secretary shall provide for the payment adjustment under such subsection for a fiscal year through an appropriate proportional reduction in the payment for costs for such items and services incurred at any time during each cost reporting period any part of which occurs during the fiscal year involved, but only (for each such cost reporting period) in the same proportion as the fraction of the cost reporting period that occurs during the fiscal year involved.

''(B) APPLICATION IN SPECIFIC CASES.—The payment adjustment described in subparagraph (A) applies for a fiscal year to at least the following:

''(i) CAPITAL-RELATED COSTS OF HOSPITAL SERVICES.—To the computation

of payment amounts for inpatient and outpatient hospital services under sections 1886(g) and 1861(v) for portions of cost reporting periods occurring during the fiscal year.

''(ii) OPERATING COSTS FOR PPS-EXEMPT HOSPITALS.—To the computation of payment amounts under section 1886(b) for operating costs of inpatient hospital services of PPS-exempt hospitals for portions of cost reporting periods occurring during the fiscal year.

''(iii) DIRECT GRADUATE MEDICAL EDUCATION.—To the computation of payment amounts under section 1886(h) for reasonable costs of direct graduate medical education costs for portions of cost reporting periods occurring during the fiscal year.

''(iv) INPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—To the computation of payment amounts under section 1814(l) for inpatient rural primary care hospital services for portions of cost

reporting periods occurring during the fiscal year.

''(v) EXTENDED CARE SERVICES OF A SKILLED NURSING FACILITY.—To the computation of payment amounts under section 1861(v) for post-hospital extended care services of a skilled nursing facility for portions of cost reporting periods occurring during the fiscal year.

''(vi) REASONABLE COST CONTRACTS.—To the computation of payment amounts under section 1833(a)(1)(A) for organizations for portions of cost reporting periods occurring during the fiscal year.

''(vii) HOME HEALTH SERVICES.—Subject to paragraph (4)(B)(ii), for payment amounts for home health services, for portions of cost reporting periods occurring during such fiscal year.

''(7) OTHER.—In applying subsection (a) for a fiscal year with respect to items and services for which payment is made under part A or B on a basis not described in a previous paragraph of this subsection, the Secretary shall provide for the payment adjustment under such subsection through an

appropriate proportional reduction in the payments (or payment bases for items and services furnished) during the fiscal year.

''(8) ADJUSTMENT OF PAYMENT LIMITS.—The Secretary shall provide for such proportional adjustment in any limits on payment established under part A or B for items and services within a sector as may be appropriate based on (and in order to properly carry out) the adjustment to the amount of payment under this subsection in the sector.

''(9) REFERENCES TO PAYMENT RATES.—Except as the Secretary may provide, any reference in this title (other than this section) to a payment rate is deemed a reference to such a rate as adjusted under this subsection.

''(e) PUBLICATION OF DETERMINATIONS; JUDICIAL REVIEW.—

''(1) ONE-TIME PUBLICATION OF SECTORS AND GENERAL PAYMENT ADJUSTMENT METHODOLOGY.—Not later than October 1, 1998, the Secretary shall publish in the Federal Register the classification of medicare items and services into the sectors of medicare services under subsection (b) and the general

methodology to be used in applying payment adjustments to the different classes of items and services within the sectors.

''(2) INCLUSION OF INFORMATION IN PRESIDENT'S BUDGET.—

''(A) IN GENERAL.—With respect to fiscal years beginning with fiscal year 2001, the President shall include in the budget submitted under section 1105 of title 31, United States Code, information on—

''(i) the fee-for-service expenditures, within each sector, for the second previous fiscal year, and how such expenditures compare to the adjusted sector allotment for that sector for that fiscal year; and

''(ii) actual annual growth rates for fee-for-service expenditures in the different sectors in the second previous fiscal year.

''(B) RECOMMENDATIONS REGARDING GROWTH FACTORS.—The President may include in such budget for a fiscal year (beginning with fiscal year 2000) recommendations regarding percentages that should be applied (for one or more fiscal years beginning with that fiscal year) instead of the baseline annual growth

rates under subsection (c)(3)(C). Such recommendations shall take into account medically appropriate practice patterns.

"(3) DETERMINATIONS CONCERNING PAYMENT ADJUSTMENTS.—

"(A) RECOMMENDATIONS OF COMMISSIONS.—By not later than March 1 of each year (beginning with 1999), the Prospective Payment Review Commission and the Physician Payment Review Commission shall jointly submit to the Secretary and the Congress a report that analyzes the previous operation (if any) of this section and that includes recommendations concerning the manner in which this section should be applied for the following fiscal year.

"(B) PRELIMINARY NOTICE BY SECRETARY.—Not later than May 15 preceding the beginning of each fiscal year (beginning with fiscal year 2000), the Secretary shall publish in the Federal Register a notice containing the Secretary's preliminary determination, for each sector of medicare services, concerning the following:

''(i) The projected allotment under subsection (c) for such sector for the fiscal year.

''(ii) Whether there will be a payment adjustment for items and services included in such sector for the fiscal year under subsection (a).

''(iii) If there will be such an adjustment, the size of such adjustment and the methodology to be used in making such a payment adjustment for classes of items and services included in such sector.

''(iv) Beginning with fiscal year 2001, the fee-for-service expenditures for such sector for the second preceding fiscal year.

Such notice shall include an explanation of the basis for such determination. Determinations under this subparagraph and subparagraph (C) shall be based on the best data available at the time of such determinations.

''(C) FINAL DETERMINATION.—Not later than September 1 preceding the beginning of each fiscal year (beginning with fiscal year 2000), the Secretary shall publish in the Federal Register a final determination, for each

sector of medicare services, concerning the matters described in subparagraph (B) and an explanation of the reasons for any differences between such determination and the preliminary determination for such fiscal year published under subparagraph (B).

''(4) LIMITATION ON ADMINISTRATIVE OR JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1878 or otherwise of—

''(A) the classification of items and services among the sectors of medicare services under subsection (b),

''(B) the determination of the amounts of allotments for the different sectors of medicare services under subsection (c),

''(C) the determination of the amount (or method of application) of any payment adjustment under subsection (d), or

''(D) any adjustment in an allotment effected under subsection (g).

''(f) FEE-FOR-SERVICE EXPENDITURES DEFINED.—In this section, the term 'fee-for-service expenditures', for items and services within a sector of medicare services in a fiscal year, means amounts payable for such items and services which are furnished during the fiscal year, and—

''(1) includes types of expenses otherwise reimbursable under parts A and B (including administrative costs incurred by organizations described in sections 1816 and 1842) with respect to such items and services, and

''(2) does not include amounts paid under section 1876.

''(g) LOOK-BACK ADJUSTMENT IN ALLOTMENTS TO REFLECT ACTUAL EXPENDITURES.—

''(1) DETERMINATIONS.—

''(A) IN GENERAL.—If the Secretary estimates under subsection (e)(3)(B) with respect to a particular fiscal year (beginning with fiscal year 2000) that—

''(i) the fee-for-service expenditures for all sectors of medicare services for the second preceding fiscal year, exceeded

''(ii) the sum of the adjusted allotments for all sectors for such year (as defined in paragraph (2)),

then the allotment for each final excess spending sector (as defined in subparagraph (B)(i)) for the particular fiscal year shall be reduced by

the look-back sector reduction amount determined under subparagraph (B)(ii) for such sector and year.

''(B) FINAL EXCESS SPENDING SECTORS.—

''(i) IN GENERAL.—In this paragraph, the term 'final excess spending sector' means, for a fiscal year, a sector of medicare services for which the Secretary determines under subsection (e)(3)(B) that—

''(I) the fee-for-service expenditures (as defined in subsection (f)) for the fiscal year, exceeded

''(II) the adjusted allotment for such fiscal year.

For purposes of clause (ii), the term 'final excess spending' means, for a fiscal year with respect to such a sector, the amount by which the amount described in subclause (I) (for the fiscal year and sector) exceeds the amount described in subclause (II) for such year and sector.

''(ii) LOOK-BACK SECTOR REDUCTION AMOUNT.—In subparagraph (A)(i), the 'look-back sector reduction amount' for a

final excess spending sector for a fiscal year is equal to the product of—

"(I) the amount of the final excess spending for such sector and year (as defined in clause (i)); and

"(II) the ratio of—

"(a) the aggregate final excess spending for the year (described in subparagraph (A)(i)), to

"(b) the sum of the amounts of the final excess spending for all final excess spending sectors.

"(2) ADJUSTED ALLOTMENT.—The adjusted allotment under this paragraph for a sector for a fiscal year is—

"(A) the amount that would be computed as the allotment under subsection (c) for the sector for the fiscal year if the actual amount of payments made in the fiscal year under the section 1876 in the fiscal year were substituted for the amount described in subsection (c)(2)(A)(ii) for that fiscal year,

"(B) adjusted to take into account the amount of any adjustment under paragraph (1)

for that fiscal year (based on expenditures in the second preceding fiscal year).''.

(b) REPORT OF TRUSTEES ON GROWTH RATE IN PART A EXPENDITURES.—Section 1817 (42 U.S.C. 1395i) is amended by adding at the end the following:

''(k) Each annual report provided in subsection (b)(2) shall include information regarding the annual rate of growth in program expenditures that would be required to maintain the financial solvency of the Trust Fund and the extent to which the provisions of section 1894 restrain the rate of growth of expenditures under this part in order to achieve such solvency.''.

SEC. 212. MAINTENANCE OF PART B PREMIUM AT CURRENT PERCENTAGE OF PART B PROGRAM COSTS.

(a) IN GENERAL.—Section 1839(e)(1) of the Social Security Act (42 U.S.C. 1395r(e)(1)) is amended—

(1) in subparagraph (A)—

(A) by striking ''and prior to January 1999'', and

(B) by inserting ''(or, if higher the percent described in subparagraph (C))'' after ''50 percent''; and

(2) by adding at the end the following:

''(C) For purposes of subparagraph (A), the percent described in this subparagraph is the ratio (expressed as

a percent) of the monthly premium established under this section for months in 1996 to the monthly actuarial rate for enrollees age 65 and over, as determined under subsection (a)(1) and applicable to such months.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to premiums for months beginning with January 1997.

TITLE III—PROMOTION OF PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) AND OF SOCIAL HEALTH MAINTENANCE ORGANIZATIONS (SHMOS)

SEC. 301. DEFINITIONS.

In this title:

(1) PACE PROVIDER.—The term ''PACE provider'' means a provider of services—

(A) that—

(i) has filed an agreement with the Secretary under section 1866 of the Social Security Act (42 U.S.C. 1395cc);

(ii) is eligible to participate in a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.); or

(iii) is eligible to receive payment for such services under any other applicable title of the Social Security Act (42 U.S.C. 301 et seq.); and

(B) that has had an application approved under this title.

(2) MEDICAID PROGRAM.—The term ''medicaid program'' means the health care program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(3) MEDICARE PROGRAM.—The term ''medicare program'' means the health care program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

SEC. 302. EXPANDING THE AVAILABILITY OF QUALIFIED ORGANIZATIONS FOR FRAIL ELDERLY COMMUNITY PROJECTS (PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)).

(a) ESTABLISHMENT OF PACE PROVIDER STATUS.—

(1) IN GENERAL.—The Secretary shall establish PACE provider status for public and nonprofit community-based organizations (including nonprofit community-based organizations that are pending qualification for such status under section 501(c)(3)

of the Internal Revenue Code of 1986) to enable such organizations to provide comprehensive health care services of proper quality on a cost-effective, capitated basis to frail elderly patients at risk of institutionalization under titles XVIII or XIX of the Social Security Act (42 U.S.C. 1935 et seq., 1396 et seq.), or under any other applicable title of that Act. Each of the initial 3 years of such status shall be conditioned upon annual reapplication for such status and timely review and approval by the Secretary as to compliance with program requirements. During the 3-year period of conditional PACE provider status, the organization may, at its option and with the approval of the Secretary, or where determined necessary by the Secretary, institute procedures such as risk-sharing of service costs to allow the organization to progressively assume full financial risk. At the conclusion of the initial 3-year period, the organization shall undertake full financial risk for the cost of services provided to enrollees. Upon successful completion of the 3-year period, an organization may continue as a PACE provider, not conditioned upon annual reapplication for such status, but must thereafter continue to meet program requirements.

(2) APPROVAL OF APPLICATIONS.—An appropriately completed initial application for PACE provider status and any subsequent reapplication required under this title is deemed approved unless the Secretary specifically disapproves it in writing—

(A) not later than 90 days after the date the completed application is filed in proper form; or

(B) not later than 90 days after the date additional information is provided to the Secretary if the Secretary requests reasonable and substantial additional information during the 90-day period described in subparagraph (A).

(3) SOLE AUTHORITY.—The Secretary shall have sole and exclusive authority from the date of enactment of this Act to approve or disapprove the initial or continuing eligibility of an organization to participate in the program established under this title.

(4) CONSIDERATION OF EXISTING ORGANIZATIONS.—In reviewing an application for PACE provider status under this title, the Secretary shall—

(A) consider whether any existing organization already operates as a PACE provider

under this title in the proposed service area identified in the application; and

(B) if the Secretary determines that such an organization exists, ensure that the potential population of eligible individuals to be served by the applicant is reasonably sufficient to sustain an additional organization without jeopardizing the economic or service viability of any other organization operating in that service area.

(b) TERMS AND CONDITIONS FOR PROVIDER STATUS.—

(1) IN GENERAL.—Except as otherwise provided by law or regulation, the terms and conditions of PACE provider status granted pursuant to this title (other than terms and conditions specific to research and demonstration programs) shall be the following:

(A) The terms and conditions of the On Lok waiver (referred to in section 603(c) of the Social Security Amendments of 1983 (Public Law 98–21, 97 Stat. 168) and extended by section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272, 100 Stat. 183)).

(B) The terms and conditions provided under the Protocol for the Program of All-inclusive Care for the Elderly (PACE), as published by On Lok, Inc. as of April 14, 1995, and made generally available—

(i) including the components of the PACE service delivery model that—

(I) focus on frail, elderly enrollees who are age 55 or older, who meet State health status criteria for a nursing home level of care;

(II) provide comprehensive, integrated acute and long-term care services, including, at a minimum, all services covered under the medicare program and the medicaid program, without regard to any limitations on scope, extent, or frequency of service, and without requirement of deductible or copayment contributions;

(III) follow an interdisciplinary team approach to care management and service delivery;

(IV) utilize capitated, integrated financing that allows the organization

to pool payments received under the medicare program, the medicaid program, or from private entities or individuals; and

(V) allow the organization to progressively assume full financial risk; and

(ii) allowing, where appropriate and with approval from the Secretary or the State, reasonable flexibility in adapting the PACE service delivery model (in cases such as programs operated in rural areas, or allowing for the use of nonstaff physicians) where such flexibility is not inconsistent with and would not impair the essential elements, objectives, and requirements of the PACE program that are identified in clause (i).

(C) Mandatory reevaluation of an enrollee's eligibility for a nursing home level of care 1 year from the date of the individual's initial enrollment with a PACE provider, in order to assure the continued eligibility of enrollees over time, except that a State may, in accordance with regulations issued by the Secretary, ease

the administrative burden imposed by such a recertification process in any case where the advanced age, severity of chronic condition, or degree of impairment of functional capacity of the enrollee offers no reasonable expectation of improvement or significant change in eligibility during that 1-year period. If a State finds that an enrollee technically no longer meets the health status eligibility criteria for a nursing home level of care, the State may deem the enrollee eligible for continued enrollment with the PACE provider if the State finds, in accordance with regulations issued by the Secretary, that in the absence of the care being provided by the PACE provider, the enrollee reasonably would be expected to requalify for the program within the succeeding 6-month period. In the case of an enrollee that, through the recertification process is found to be ineligible for continuation in the program (including ineligible for deemed eligibility) the PACE provider shall assist the enrollee by making appropriate referrals and by making the enrollee's medical records available to new providers.

(D) A State may, upon notice to the Secretary, modify requirements under the State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) that relate to income or resources for otherwise eligible individuals where such modifications are comparable to modifications previously authorized by the Secretary for a State under a waiver granted prior to December 31, 1996, on behalf of organizations operating sites authorized under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509, 100 Stat. 2063), unless the Secretary formally finds that any such modification is not reasonably comparable to a modification previously authorized for the State under a waiver.

(2) INFORMATION REQUIREMENTS.—

(A) IN GENERAL.—The Secretary's approval of PACE provider status shall not be conditioned upon an organization collecting information for purposes other than operational purposes, including monitoring of cost and quality of care provided, except to the extent, if any, that any such information might have been required of a organization participating under

waivers as of December 31, 1996, but such unusual requirement may not continue beyond October 1, 1997. Issuance of interim and final regulations and implementation of this title shall not be conditioned upon any such information. Nothing in the preceding sentence shall be construed as prohibiting the Secretary, subsequent to the collection and review of any such unusual information, to make necessary modifications, if any, to implementing regulations for this title. The Secretary shall issue any regulations required under this title in a timely manner.

(B) RESEARCH.—The Secretary may require information from an organization operating as a PACE provider under this title for purposes of general research or general evaluation, but only if the organization agrees to participate in such research or evaluation and the organization is appropriately compensated for any expenses incurred, or where such research is undertaken entirely at the expense of the Secretary.

(c) ELIGIBILITY FOR PROVIDER STATUS.—

(1) IN GENERAL.—Upon successful completion of the first 3 years as a PACE provider under this title (conditioned upon annual review and annual approval of a renewal application by the Secretary, as provided in subsection (a)(1)), an organization that continues to meet the requirements of this title shall continue as a PACE provider under any applicable title of the Social Security Act (42 U.S.C. 301 et seq.), and shall be recognized as such in accordance with regulations promulgated by the Secretary, except that such regulations shall not condition such recognition upon formal annual review and approval.

(2) REQUIREMENTS.—No organization may be eligible to be a PACE provider under this title or under any applicable title of the Social Security Act (42 U.S.C. 301 et seq.) if—

(A) the Secretary specifically and formally finds that projected reimbursement for such organization would not, without any reimbursement modifications specified in the Secretary's finding, or, in the case of reimbursement under the medicaid program, a finding by the State, result in payments below the projected costs for a comparable population under the medicare program, the medicaid program, or under a

program operated under any other applicable title of such Act, or that the care provided by such organization is significantly deficient; and

(B) such projected reimbursement costs or significant deficiencies in quality of care are not appropriately adjusted or corrected on a timely basis (as determined by the Secretary) in accordance with the specific recommendations for reimbursement adjustments or corrections in the quality of service included in the Secretary's (or the State's, as applicable) formal finding under subparagraph (A).

(d) REIMBURSEMENT.—Notwithstanding any other provision of law, an organization that is eligible to be a PACE provider under any applicable title of the Social Security Act (42 U.S.C. 301 et seq.) as a result of this title, shall ordinarily be reimbursed on a capitation basis. Any such organization may provide additional services as deemed appropriate by the organization for qualified enrollees without regard to whether such services are specifically reimbursable through capitation payments. To the extent such services, in terms of type or frequency, are not reimbursable, no payments for such services may be required of enrollees.

(e) APPLICATION TO ON LOK WAIVERS.—The provisions of this title also shall apply to an organization operating under the On Lok waiver described in subsection (b)(1)(A).

(f) APPLICATION OF INCOME AND RESOURCES STANDARDS FOR CERTAIN INSTITUTIONALIZED SPOUSES.—Section 1924 of the Social Security Act (42 U.S.C. 1396r–5) (relating to the treatment of income and resources for certain institutionalized spouses) shall apply to any individual receiving services from an organization operating as a PACE provider under this title.

(g) PROVISION OF SERVICES TO ADDITIONAL POPULATIONS.—Nothing in this title shall prevent any participating organization from independently developing distinct programs to provide appropriate services to frail populations other than the elderly under any provision of law other than this title, except where the Secretary finds that the provision of such services impairs the ability of the organization to provide services under this title.

SEC. 303. APPLICATION OF SPOUSAL IMPOVERISHMENT RULES.

Section 1924(a)(5) of the Social Security Act (42 U.S.C. 1396r–5(a)(5)) is amended to read as follows:

''(5) APPLICATION TO INDIVIDUALS RECEIVING SERVICES FROM CERTAIN ORGANIZATIONS.—This

section applies to individuals receiving institutional or noninstitutional services from any organization—

''(A) operating under a waiver under—

''(i) section 603(c) of the Social Security Amendments of 1983 (Public Law 98–21, 97 Stat. 168) (as in effect on the day before the date of enactment of the Medicare Modernization and Patient Protection Act of 1997);

''(ii) section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509, 100 Stat. 2063) (as so in effect); or

''(iii) section 301 of the Medicare Modernization and Patient Protection Act of 1997; or

''(B) that is a PACE provider under the Medicare Modernization and Patient Protection Act of 1997.''.

SEC. 304. PERMITTING EXPANSION AND MAKING PERMANENT SHMO WAIVERS.

Notwithstanding any other provision of law, in the case of projects described in section 2355(b) of the Deficit Reduction Act of 1984 (Public Law 98–369, 98 Stat. 1103)—

(1) there shall be no limitation on the number of projects that the Secretary may approve under such section;

(2) there shall be no limitation on the number of individuals that may participate in any such project;

(3) there shall be no limitation on the period of the waivers under subsection (c) of such section with respect to such a project so long as the Secretary continues to find that the project meets the applicable requirements of such section; and

(4) the projects shall not be required to submit research-related reports after completion of the authorized period of the project (determined without regard to paragraph (3)).

SEC. 305. REPEALS; EFFECTIVE DATE.

(a) REPEALS.—Except as provided in subsection (b), section 603(c) of the Social Security Amendments of 1983 (Public Law 98–21, 97 Stat. 168), section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272, 100 Stat. 183), and section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509, 100 Stat. 2063) are repealed.

(b) REGULATIONS.—Not later than the first day of the month that begins 9 months after the date of enactment of this Act, the Secretary shall issue, implement, and make effective interim final regulations applicable to the provisions of this title. Until such date or the date that interim final regulations applicable to this title are effective and implemented, if earlier, the authority for—

(1) On Lok and up to 15 demonstration sites, as authorized under section 603(c) of the Social Security Amendments of 1983 (Public Law 98–21, 97 Stat. 168) (as in effect on the day before the date of enactment of this Act) and extended by section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272, 100 Stat. 183); and

(2) demonstration sites under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509, 100 Stat. 2063) (as so in effect),

shall remain in effect. Upon issuance and implementation of interim final regulations governing PACE providers, On Lok and any demonstration site that has completed an initial 3-year demonstration period, and which are otherwise qualified under such regulations, shall be eligible for

PACE provider status without requirement of annual reapplication so long as On Lok and the site comply, as determined by the Secretary in a timely fashion, with applicable program requirements. A demonstration site otherwise qualified, but which has not completed a 3-year period under waivers, shall convert from a waivered program to a PACE provider with such status predicated upon annual review and approval by the Secretary under this title. Following successful completion, as determined by the Secretary, of the third year, such site may continue as a PACE provider not conditioned upon annual reapplication for such status but must thereafter continue to meet program requirements.

(c) TRANSITION RULE.—Any organization informally known as a pre-PACE site operating on a capitation basis under only the medicaid program and which has formally expressed the intent to move to dual capitation under both the medicare program and the medicaid program, but which, as of the date of enactment of this Act, has not received waivers authorized under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509, 100 Stat. 2063), shall be eligible to operate as a PACE provider on a temporary basis if the organization applies for such status under the medicare program and the medicaid program prior to any issuance of interim or

final regulations by the Secretary and the organization meets the terms and conditions applied to organizations operating under demonstration authority provided under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509, 100 Stat. 2063) prior to the date of enactment of this Act. Upon issuance of interim or final regulations governing PACE providers, an organization operating as a PACE provider under the authority of this subsection, shall apply for regular PACE provider status under this title.

TITLE IV—OTHER MEDICARE CHANGES

SEC. 401. APPLICATION OF COMPETITIVE ACQUISITION PROCESS FOR PART B ITEMS AND SERVICES.

(a) GENERAL RULE.—Part B of title XVIII of the Social Security Act is amended by inserting after section 1846 the following:

''COMPETITION ACQUISITION FOR ITEMS AND SERVICES

''SEC. 1847. (a) ESTABLISHMENT OF BIDDING AREAS.—

''(1) IN GENERAL.—The Secretary is authorized to establish competitive acquisition areas for the purpose of awarding a contract or contracts for the furnishing under this part of the items and services described in subsection (c) on or after January 1,

1997. The Secretary may establish different competitive acquisition areas under this subsection for different classes of items and services under this part.

''(2) CRITERIA FOR ESTABLISHMENT.—The competitive acquisition areas established under paragraph (1) shall be chosen based on the availability and accessibility of multiple suppliers and the probable savings to be realized by the use of competitive bidding in the furnishing of items and services in the area.

''(b) AWARDING OF CONTRACTS IN AREAS.—

''(1) IN GENERAL.—The Secretary shall conduct a competition among individuals and entities supplying items and services under this part for each competitive acquisition area established under subsection (a) for each class of items and services.

''(2) CONDITIONS OF COMPETITION.—

''(A) SECRETARIAL FLEXIBILITY.—In conducting the competition, the Secretary may provide, with respect to items and services that are subject to the competition and are furnished in the area involved, that—

''(i) the selected entity (or entities) shall be the exclusive supplier (or suppliers) of such items and services in the area, if such entity (or entities) have the sufficient capacity to provide all such items and services required in the area under this part; or

''(ii) the amount of payment made under this part for such items and services shall be determined based upon the lowest bid among entities participating in that competition for all suppliers of such items and services in the area who agree to accept such payment amount as payment in full under this part.

''(B) TREATMENT OF RELATED PROFESSIONAL SERVICES.—In the case of a competition relating to diagnostic tests, a bid may not be accepted in relation to related professional services unless the services will be furnished by a physician who is a participating physician or otherwise agrees to accept payment on an assignment-related basis for all such services.

''(3) CONDITIONS FOR AWARDING CONTRACT.—The Secretary may not award a contract to any individual or entity under the competition conducted pursuant to paragraph (1) to furnish an item or service under this part unless the Secretary finds that the individual or entity—

''(A) meets quality standards specified by the Secretary for the furnishing of such item or service; and

''(B) in the case of a competition described in subsection (b)(2)(A)(i), offers to furnish a total quantity of such item or service that is sufficient to meet the expected need within the competitive acquisition area.

''(4) CONTENTS OF CONTRACT.—A contract entered into with an individual or entity under the competition conducted pursuant to paragraph (1) shall specify (for all of the items and services within a class)—

''(A) in the case of a competition described in subsection (b)(2)(A)(i), the quantity of items and services the entity shall provide; and

''(B) such other terms and conditions as the Secretary may require.

''(c) SERVICES DESCRIBED.—The items and services to which the provisions of this section shall apply are as follows:

''(1) Durable medical equipment and related supplies, including oxygen and oxygen equipment.

''(2) Clinical laboratory services.

''(3) Prosthetic devices, orthotics, prosthetics, and related supplies.

''(4) Diagnostic tests, including magnetic resonance imaging tests and computerized axial tomography scans, including a physician's interpretation of the results of diagnostic tests.

''(5) Surgical dressings.

''(6) Such other items and services for which the Secretary determines that the use of competitive acquisition under this section will be appropriate and cost-effective.''.

(b) IMPLEMENTATION OF COMPETITION.—

(1) LIMITATION TO SELECTED SUPPLIERS IN CASE OF EXCLUSIVE COMPETITIONS.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended—

(A) by striking ''or'' at the end of paragraph (14);

(B) by striking the period at the end of paragraph (15) and inserting ''; or''; and

(C) by inserting after paragraph (15) the following:

''(16) where such expenses are for an item or service furnished in a competitive acquisition area (as established by the Secretary under section 1847(a)) pursuant to a competition described in section 1847(b)(2)(A)(i) by an individual or entity other than the supplier with whom the Secretary has entered into a contract under section 1847(b) for the furnishing of such item or service in that area, except in the case of professional services described in section 1847(c)(4) and in such other cases (such as an emergency) as the Secretary may specify.''.

(2) LIMITATION TO LOWEST BID IN CASE OF NONEXCLUSIVE COMPETITIONS.—Section 1833(a) of the Social Security Act (42 U.S.C. 1395l(a)) is amended—

(A) by striking ''and'' at the end of paragraph (6);

(B) by striking the period at the end of paragraph (7) and inserting ''; and''; and

(C) by adding at the end the following:

''(8) notwithstanding the previous provisions of this subsection, in the case of an item or service which is subject to a competition described in section 1847(b)(2)(A)(ii), 80 percent of the amount determined pursuant to the competition.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished under part B of title XVIII of the Social Security Act on or after January 1, 1997.

SEC. 402. SIMPLER PROCEDURE FOR INHERENT REASONABLENESS DETERMINATIONS.

(a) IN GENERAL.—The first sentence of section 1834(a)(10)(B) of the Social Security Act (42 U.S.C. 1395m(a)(10)(B)) is amended by striking ''paragraphs (8) and (9)'' and all that follows up to the period at the end and inserting ''section 1842(b)(8) to covered items and suppliers of such items and payments under this subsection as such provisions apply to items and services and entities and a reasonable charge under section 1842(b)''.

(b) ELIMINATION OF OBSOLETE PROVISIONS.—Section 1842(b) of the Social Security Act (42 U.S.C. 1395u(b)) is amended—

(1) in paragraph (8)—

(A) by striking subparagraphs (B) and (C), and

(B) in subparagraph (A)—

(i) by striking ''(A)'', and

(ii) by redesignating clauses (i) and (ii) as subparagraphs (A) and (B), respectively; and

(2) by striking paragraph (9).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items furnished on or after January 1, 1997.

SEC. 403. PROMOTING ADVANCE DIRECTIVES.

(a) INCLUSION OF DIRECTIVES IN PATIENT'S MEDICAL RECORD.—Section 1866(f)(1)(B) of the Social Security Act (42 U.S.C. 1395cc(f)(1)(B)) is amended by inserting before the semicolon at the end the following: ''and, if the individual has executed such a directive, to ensure that a copy of such directive is included in the medical chart for the individual''.

(b) ESTABLISHMENT AND DISSEMINATION OF UNIFORM NATIONAL FORMS.—Section 1866(f) of the Social Security Act (42 U.S.C. 1395cc(f)) is amended—

(1) in paragraph (1)(A), by striking the semicolon at the end and insert a comma and the following:

''as well as a copy of the national uniform advance directive form established under paragraph (4)''; and

(2) by adding at the end the following:

''(4) By January 1, 1997, the Secretary shall establish minimum standards for advance directives and a national uniform advance directives form which may be used in any State.''.

(c) HEALTH PLAN INCENTIVES.—Section 1876(c)(8) of the Social Security Act (42 U.S.C. 1395mm(c)(8)) is amended by adding at the end the following: ''Nothing in this title shall be construed as preventing such an organization from encouraging, through education and dissemination of promotional material and the organization of information sessions, enrollees to learn about and execute advance directives.''.

(d) INFORMATION CAMPAIGN.—The Secretary shall provide for an information campaign concerning the execution and use of advance directives, particularly with respect to individuals eligible for benefits under the medicare program. Such campaign shall include training of medicare hotline personnel concerning the execution and use of such directives and the availability of community resources.

SEC. 404. ANTIFRAUD EFFORTS.

(a) INCREASED PENALTIES FOR MEDICARE FRAUD.—

(1) OFFENSE.—Part I of title 18, United States Code, is amended by inserting after chapter 50A the following:

"CHAPTER 50B—MEDICARE FRAUD

"§ 1101. Medicare fraud

"(a) DEFINITION.—In this section, the term 'health care provider' means—

"(1) a physician, nurse, dentist, therapist, pharmacist, or other professional provider of health care; and

"(2) a hospital, health maintenance organization, pharmacy, laboratory, clinic, or other health care facility or a provider of medical services, medical devices, medical equipment, or other medical supplies.

"(b) OFFENSE.—A health care provider that engages in conduct constituting an offense under section 1341 or 1343 of this title for the purpose of or in connection with the provision of health care services or supplies or the payment therefore or reimbursement of the costs thereof under the medicare program under title XVIII of the Social Security Act, when—

''(1) the amount of loss caused by the fraudulent conduct exceeds $10,000; or

''(2) the offender had previously been convicted of fraud in Federal or State court,

shall be fined under this title, imprisoned in accordance with section 1102 of this title, or both.

''§ 1102. Penalties

''(a) IN GENERAL.—In the case of an offense under section 1101 of this title not described in subsection (b) or (c) of this section, the offender shall be sentenced to a term of imprisonment of not more than 10 years.

''(b) SERIOUS PHYSICAL INJURY OR ENDANGERMENT OF LIFE OF PATIENT.—In the case of an offense under section 1101 of this title that—

''(1) caused serious physical injury to a patient; or

''(2) endangered the life of a patient,

the offender shall be sentenced to a term of imprisonment of not more than 20 years.

''(c) DEATH OF PATIENT.—In the case of an offense under section 1101 of this title that caused the death of a patient, the offender shall be sentenced to a term of imprisonment of not more than life.

"§ 1103. Restitution

''(a) IN GENERAL.—In sentencing a person convicted of an offense under section 1101 of this title, the court shall order the offender to pay restitution to the patient and the Federal Government for economic loss sustained as a result of the offense.

''(b) RESTITUTION PROCEDURE.—Except to the extent inconsistent with this section, sections 3363 and 3364 of this title apply to restitution made under this section.''.

(2) CLERICAL AMENDMENT.—The table of chapters at the beginning of part I of title 18, United States Code, is amended by inserting after the item relating to chapter 50A the following:

''50B. Medicare fraud.''.

(b) PERMITTING FORFEITURE FOR REAL OR PERSONAL PROPERTY DERIVED FROM MEDICARE FRAUD.—Section 982(a) of title 18, United States Code, is amended by adding at the end the following:

''(6) The court, in imposing sentence on a person convicted of an offense under section 1101 of this title that relates to the medicare program under title XVIII of the Social Security Act, shall order that the offender forfeit to the United States any real or personal property constituting or derived from proceeds that the offender obtained directly or indirectly as the result of the offense.''.

(c) STUDY ON STANDARDIZATION OF CLAIMS ADMINISTRATION.—

(1) STUDY.—The Secretary shall conduct a study on the feasibility and desirability of establishing a standardized medicare claims administration process, implementing other measures to improve recordkeeping, and taking other appropriate steps to reduce waste, fraud, and abuse in making payments under the medicare program.

(2) REPORT.—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit a report to Congress on the study conducted under paragraph (1). The Secretary shall include in the report such recommendations as the Secretary considers appropriate.

(d) REPORT ON CONSOLIDATION OF ANTIFRAUD EFFORTS.—Not later than 1 year after the date of enactment of this Act, the Vice President's Commission on Reinventing Government shall submit a report to Congress on the effectiveness of the current efforts of the Federal Government to combat waste, fraud, and abuse in the medicare program and on whether such efforts would be enhanced by the establishment of a coordinated, all-payer, multi-jurisdiction antifraud program.

SEC. 405. HOSPICE BENEFITS.

(a) RESTRUCTURING OF BENEFIT PERIOD.—

(1) IN GENERAL.—Section 1812 of the Social Security Act (42 U.S.C. 1395d) is amended in subsections (a)(4) and (d)(1), by striking '', a subsequent period of 30 days, and a subsequent extension period'' and inserting ''and an unlimited number of subsequent periods of 60 days each''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1812 of the Social Security Act (42 U.S.C. 1395d) is amended in subsection (d)(2)(B) by striking ''90- or 30-day period or a subsequent extension period'' and inserting ''90-day period or a subsequent 60-day period''.

(B) Section 1814(a)(7)(A) of the Social Security Act (42 U.S.C. 1395f(a)(7)(A)) is amended—

(i) in clause (i), by inserting ''and'' at the end;

(ii) in clause (ii)—

(I) by striking ''30-day'' and inserting ''60-day''; and

(II) by striking ''and'' at the end and inserting a period; and

(iii) by striking clause (iii).

(b) AMBULANCE SERVICES, DIAGNOSTIC TESTS, CHEMOTHERAPY SERVICES, AND RADIATION THERAPY SERVICES INCLUDED IN HOSPICE CARE.—Section 1861(dd)(1) of the Social Security Act (42 U.S.C. 1395x(dd)(1)) is amended—

(1) in subparagraph (E), by inserting ''anticancer chemotherapeutic agents and other'' before ''drugs'';

(2) in subparagraph (G), by striking ''and'' at the end;

(3) in subparagraph (H), by striking the period at the end and inserting a comma; and

(4) by inserting after subparagraph (H) the following:

''(I) ambulance services,

''(J) diagnostic tests, and

''(K) radiation therapy services.''.

(c) CONTRACTING WITH INDEPENDENT PHYSICIANS OR PHYSICIAN GROUPS FOR HOSPICE CARE SERVICES PERMITTED.—Section 1861(dd)(2) of the Social Security Act (42 U.S.C. 1395x(dd)(2)) is amended—

(1) in subparagraph (A)(ii)(I), by striking ''(F),''; and

(2) in subparagraph (B)(i), by inserting ''or under contract with'' after ''employed by''.

(d) WAIVER OF CERTAIN STAFFING REQUIREMENTS FOR HOSPICE CARE PROGRAMS IN NONURBANIZED AREAS.—Section 1861(dd)(5) of the Social Security Act (42 U.S.C. 1395x(dd)(5)) is amended—

(1) in subparagraph (B), by inserting ''or (C)'' after ''subparagraph (A)'' each place it appears; and

(2) by adding at the end the following:

''(C) The Secretary may waive the requirements of paragraph (2)(A)(i) and (2)(A)(ii) for an agency or organization with respect to the services described in paragraph (1)(B) and, with respect to dietary counseling, paragraph (1)(H), if such agency or organization—

''(i) is located in an area which is not an urbanized area (as defined by the Bureau of Census), and

''(ii) demonstrates to the satisfaction of the Secretary that the agency or organization has been unable, despite diligent efforts, to recruit appropriate personnel.''.

(e) LIMITATION ON LIABILITY OF BENEFICIARIES AND PROVIDERS FOR CERTAIN HOSPICE COVERAGE DENIALS.—

(1) IN GENERAL.—Section 1879(g) of the Social Security Act (42 U.S.C. 1395pp(g)) is amended—

(A) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively, and indenting appropriately;

(B) by striking ''is,'' and inserting ''is—'';

(C) by making the remaining text of subsection (g), as amended, that follows ''is—'' a new paragraph (1) and indenting such paragraph appropriately;

(D) by striking the period at the end and inserting ''; and''; and

(E) by adding at the end the following:

''(2) with respect to the provision of hospice care to an individual, a determination that the individual is not terminally ill.''.

(2) WAIVER PERIOD EXTENDED.—Section 9305(f)(2) of the Omnibus Budget Reconciliation Act of 1986 is amended by striking ''and before December 31, 1995.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection take effect December 31, 1995.

(f) EXTENDING THE PERIOD FOR PHYSICIAN CERTIFICATION OF AN INDIVIDUAL'S TERMINAL ILLNESS.—Section 1814(a)(7)(A)(i)(II) of the Social Security Act (42 U.S.C. 1395f(a)(7)(A)(i)(II)) is amended by striking '', not later than 2 days after hospice care is initiated (or,

if each certify verbally not later than 2 days after hospice care is initiated, not later than 8 days after such care is initiated),'' and inserting ''at the beginning of the period''.

(g) EFFECTIVE DATE.—Except as provided in subsection (e)(3), the amendments made by this section apply to benefits provided on or after the date of enactment of this Act, regardless of whether or not an individual has made an election under section 1812(d) of the Social Security Act (42 U.S.C. 1395d(d)) before that date.

SEC. 406. STUDY PROVIDING PHARMACY SERVICES TO MEDICARE BENEFICIARIES.

(a) STUDY.—The Secretary shall conduct a thorough study in order to identify—

(1) any cost savings to the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) resulting from the provision of pharmacy services (described in subsection (b)) to beneficiaries under that program; and

(2) the various methods of payment for those pharmacy services, including a fee schedule and a resource-based value scale.

(b) PHARMACY SERVICES DESCRIBED.—The pharmacy services described in this subsection are—

(1) consultations with a physician relative to a change in an individual's drug regimen;

(2) consultations with a physician which results in improved compliance with the drug regimen established by that physician for certain drugs frequently prescribed to beneficiaries under the medicare program; and

(3) disease management programs for hypertension, asthma, and other chronic conditions prevalent in beneficiaries under the medicare program.

(c) RECOMMENDATIONS.—The Secretary shall develop recommendations on—

(1) which pharmacy services should be covered by the medicare program; and

(2) the levels at which those services should be reimbursed by that program.

(d) REPORT.—Not later than 2 years after the date of enactment of this Act, the Secretary shall submit a report to Congress which shall contain a detailed statement of the findings and conclusions of the Secretary, together with its recommendations for such legislation and administrative actions as the Secretary considers appropriate.

SEC. 407. RESPITE BENEFIT.

(a) ENTITLEMENT.—Section 1832(a)(2) of the Social Security Act (42 U.S.C. 1395k(a)(2)) is amended—

(1) by striking ''and'' at the end of subparagraph (I);

(2) by striking the period at the end of subparagraph (J) and inserting ''; and''; and

(3) by adding at the end the following:

''(K) respite services for not more than 32 hours each year.''.

(b) CONDITIONS AND LIMITATIONS ON PAYMENT.—

(1) PAYMENT RATE.—Section 1833(a)(2) (42 U.S.C. 1395l(a)(2)) is amended by—

(A) in subparagraph (E), by striking ''and'' at the end;

(B) in subparagraph (F), by adding ''and'' at the end; and

(C) by adding at the end the following:

''(G)(i) with respect to respite services, payment shall be made at a rate equal to $7.50 per hour for 1998 and at a rate to be determined by the Secretary in subsequent years; and

''(ii) notwithstanding any provisions of section 1861(v), in the case of respite services furnished by a home health agency (or other organization designated by the Secretary pursuant to regulations), payment to the agency or other organization for respite services may not exceed 100 percent of the hourly respite allowance

times the number of hours of respite for which the agency authorizes payment;''.

(2) CONDITIONS OF PAYMENT.—Section 1835(a)(2) (42 U.S.C. 1395n(a)(2)) is amended—

(A) by striking ''and'' at the end of subparagraph (E);

(B) by striking the period at the end of subparagraph (F) and inserting ''; and''; and

(C) by inserting after subparagraph (F) the following:

''(G) in the case of respite services, the individual for whom payment is claimed is severely impaired due to irreversible dementia (as evidenced by a score of 3 or more errors on the Short Portable Mental Status Questionnaire) and either needs assistance in at least one out of five activities of daily living (bathing, dressing, transferring, toileting, and eating) or in at least 1 out of 4 instrumental activities of daily living (meal preparation, medication management, money management, and telephoning), or needs constant supervision because of one or more behavioral problems, as defined by the Secretary.''.

(3) FAMILY DESIGNATION OF RESPITE SERVICES PROVIDER AND CARE GIVER.—Section 1835(a)(2) (42 U.S.C. 1395n(a)(2)) is amended by adding at the end the following: ''In the case of respite services that are the subject of the certification described in subparagraph (G), the entity or individual providing the care for which respite is sought shall designate a respite services caregiver either through a home health agency or (if the Secretary designates other organizations to provide or arrange for such services) another organization. The agency or organization shall determine the amount of respite entitlement remaining in the calendar year and inform the entity or individual of the extent to which respite services may be authorized. When services have been provided, the entity or individual shall inform the agency or organization, which shall then make payment to the caregiver. Where additional payment is made on behalf of the beneficiary, the agency or organization shall ensure that the entity or individual is informed of the limits applicable to payments for such services. No payment may be made under this title for respite services if the per-hour charge to the patient for care by respite aides

exceeds by more than $2 the hourly rates established under this title.''.

(c) DEFINITIONS.—Section 1861 (42 U.S.C. 1395x) is amended—

(1) in subsection (m)—

(A) by striking ''and'' at the end of paragraph (6);

(B) by adding ''and'' at the end of paragraph (7); and

(C) by inserting after paragraph (7) the following:

''(8) respite services as described in subsection (oo);'';

(2) in subsection (o)—

(A) by striking ''and'' at the end of paragraph (6);

(B) by adding ''and'' at the end of paragraph (7); and

(C) by inserting after paragraph (7) the following:

''(8) agrees to provide or arrange for respite services as described in subsection (oo);''; and

(3) by adding after subsection (nn) the following:

''Respite Services; Respite Aides; Respite Providers

''(oo)(1) The term 'respite services' means temporary care provided to individuals who meet the requirements of section 1835(a)(2) for the purposes of ensuring periodic time-off for co-resident primary informal caregivers. Although respite providers may provide assistance with personal care or household maintenance activities, their primary function is to provide protective supervision for persons with Alzheimer's and related dementias whose memory, orientation, judgment, and reasoning abilities have become so impaired that, for safety's sake, they require the constant attention or close physical proximity of another person at all or almost all hours of the day or night.

''(2) The term 'respite aides' means individuals who have been designated by the Secretary as qualified to act as caregivers for purposes of providing the services described in paragraph (1). Respite aides may be nurse aides who meet the requirements of section 1819(b)(5), home health aides who meet the requirements of section 1891(a)(3), or other individuals licensed by the State or recognized by the Secretary as having the skills necessary to provide such services.

''(3) The term 'respite providers' means organizations identified by the Secretary in regulations as qualified to provide or arrange for respite services under this title.

The Secretary may establish by regulation such requirements for respite providers as the Secretary determines are appropriate.''.

(d) PAYMENT FROM SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND FOR RESPITE SERVICES FURNISHED TO INDIVIDUALS WITH ONLY HOSPITAL INSURANCE COVERAGE.—Section 1812(a) (42 U.S.C. 1395d(a)) is amended—

(1) by striking ''and'' at the end of paragraph (3);

(2) by striking the period at the end of paragraph (4) and inserting ''; and''; and

(3) by adding at the end the following:

''(5) respite services, as described in section 1832(a)(2)(K), except that such services shall be furnished under the Supplementary Medical Insurance Program.''.

(e) EFFECTIVE DATE.—The amendments made by this section shall be effective for services provided in fiscal year 2002 and thereafter.

TITLE V—PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES

SEC. 501. PAYMENT FOR HOME HEALTH SERVICES.

(a) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) (as amended by section 211 of this Act) is amended by adding at the end the following:

''PAYMENT FOR HOME HEALTH SERVICES

''SEC. 1895. (a) IN GENERAL.—Notwithstanding section 1861(v), the Secretary shall provide for payments for home health services in accordance with a prospective payment system as follows:

''(1) PER VISIT PAYMENTS.—Subject to subsection (c), the Secretary shall make per visit payments to a home health agency in accordance with this section for each type of home health service described in paragraph (2) furnished to an individual who at the time the service is furnished is under a plan of care by the home health agency under this title (without regard to whether or not the item or service was furnished by the agency or by others under arrangement with them made by the agency, under any other contracting or consulting arrangement, or otherwise).

''(2) TYPES OF SERVICES.—The types of home health services described in this paragraph are the following:

''(A) Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse.

''(B) Physical therapy.

''(C) Occupational therapy.

''(D) Speech-language pathology services.

''(E) Medical social services under the direction of a physician.

''(F) To the extent permitted in regulations, part-time or intermittent services of a home health aide who has successfully completed a training program approved by the Secretary.

''(b) ESTABLISHMENT OF PER VISIT RATE FOR EACH TYPE OF ASSISTANCE.—

''(1) IN GENERAL.—The Secretary shall, subject to paragraph (3), establish a per visit payment rate for a home health agency in an area (which shall be the same area used to determine the area wage index applicable to hospitals under section 1886(d)(3)(E)) for each type of home health service described in subsection (a)(2). Such rate shall be

equal to the national per visit payment rate determined under paragraph (2) for each such type, except that the labor-related portion of that rate shall be adjusted by the area wage index applicable under section 1886(d)(3)(E) for the area in which the agency is located (as determined without regard to any reclassification of the area under section 1886(d)(8)(B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under section 1886(d)(10) for cost reporting periods beginning after October 1, 1996).

''(2) NATIONAL PER VISIT PAYMENT RATE.—The national per visit payment rate for each type of service described in subsection (a)(2)—

''(A) for fiscal year 1998, is an amount equal to the national average amount reimbursed per visit under this title to home health agencies for such type of service (including medical supplies) during the most recent 12-month cost reporting period ending on or before December 31, 1995, updated by the home health market basket percentage increase for each year before the date in such fiscal year in which this section first applies; and

"(B) for each subsequent fiscal year, is an amount equal to the national per visit payment rate in effect under this paragraph for the preceding fiscal year, increased by the home health market basket percentage increase for such subsequent fiscal year.

"(3) PAYMENTS ABOVE PER VISIT RATES.—

"(A) ELECTION.—A home health agency may elect to receive per visit payments in excess of the per visit payment rate under paragraph (1) up to the per visit payment limit under subparagraph (B) if the agency can demonstrate to the satisfaction of the Secretary that it can reasonably expect to incur such costs and that total payments will not exceed the agency's aggregate limit under subsection (c). The Secretary shall further provide for exemptions, exceptions, and adjustments to the per visit payment limit of this section on the same basis as are provided under subsection (c)(3) with respect to the limitations on final payment.

"(B) PER VISIT PAYMENT LIMIT.—For fiscal year 1998, the per visit payment limit under this subparagraph is calculated as established by section 1861(v)(1)(L). For each subsequent

year, such payment limit is equal to the limit for the preceding fiscal year under this subparagraph increased by the home health market basket index for the fiscal year involved.

''(4) HOME HEALTH MARKET BASKET PERCENTAGE INCREASE.—For purposes of this subsection, the term 'home health market basket percentage increase' means, with respect to a fiscal year, a percentage (estimated by the Secretary before the beginning of the fiscal year) determined and applied with respect to the types of home health services described in subsection (a)(2) in the same manner as the market basket percentage increase under section 1886(b)(3)(B)(iii) is determined and applied to inpatient hospital services for discharges in the fiscal year.

''(c) AGGREGATE LIMITS.—

''(1) PHASE I AGGREGATE LIMIT.—

''(A) IN GENERAL.—Before the end of the second 12-month period beginning on the effective date of this section, except as provided in paragraphs (3) and (4), a home health agency may not receive aggregate per visit payments

under subsection (a) for such a 12-month period in excess of an amount equal to the product of—

"(i) the number of unduplicated medicare beneficiaries receiving home health services from the agency during the period; and

"(ii) the per patient limit determined for such period.

"(B) ESTABLISHMENT OF PER PATIENT LIMITS FOR INITIAL YEAR.—

"(i) IN GENERAL.—For the initial 12-month period, the per patient limit for an agency is equal to the product of—

"(I) the sum of 75 percent of the updated per visit costs described in clause (ii) for the agency and 25 percent of the regional average described in clause (iii) for the agency; and

"(II) the average annual number of medicare home health agency visits per unduplicated medicare beneficiary for fiscal year 1996.

"(ii) UPDATED PER VISIT COSTS.—The updated per visit costs described in

this clause, for a home health agency for a payment period, is the average per visit reasonable costs for home health services of the agency, calculated for the base year, based on fiscal year 1995 cost per visit, updated by the home health market basket percentage increase through the payment period involved.

''(iii) REGIONAL AVERAGE.—The regional average described in this clause, for a home health agency for a payment period, is the average of the updated per visit costs described in clause (ii) for the period for home health agencies located in the same census region in which the agency is located.

''(C) ESTABLISHMENT OF PER PATIENT LIMITS FOR SECOND YEAR.—For the second 12-month period, the per patient limit for an agency is equal to the product of—

''(i) the sum of—

''(I) 50 percent of the updated per visit costs described in subparagraph (B)(ii) for the agency for the period, and

"(II) 50 percent of the regional average described in subparagraph (B)(iii) for the agency for the period; and

"(ii) the average annual number of medicare home health agency visits per unduplicated medicare beneficiary for fiscal year 1996.

"(D) NEW PROVIDERS AND PROVIDERS WITHOUT BASE YEAR.—For a new home health agency or a home health agency for which there is no base year under subparagraph (B)(ii), the per patient limit shall be equal to the mean of these limits applied to home health agencies in the same census region in which the agency is located as determined by the Secretary. A home health agency shall not be treated as a new home health agency by reason of any corporate restructuring or change of name.

"(2) PHASE II AGGREGATE LIMITS.—

"(A) IN GENERAL.—After the end of the second 12-month period beginning on the effective date of this section and until the effective

date of any episodic prospective payment system (including a system developed under subsection (h)) that is enacted by the Congress, except as provided in paragraphs (3) and (4), a home health agency may not receive aggregate per visit payments under subsection (a) for a 12-month payment period in excess of an amount equal to the sum of the following:

''(i) The sum (for all case-mix categories) of the products (determined separately for each such category) of—

''(I) the total number of episodes for the category for which the agency receives payments during the payment period, and

''(II) the per episode limit determined under subparagraph (B) for the category and payment year.

''(ii) The product of—

''(I) the number of unduplicated medicare beneficiaries receiving home health services from the agency beyond 120 days during the payment year, and

"(II) the per patient limit for services provided beyond 120 days, as specified in subparagraph (E).

"(B) ESTABLISHMENT OF PER EPISODE LIMITS FOR FIRST 120 DAYS.—

"(i) IN GENERAL.—The per episode limit under this subparagraph for a payment year for a case-mix category for the area in which a home health agency is located (which shall be the same area used to determine the area wage index applicable to hospitals under section 1886(d)(3)(E)) is equal to the product of—

"(I) the mean number of visits for each type of home health service described in subsection (a)(2) furnished during an episode of such case-mix category in such area during fiscal year 1996; and

"(II) the per visit payment rate established under subsection (b) for such type of home health service for the fiscal year for which the determination is being made.

''(ii) DETERMINATION OF AREA.—In the case of an area which the Secretary determines has an insufficient number of home health agencies to establish an appropriate per episode limit under this subparagraph, the Secretary may establish an area other than the area used to determine the area wage under section 1886(d)(3)(E) for purposes of establishing an appropriate per episode limit.

''(C) CASE-MIX CATEGORY.—For purposes of this paragraph, the term 'case-mix category' means each of the 18 case-mix categories established under the Home Health Agency Prospective Payment Demonstration Project conducted by the Health Care Financing Administration. The Secretary may develop and apply a more accurate methodology for determining case-mix categories subject to prior public notice and comment under section 553 of title 5, United States Code.

''(D) EPISODE.—

''(i) IN GENERAL.—For purposes of this paragraph, the term 'episode' means the continuous 120-day period that—

"(I) begins on the date of an individual's first visit for a type of home health service described in subsection (a)(2) for a case-mix category, and

"(II) is immediately preceded by a 45-day period in which the individual did not receive visits for a type of home health service described in subsection (a)(2).

"(ii) PRORATION OF EPISODE LIMIT SPANNING PAYMENT YEARS.—The Secretary shall provide for such rules as appropriate to prorate episode limits under this paragraph which begin during a payment year and end in a subsequent payment year.

"(E) ESTABLISHMENT OF A PER PATIENT ANNUAL LIMIT FOR SERVICES PROVIDED AFTER 120 DAYS.—

"(i) IN GENERAL.—The per patient limit for services provided by a home health agency after 120 days for a payment period is equal to the product of—

"(I) the sum of 50 percent of the updated per visit costs described in

paragraph (1)(B)(ii) for the agency and year and 50 percent of the regional average described in paragraph (1)(B)(iii) for the agency and year; and

''(II) the average annual number of medicare home health agency visits over 120 days per unduplicated medicare beneficiary for fiscal year 1996.

''(ii) NEW PROVIDERS AND PROVIDERS WITHOUT BASE YEAR.—The provisions of subparagraph (D) of paragraph (1) shall apply with respect to clause (i)(I) in the same manner as they apply to subparagraph (B)(ii) of paragraph (1).

''(3) EXEMPTIONS AND EXCEPTIONS.—

''(A) EXTRAORDINARY COSTS.—The Secretary shall provide for an exemption from, or an exception and adjustment to, at the request of the home health agency, the methods under this subsection for determining payment limits where events beyond the home health agency's control or extraordinary circumstances, including the case mix of such home health agency,

create reasonable costs for a payment year which exceed the applicable payment limits.

''(B) OTHER FACTORS.—The Secretary may provide for such other exemptions from, and exceptions and adjustments to, such methods, as the Secretary deems appropriate, as determined by the Secretary.

''(C) TIMELY DETERMINATION.—The Secretary shall announce a decision on any request for an exemption, exception, or adjustment under this paragraph not later than 120 days after receiving a completed application from the home health agency for such exemption, exception, or adjustment, and shall include in such decision a detailed explanation of the grounds on which such request was approved or denied.

''(D) LIMITATION.—The cumulative expenditures for exemptions and exceptions under this paragraph shall not exceed the cumulative amount that would have been payable under paragraph (4)(B) if the 10 percent limitation under clause (ii) of such paragraph did not apply.

''(4) RECONCILIATION OF AMOUNTS.—

"(A) PAYMENTS IN EXCESS OF LIMITS.—If a home health agency has received aggregate per visit payments under subsection (a) for a fiscal year in excess of the amount determined under paragraph (1) with respect to such home health agency for such fiscal year, the Secretary shall reduce payments under this section to the home health agency in the following fiscal year in such manner as the Secretary considers appropriate (including on an installment basis) to recapture the amount of such excess.

"(B) SHARE OF SAVINGS.—

"(i) COMPUTATION.—If a home health agency has received aggregate per visit payments under subsection (a) for a payment year in an amount less than the limit determined under paragraph (1) or (2) (as applicable) with respect to such home health agency for such payment year and, with respect only to paragraphs (1) and (2)(E), the home health agency has an average payment per unduplicated medicare beneficiary at or below 125 percent of the regional average (described in paragraph

(1)(B)(iii) or (2)(E)(iii), respectively), subject to clause (ii), the Secretary shall pay such home health agency a payment equal to 50 percent of the difference between the aggregate payment and each applicable limit under paragraphs (1), (2)(B), or (2)(E).

''(ii) LIMITATION.—In no case shall payments under clause (i) for an agency for a year exceed 10 percent of the aggregate per visit payments made to the agency for the year.

''(iii) INSTALLMENT PAYMENTS.—The Secretary may make the payments to a home health agency under clause (i) during a payment year on an installment basis based on the estimated payment that the agency would be eligible to receive with respect to such payment year.

''(d) MEDICAL REVIEW PROCESS.—The Secretary shall implement a medical review process for the system of payments described in this section that shall provide an assessment of the pattern of care furnished to individuals receiving home health services for which payments are

made under this section to ensure that such individuals receive appropriate home health services.

''(e) ADJUSTMENTS.—

''(1) IN GENERAL.—The Secretary shall provide for appropriate adjustments to payments to a home health agency under this section to ensure that the agency does not engage in the following for the purposes of circumventing the limits:

''(A) Discharging patients to another home health agency or similar provider.

''(B) Altering corporate structure or name to avoid being subject to this section or for the purpose of increasing payments under this title.

''(2) TRACKING OF PATIENTS THAT SWITCH HOME HEALTH AGENCIES.—

''(A) DEVELOPMENT OF SYSTEM.—The Secretary shall develop a system that tracks home health patients that receive home health services described in subsection (a)(2) from more than 1 home health agency.

''(B) ADJUSTMENT OF LIMITS.—The Secretary shall adjust limits under this section to

each home health agency that furnishes an individual with a type of home health service described in subsection (a)(2) to ensure that aggregate payments on behalf of such individual during such episode do not exceed the amount that would be paid under this section if the individual received such services from a single home health agency.

''(3) MONITORING LOW-COST CASES.—

''(A) IN GENERAL.—The Secretary shall develop and implement a system designed to monitor significant changes in the percentage distribution of low-cost and high-cost patients for which home health services are furnished by a home health agency over such percentage distribution determined for the agency under subparagraph (B).

''(B) DISTRIBUTION.—The Secretary shall profile home health service patients to determine the distribution of patients for the purpose of determining regional and national trends.

''(C) LOW-COST AND HIGH-COST PATIENTS.—For purposes of this paragraph, the Secretary shall define a low-cost and high-cost

patient in a manner that provides that a home health agency has an incentive to be cost-efficient in delivering home health services and that the volume of such services does not increase as a result of factors other than patient needs.

''(D) REPORT ON ACCESS.—The Secretary shall report to Congress on an annual basis findings and recommendations for ensuring access to appropriate home health services.

''(f) SPECIAL RULE FOR CHRISTIAN SCIENCE PROVIDERS.—

''(1) PAYMENT PERMITTED FOR SERVICES.—Notwithstanding any other provision of this title, payment shall be made under this title for home health services furnished by Christian Science providers who meet applicable requirements of the First Church of Christ, Scientist, Boston, Massachusetts, and are certified for purposes of this title under criteria established by the Secretary, in accordance with a payment methodology established by the Secretary.

''(2) EFFECTIVE DATE.—Paragraph (1) shall apply to services furnished during cost reporting periods which begin after the date on which the Secretary establishes the payment methodology and the certification criteria described in paragraph (1).

''(g) REPORT BY MEDICARE PROSPECTIVE PAYMENT REVIEW COMMISSION.—During the first 3 years in which payments are made under this section, the Medicare Prospective Payment Review Commission shall annually submit a report to Congress on the effectiveness of the payment methodology established under this section that shall include recommendations regarding the following:

''(1) Case-mix and volume increases.

''(2) Quality monitoring of home health agency practices.

''(3) Whether providers of service are adequately reimbursed.

''(4) On the adequacy of the exemptions and exceptions to the limits provided under subsection (c)(1)(E).

''(5) The appropriateness of the methods provided under this section to adjust the aggregate limits and annual payment updates to reflect changes

in the mix of services, number of visits, and assignment to case categories to reflect changing patterns of home health care.

''(6) The geographic areas used to determine the per episode and per patient limits.

''(h) DEVELOPMENT OF EPISODIC PROSPECTIVE PAYMENT SYSTEM FOR HOME HEALTH SERVICES.—

''(1) IN GENERAL.—The Secretary shall develop a method of payments for home health services under this title in accordance with an episodic prospective payment system. In developing the system, the Secretary shall take into consideration—

''(A) the data and processes from subsection (c)(2) that have proven valid and reliable, and

''(B) the degree of disruption resulting from changing the payment system.

''(2) ADDITIONAL CONSIDERATIONS.—The per episode amount under the system shall include all services covered and paid under home health services under this title as of the date of enactment of this section, including medical supplies. In defining an episode of care under the system, the Secretary shall consider an appropriate length of time for an episode, the use of services and the number of visits

provided within an episode, potential changes in the mix of services provided within an episode and their cost, and a general system design that will provide for continued access to quality services. The per episode amount shall be based on the most current data available to the Secretary and shall include consideration of the cost of new regulatory requirements, changes in technology, and new care practices.

''(3) USE OF CASE MIX ADJUSTER.—Under the system the Secretary shall employ an appropriate case mix adjuster that explains a significant amount of the variation in cost.

''(4) UPDATES AND LABOR ADJUSTMENT.—Under the system, the episode payment amount shall be updated annually by the home health market basket index and the labor portion of the episode amount shall be adjusted for geographic differences in labor-related costs based on the most current hospital wage index.

''(5) OUTLIERS.—Under the system the Secretary may designate a payment provision for outliers, recognizing the need to adjust payments due to unusual variations in the type or amount of medically necessary care.

''(6) COORDINATION REQUIREMENT.—Under the system, a home health agency shall be responsible for coordinating all care for a beneficiary under this title.

''(7) INPUT.—The system shall be developed with input from and coordination with representatives from the home health services industry and consumers of home health services.

''(8) PROPOSAL.—The Secretary shall submit to Congress a proposal for the system, consistent with this subsection, not later than 4 years after the date of enactment of this section.

''(9) IMPLEMENTATION.—The system developed under this subsection shall become effective only pursuant to an Act of Congress. It is the intent of Congress that the effective date of the system be not later than 18 months after enactment of such an Act.

''(i) DEVELOPMENT OF DATA BASE.—Within 60 days after the date of enactment of this section, the Secretary shall initiate the development of a data base upon which a fair and accurate case mix adjustor, as required by subsections (c)(2)(C) and (h)(3), can be developed and implemented. The data base must—

''(1) be capable of linking case mix data with cost and utilization data;

''(2) contain data from HCFA Forms 485 and UB–92;

''(3) contain additional data elements sufficient to support the case-mix categories in subsection (c)(2)(C); and

''(4) contain any additional data elements determined necessary by the Secretary in consultation with representatives of the home health industry.''.

(b) APPEALS TO PROVIDER REIMBURSEMENT REVIEW BOARD.—Section 1878(a) of the Social Security Act (42 U.S.C. 1395oo(a)) is amended by inserting '', any home health agency which has received payment pursuant to section 1895 may obtain a hearing by the Board, with respect to such payment,'' after ''subsection (h)''.

(c) SUNSET OF REASONABLE COST LIMITATIONS.—Section 1861(v)(1)(L) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)) is amended by adding at the end the following:

''(iv) This subparagraph shall apply only to services furnished by home health agencies before the effective date of section 1895.''.

(d) EFFECTIVE DATE.—The amendments made by subsections (a) and (c) shall apply to payment for home

health services furnished on or after such date (not later than 6 months after the date of enactment of this Act) as the Secretary specifies.

SEC. 502. REVIEW BY PEER REVIEW ORGANIZATION OF HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1154 of the Social Security Act (42 U.S.C. 1320c–3) is amended by adding at the end the following:

''(g)(1) Each contract under this part shall require that the utilization and quality control peer review organization's review responsibility pursuant to subsection (a)(1) will include review of the level of care and quality of services provided individuals receiving home health services pursuant to sections 1812(a)(3) and 1832(a)(2)(A)(i).

''(2) If—

''(A) a home health agency has determined that a patient does not meet the conditions for payment of home health services under section 1814 or section 1833,

''(B) the home health agency has determined that a patient no longer requires home health services,

''(C) the home health agency has determined that a patient requires a level of care which is inconsistent with the care prescribed by the patient's attending physician, or

''(D) the patient has been authorized by the home health agency to receive a level of care less than that considered by the patient as appropriate to meet the patient's needs,

the home health agency shall provide the patient (or the patient's representative) with a notice (meeting the conditions prescribed by the Secretary under section 1879) of the determination.

''(3)(A) If the patient (or patient's representative)—

''(i) has received a notice under paragraph (2), and

''(ii) requests the appropriate peer review organization to review the determination,

the organization shall conduct a review under subsection (a) of the validity of the home health agency's determination and shall provide notice (by telephone and in writing) to the patient or representative and the home health agency and attending physician involved of the results of the review. Such review shall be conducted regardless of whether the home health agency will charge for continued home

health services or whether the patient will be liable for payment for such continued care.

''(B) If a patient (or a patient's representative) requests review under subparagraph (A) while the patient is still a patient of the home health agency and not later than noon of the first working day after the date the patient receives the notice under paragraph (2), then—

''(i) the home health agency shall provide to the appropriate peer review organization the records required to review the determination by the close of business of such first working day, and

''(ii) the peer review organization must provide the notice under subparagraph (A) by not later than one full working day after the date the organization has received the request and such records.

''(4) If—

''(A) a request is made under paragraph (3)(A) not later than noon of the first working day after the date that the patient (or patient's representative) receives the notice under paragraph (2), and

''(B) the conditions described in section 1879(a)(2) with respect to the patient or representative are met,

the home health agency shall not charge the patient for home health services furnished before noon of the day

after the date the patient or representative receives notice of the peer review organization's decision.

''(5) In any review conducted under paragraph (2) or (3), the organization shall solicit the views of the patient involved (or the patient's representative).

''(h) The utilization and quality control peer review organization shall monitor the delivery of home health services in a manner which includes a review of home health agencies that present significant variation in utilization.''.

(b) HEARING RIGHTS.—Section 1155 of the Social Security Act (42 U.S.C. 1320c–4) is amended by adding at the end the following: ''Notwithstanding the previous provisions of this section, any beneficiary receiving home health services subject to review under section 1154(g), and the provider, who is dissatisfied with a determination, shall be entitled to a hearing by the Secretary and to judicial review of any final determination to the same extent as provided under section 1869.''.

(c) ELIMINATION OF CERTAIN FISCAL INTERMEDIARY RESPONSIBILITIES.—Section 1816(j) of the Social Security Act (42 U.S.C. 1395h(j)) is amended by striking ''home health services,''.

(d) EFFECTIVE DATE.—The amendments made by subsections (a) and (c) shall apply to contract years beginning after the date of enactment of this Act.

SEC. 503. RETROACTIVE REINSTATEMENT OF PRESUMPTIVE WAIVER OF LIABILITY.

(a) IN GENERAL.—Section 9305(g)(3) of the Omnibus Budget Reconciliation Act of 1986, as amended by section 426(d) of the Medicare Catastrophic Coverage Act of 1988 and section 4207(b)(3) of the Omnibus Budget Reconciliation Act of 1990 (as renumbered by section 160(d)(4) of the Social Security Act Amendments of 1994), is amended by striking ''December 31, 1995'' and inserting ''the date of implementation of a prospective payment system for home health care services under section 1894(h) of the Social Security Act''.

(b) PRESUMPTION.—The second sentence of section 9205 of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended by striking ''December 31, 1995'' and inserting ''the date of implementation of a prospective payment system for home health care services under section 1894(h) of such Act''.

TITLE VI—PROSPECTIVE PAYMENT SYSTEM FOR NURSING FACILITIES

SEC. 601. DEFINITIONS.

In this title:

(1) ACUITY PAYMENT.—The term ''acuity payment'' means a fixed amount that will be added to the facility-specific prices for certain resident classes designated by the Secretary as requiring heavy care.

(2) AGGREGATED RESIDENT INVOICE.—The term ''aggregated resident invoice'' means a compilation of the per resident invoices of a nursing facility which contain the number of resident days for each resident and the resident class of each resident at the nursing facility during a particular month.

(3) ALLOWABLE COSTS.—The term ''allowable costs'' means costs which HCFA has determined to be necessary for a nursing facility to incur according to the Provider Reimbursement Manual (in this title referred to as ''HCFA-Pub. 15'').

(4) BASE YEAR.—The term ''base year'' means the most recent cost reporting period (consisting of a period which is 12 months in length, except for facilities with new owners, in which case the period is not less than 4 months and not more than 13

months) for which cost data of nursing facilities is available to be used for the determination of a prospective rate.

(5) CASE MIX WEIGHT.—The term ''case mix weight'' means the total case mix score of a facility calculated by multiplying the resident days in each resident class by the relative weight assigned to each resident class, and summing the resulting products across all resident classes.

(6) COMPLEX MEDICAL EQUIPMENT.—The term ''complex medical equipment'' means items such as ventilators, intermittent positive pressure breathing machines, nebulizers, suction pumps, continuous positive airway pressure devices, and bead beds such as air fluidized beds.

(7) DISTINCT PART NURSING FACILITY.—The term ''distinct part nursing facility'' means an institution which has a distinct part that is certified under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) and meets the requirements of section 201.1 of the Skilled Nursing Facility Manual published by HCFA (in this title referred to as ''HCFA-Pub. 12'').

(8) EFFICIENCY INCENTIVE.—The term ''efficiency incentive'' means a payment made to a nursing facility in recognition of incurring costs below a prespecified level.

(9) FIXED EQUIPMENT.—The term ''fixed equipment'' means equipment which meets the definition of building equipment in section 104.3 of HCFA-Pub. 15, including attachments to buildings such as wiring, electrical fixtures, plumbing, elevators, heating systems, and air conditioning systems.

(10) GEOGRAPHIC CEILING.—The term ''geographic ceiling'' means a limitation on payments in any given cost center for nursing facilities in 1 of no fewer than 8 geographic regions, further subdivided into rural and urban areas, as designated by the Secretary.

(11) HCFA.—The term ''HCFA'' means the Health Care Financing Administration.

(12) HEAVY CARE.—The term ''heavy care'' means an exceptionally high level of care which the Secretary has determined is required for residents in certain resident classes.

(13) INDEXED FORWARD.—The term ''indexed forward'' means an adjustment made to a per diem

rate to account for cost increases due to inflation or other factors during an intervening period following the base year and projecting such cost increases for a future period in which the rate applies. Indexing forward under this title shall be determined from the midpoint of the base year to the midpoint of the rate year.

(14) MDS.—The term ''MDS'' means a resident assessment instrument, currently recognized by HCFA, any extensions to MDS, and any extensions to accommodate subacute care which contain an appropriate core of assessment items with definitions and coding categories needed to comprehensively assess a nursing facility resident.

(15) MAJOR MOVABLE EQUIPMENT.—The term ''major movable equipment'' means equipment that meets the definition of major movable equipment in section 104.4 of HCFA-Pub. 15.

(16) NURSING FACILITY.—The term ''nursing facility'' means an institution that meets the requirements of a ''skilled nursing facility'' under section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a)) and of a ''nursing facility'' under section 1919(a) of that Act (42 U.S.C. 1396r(a)).

(17) PER BED LIMIT.—The term ''per bed limit'' means a per-bed ceiling on the fair asset value of a nursing facility for 1 of the geographic regions designated by the Secretary.

(18) PER DIEM RATE.—The term ''per diem rate'' refers to a rate of payment for the costs of covered services for a resident day.

(19) RELATIVE WEIGHT.—The term ''relative weight'' means the index of the value of the resources required for a given resident class relative to the value of resources of either a base resident class or the average of all the resident classes.

(20) R.S. MEANS INDEX.—The term ''R.S. Means Index'' means the index of the R. S. Means Company, Inc., specific to commercial or industrial institutionalized nursing facilities, that is based upon a survey of prices of common building materials and wage rates for nursing facility construction.

(21) REBASE.—The term ''rebase'' means the process of updating nursing facility cost data for a subsequent rate year using a more recent base year.

(22) RENTAL RATE.—The term ''rental rate'' means a percentage that will be multiplied by the

fair asset value of property to determine the total annual rental payment in lieu of property costs.

(23) RESIDENT CLASSIFICATION SYSTEM.—The term ''resident classification system'' means a system that categorizes residents into different resident classes according to similarity of their assessed condition and required services of the residents.

(24) RESIDENT DAY.—The term ''resident day'' means the period of services for 1 resident, regardless of payment source, for 1 continuous 24 hours of services. The day of admission of the resident constitutes a resident day but the day of discharge does not constitute a resident day. Bed hold days are not to be considered resident days, and bed hold day revenues are not to be offset.

(25) RESOURCE UTILIZATION GROUPS, VERSION III.—The term ''Resource Utilization Groups, Version III'' (in this title referred to as ''RUG–III'') refers to a category-based resident classification system used to classify nursing facility residents into mutually exclusive RUG–III groups. Residents in each RUG–III group utilize similar quantities and patterns of resources.

(26) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(27) SUBACUTE CARE.—The term ''subacute care'' means comprehensive inpatient care designed for an individual that has an acute illness, injury, or exacerbation of a disease process. The care is goal oriented treatment rendered immediately after, or instead of, acute hospitalization to treat 1 or more specific active complex medical conditions or to administer 1 or more technically complex treatments, in the context of a person's underlying long-term conditions and overall situation. In most cases, the individual's condition is such that the care does not depend heavily on high technology monitoring or complex diagnostic procedures. Subacute care requires the coordinated services of an interdisciplinary team including physicians, nurses, and other relevant professional disciplines, who are trained and knowledgeable to assess and manage these specific conditions and perform the necessary procedures. Subacute care is given as part of a specifically defined program, regardless of the site. Subacute care is generally more intensive than traditional nursing facility care and less than acute care. It requires frequent (daily to weekly) recurrent patient assessment and review of the clinical course and treatment plan for a limited (several days to several months) time

period, until the condition is stabilized or a predetermined treatment course is completed.

SEC. 602. PAYMENT OBJECTIVES.

Payment rates under the Prospective Payment System for nursing facilities shall reflect the following objectives:

(1) To maintain an equitable and fair balance between cost containment and quality of care in nursing facilities.

(2) To encourage nursing facilities to admit residents without regard to such residents' source of payment.

(3) To provide an incentive to nursing facilities to admit and provide care to persons in need of comparatively greater care, including those in need of subacute care.

(4) To maintain administrative simplicity, for both nursing facilities and the Secretary.

(5) To encourage investment in buildings and improvements to nursing facilities (capital formation) as necessary to maintain quality and access.

SEC. 603. POWERS AND DUTIES OF THE SECRETARY.

(a) RULES AND REGULATIONS.—The Secretary shall establish by regulation all rules and regulations necessary for implementation of this title. The rates determined

under this title shall be determined in a budget neutral manner and shall reflect the objectives described in section 602 of this title.

(b) FILING REQUIREMENTS.—The Secretary may require that each nursing facility file such data, statistics, schedules, or information as required to enable the Secretary to implement this title.

SEC. 604. RELATIONSHIP TO TITLE XVIII OF THE SOCIAL SECURITY ACT.

(a) IN GENERAL.—No provision in this title shall replace, or otherwise affect, the skilled nursing facility benefit under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(b) PROVISIONS OF HCFA–15.—The provisions of HCFA-Pub. 15 shall apply to the determination of allowable costs under this title except to the extent that such provisions conflict with any other provision in this title.

SEC. 605. ESTABLISHMENT OF RESIDENT CLASSIFICATION SYSTEM.

(a) IN GENERAL.—

(1) ESTABLISHMENT.—The Secretary shall establish a resident classification system which shall group residents into classes according to similarity of their assessed condition and required services.

(2) MODEL FOR SYSTEM.—The resident classification system shall be modelled after the RUG-III system and all updated versions of that system, and shall be expanded into subacute categories and costs of care.

(3) REFLECTIVE OF CERTAIN TIME AND COSTS.—The resident classification system shall reflect of the necessary professional and paraprofessional nursing staff time and costs required to address the care needs of nursing facility residents.

(b) RELATIVE WEIGHT FOR EACH RESIDENT CLASS.—

(1) IN GENERAL.—The Secretary shall assign a relative weight for each resident class based on the relative value of the resources required for each resident class. If the Secretary determines it to be appropriate, the assignment of relative weights for resident classes shall be developed for each geographic region as determined in accordance with subsection (c).

(2) UTILIZATION OF MDSS.—In assigning the relative weights of the resident classes in a geographic region, the Secretary shall utilize information derived from the most recent MDSs of all the nursing facilities in a geographic region.

(3) RECALIBRATED EVERY 3 YEARS.—Every 3 years the Secretary shall recalibrate the relative weights of the resident classes in each geographic region based on any changes in the cost or amount of resources required for the care of a resident in the resident class.

(c) GEOGRAPHIC REGIONS; PEER GROUPINGS.—

(1) GEOGRAPHIC REGIONS.—The Secretary shall designate at least 3 geographic regions for the total United States. Within each geographic region, the Secretary shall take appropriate account of variations in cost between urban and rural areas.

(2) PEER GROUPING.—The Secretary shall ensure that there are no peer grouping of nursing facilities based on facility size or whether the nursing facilities are hospital-based or not.

SEC. 606. COST CENTERS FOR NURSING FACILITY PAYMENT.

(a) PAYMENT RATES.—Consistent with the objectives described in section 602 of this title, the Secretary shall determine payment rates for nursing facilities using the following cost/service groupings:

(1) The nursing service cost center shall include salaries and wages for the Director of Nursing, quality assurance nurses, registered nurses, licensed

practical nurses, nurse aides (including wages related to initial and ongoing nurse aid training and other ongoing or periodic training costs incurred by nursing personnel), contract nursing, fringe benefits and payroll taxes associated therewith, medical records, and nursing supplies.

(2) The administrative and general cost center shall include all expenses (including salaries, benefits, and other costs) related to administration, plant operation, maintenance and repair, housekeeping, dietary (excluding raw food), central services and supply (excluding medical or nursing supplies), laundry, and social services, excluding overhead allocations to ancillary services.

(3) Ancillary services that are paid on a fee-for-service basis shall include physical therapy, occupational therapy, speech therapy, respiratory therapy, and hyperalimentation. The fee-for-service ancillary service payments under part A of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) shall not affect the reimbursement of ancillary services under part B of title XVIII of that Act (42 U.S.C. 1395j et seq.).

(4) The cost center for selected ancillary services and other costs shall include drugs, raw food,

IV therapy, x-ray services, laboratory services, property tax, property insurance, and all other costs not included in the other 4 cost-of-service groupings.

(5) The property cost center shall include depreciation on the buildings and fixed equipment, major movable equipment, motor vehicles, land improvements, amortization of leasehold improvements, lease acquisition costs, capital leases, interest on capital indebtedness, mortgage interest, lease costs, and equipment rental expense.

(b) PER DIEM RATE.—The Secretary shall pay nursing facilities a prospective, facility-specific, per diem rate based on the sum of the per diem rates established for the nursing service, administrative and general, and property cost centers as determined in accordance with sections 528, 529, and 532.

(c) FACILITY-SPECIFIC PROSPECTIVE RATE.—The Secretary shall pay nursing facilities a facility-specific prospective rate for each unit of the fee-for-service ancillary services as determined in accordance with section 610 of this title.

(d) REIMBURSEMENT FOR SELECTIVE ANCILLARY SERVICES.—Nursing facilities shall be reimbursed by the Secretary for selected ancillary services and other costs on

a retrospective basis in accordance with section 611 of this title.

SEC. 607. RESIDENT ASSESSMENT.

(a) IN GENERAL.—In order to be eligible for payments under this title, a nursing facility shall perform a resident assessment in accordance with section 1819(b)(3) of the Social Security Act (42 U.S.C. 1395i–3(b)(3)) within 14 days of admission of the resident and at such other times as required by that section.

(b) RESIDENT CLASS.—The resident assessment shall be used to determine the resident class of each resident in the nursing facility for purposes of determining the per diem rate for the nursing service cost center in accordance with section 608 of this title.

SEC. 608. THE PER DIEM RATE FOR NURSING SERVICE COSTS.

(a) IN GENERAL.—

(1) NURSING SERVICE COST CENTER RATE.—The Secretary shall calculate the nursing service cost center rate using a prospective, facility-specific per diem rate based on the nursing facility's case-mix weight and nursing service costs during the base year.

(2) CASE-MIX WEIGHT.—For purposes of paragraph (1), the case-mix weight of a nursing facility

shall be obtained by multiplying the number of resident days in each resident class at a nursing facility during the base year by the relative weight assigned to each resident class in the appropriate geographic region. Once this calculation is performed for each resident class in the nursing facility, the sum of these products shall constitute the case-mix weight for the nursing facility.

(3) FACILITY NURSING UNIT VALUE.—A facility nursing unit value for the nursing facility for the base year shall be obtained by dividing the nursing service costs for the base year, which shall be indexed forward from the midpoint of the base period to the midpoint of the rate period using the DRI McGraw-Hill HCFA Nursing Home Without Capital Market Basket, by the case-mix weight of the nursing facility for the base year.

(4) FACILITY-SPECIFIC NURSING SERVICES PRICE.—A facility-specific nursing services price for each resident class shall be obtained my multiplying the lower of the indexed facility unit value of the nursing facility during the base year or the geographic ceiling, as determined in accordance with subsection (b), by the relative weight of the resident class.

(5) PATIENT CLASSIFICATIONS.—For patient classifications associated with the use of complex medical equipment and other specialized, noncustomary equipment (particularly subacute classifications), the Secretary shall provide for a daily allowance for such equipment based upon the amortized value of such equipment over the life of the equipment.

(6) SELECTED RESIDENT CLASSIFICATIONS.—For selected resident classifications (particularly subacute classifications) requiring additional or specialized medical administrative staff, the Secretary shall provide for a daily allowance to cover these costs.

(7) DESIGNATION OF CERTAIN RESIDENT CLASSES.—The Secretary shall designate certain resident classes, such as subacute resident classes, as requiring heavy care. An acuity payment of 3 percent of the facility-specific nursing services price shall be added to the facility-specific price for each resident that the Secretary has designated as requiring heavy care.

(8) PER DIEM RATE.—The per diem rate for the nursing service cost center for each resident in

a resident class shall constitute the facility-specific price, plus the acuity payment where appropriate.

(9) PER DIEM RATE REBASED ANNUALLY.—The Secretary shall annually rebate the per diem rate for the nursing service cost center, including the facility-specific price and the acuity payment.

(10) PAYMENT.—To determine the payment amount to a nursing facility for the nursing service cost center, the Secretary shall multiply the per diem rate (including the acuity payment) for a resident class by the number of resident days for each resident class based on aggregated resident invoices which each nursing facility shall submit on a monthly basis.

(b) GEOGRAPHIC CEILING.—

(1) FACILITY UNIT VALUE.—The facility unit value identified in subsection (a)(3) shall be subjected to geographic ceilings established for the geographic regions designated by the Secretary in section 605 of this title.

(2) DETERMINATION.—

(A) IN GENERAL.—The Secretary shall determine the geographic ceiling by creating an array of indexed facility unit values in a geographic region from lowest to highest. Based on

this array, the Secretary shall identify a fixed proportion between the indexed facility unit value of the nursing facility which contained the medianth resident day in the array (except as provided in subsection (b)(4) of this section) and the indexed facility unit value of the nursing facility which contained the 95th percentile resident day in that array during the first year of operation of the Prospective Payment System for nursing facilities. The fixed proportion shall remain the same in subsequent years.

(B) SUBSEQUENT YEARS.—To obtain the geographic ceiling on the indexed facility unit value for nursing facilities in a geographic region in each subsequent year, the fixed proportion identified pursuant to subparagraph (A) shall be multiplied by the indexed facility unit value of the nursing facility which contained the medianth resident day in the array of facility unit values for the geographic region during the base year.

(3) EXCLUSIONS FROM DETERMINATION.—For purposes of determining the geographic ceiling for a

nursing service cost center, the Secretary shall exclude low volume and new nursing facilities (as defined in section 614 of this title).

(c) EXCEPTIONS TO GEOGRAPHIC CEILING.—The Secretary shall establish by regulation procedures for allowing exceptions to the geographic ceiling imposed on a nursing service cost center. The procedure shall permit exceptions based on the following factors:

(1) Local supply or labor shortages which substantially increase costs to specific nursing facilities.

(2) Higher per resident day usage of contract nursing personnel, if utilization of contract nursing personnel is warranted by local circumstances and the provider has taken all reasonable measures to minimize contract personnel expense.

(3) Extraordinarily low proportion of distinct part nursing facilities in a geographic region resulting in a geographic ceiling that unfairly restricts the reimbursement of distinct part facilities.

(4) Regulatory changes that increase costs to only a subset of the nursing facility industry.

(5) The offering of a new institutional health service or treatment program by a nursing facility (in order to account for initial startup costs).

(6) Disproportionate usage of part-time employees, where adequate numbers of full-time employees cannot reasonably be obtained.

(7) Other cost producing factors specified by the Secretary in regulations that are specific to a subset of facilities in a geographic region (except case-mix variation).

SEC. 609. THE PER DIEM RATE FOR ADMINISTRATIVE AND GENERAL COSTS.

(a) IN GENERAL.—

(1) PAYMENT.—The Secretary shall make payments for the administrative and general cost center by using a facility-specific, prospective, per diem rate.

(2) STANDARDS FOR PER DIEM RATE.—The Secretary shall assign a per diem rate to a nursing facility by applying 2 standards that is calculated as follows:

(A) STANDARD A.—The Secretary shall determine a Standard A for each geographic region by creating an array of indexed nursing facility administrative and general per diem costs from lowest to highest. The Secretary shall then identify a fixed proportion by dividing the indexed administrative and general per diem costs

of the nursing facility that contains the medianth resident day of the array (except as provided in subsection (a)(4)) into the indexed administrative and general per diem costs of the nursing facility that contains the 75th percentile resident day in that array. Standard A for each base year shall constitute the product of this fixed proportion and the administrative and general indexed per diem costs of the nursing facility that contains the medianth resident day in the array of such costs during the base year.

(B) STANDARD B.—The Secretary shall determine a Standard B for each geographic region by using the same calculation as in subparagraph (A) except that the fixed proportion shall use the indexed administrative and general costs of the nursing facility containing the 85th percentile, rather than the 75th percentile, resident day in the array of such costs.

(3) GEOGRAPHIC REGIONS.—The Secretary shall use the geographic regions identified in section 605(c) of this title for purposes of determining Standards A and B.

(4) EXCLUSION.—The Secretary shall exclude low volume and new nursing facilities (as defined in section 614 of this title) for purposes of determining Standard A and Standard B.

(5) PER DIEM RATE.—To determine a nursing facility's per diem rate for the administrative and general cost center, Standards A and B shall be applied to a nursing facility's administrative and general per diem costs, indexed forward using the DRI McGraw-Hill HCFA Nursing Home Without Capital Market Basket, as follows:

(A) Each nursing facility having indexed costs which are below the median shall be assigned a rate equal to their individual indexed costs plus an ''efficiency incentive'' equal to ½ of the difference between the median and Standard A.

(B) Each nursing facility having indexed costs which are below Standard A but are equal to or exceed the median shall be assigned a per diem rate equal to their individual indexed costs plus an ''efficiency incentive'' equal to ½ of the difference between the nursing facility's indexed costs and Standard A.

(C) Each nursing facility having indexed costs which are between Standard A and Standard B shall be assigned a rate equal to Standard A plus ½ of the difference between the nursing facility's indexed costs and Standard A.

(D) Each nursing facility having indexed costs which exceed Standard B shall be assigned a rate as if their costs equaled Standard B. These nursing facilities shall be assigned a per diem rate equal to Standard A plus ½ of the difference between Standard A and Standard B.

(E) For purposes of subparagraphs (A) through (D), the median represents the indexed administrative and general per diem costs of a nursing facility that contains the medianth resident day in the array of such costs during the base year in the geographic region.

(b) REBASING.—Not less than annually, the Secretary shall rebase the payment rates for administrative and general costs.

SEC. 610. PAYMENT FOR FEE-FOR-SERVICE ANCILLARY SERVICES.

(a) IN GENERAL.—The Secretary shall make payments for the ancillary services described in section 606(a)(3) on a prospective fee-for-service basis.

(b) PAYMENT METHODOLOGY.—The Secretary shall identify the fee for each of the fee-for-service ancillary services for a particular nursing facility by dividing the nursing facility's reasonable costs, including overhead allocated through the cost finding process, of providing each particular service, indexed forward using the DRI McGraw-Hill HCFA Nursing Home Without Capital Market Basket, by the units of the particular service provided by the nursing facility during the cost year.

(c) COMPUTATION PERIOD.—The fee for each of the fee-for-service ancillary services shall be calculated by the Secretary under this title at least once a year for each facility and ancillary service.

SEC. 611. REIMBURSEMENT OF SELECTED ANCILLARY SERVICES AND OTHER COSTS.

(a) IN GENERAL.—Reimbursement of selected ancillary services and other costs identified in section 606(a)(4) of this title shall be reimbursed by the Secretary on a retrospective basis as pass-through costs, including overhead allocated through the cost-finding process.

(b) CHARGE-BASED INTERIM RATES.—The Secretary shall set charge-based interim rates for selected ancillary services and other costs for each nursing facility providing such services. Any overpayments or underpayments resulting from the difference between the interim and final settlement rates shall be either refunded by the nursing facility or paid to the nursing facility following submission of a timely filed medicare cost report.

SEC. 612. PER DIEM PAYMENT FOR PROPERTY COSTS.

(a) IN GENERAL.—The Secretary shall make a per diem payment for property costs based on a gross rental system. The amount of the payment shall be determined as follows:

(1) BUILDING AND FIXED EQUIPMENT VALUE.—In the case of a new facility in any geographic region, the cost for building and fixed equipment used in determining the gross rental shall be equivalent to the median cost of home construction in the region (as measured by RS Means). Such cost shall then be multiplied by the factor 1.2 to account for land and the value of movable equipment. The resulting value shall be indexed each year using the RS Means Construction Cost Index.

(2) AGE.—

(A) IN GENERAL.—The gross rental system establishes a facility's value based on its age. The older the facility, the less its value. Additions, replacements, and renovations shall be recognized by lowering the age of the facility and, thus, increasing the facility's value. Existing facilities, 1 year or older, shall be valued at the new bed value less 2 percent per year according to the ''age'' of the facility. Facilities shall not be depreciated to an amount less than 50 percent of the new construction bed value.

(B) ADDITION OF BEDS.—The addition of beds shall require a computation by the Secretary of the weighted average age of the facility based on the construction dates of the original facility and the additions.

(C) REPLACEMENT OF BEDS.—The replacement of existing beds shall result in an adjustment to the age of the facility. A weighted average age shall be calculated by the Secretary according to the year of initial construction and the year of bed replacement. If a facility has a series of additions or replacements, the Secretary shall assume that the oldest beds are the

ones being replaced when computing the average facility age.

(D) RENOVATIONS OR MAJOR IMPROVEMENTS.—Renovations or major improvements shall be calculated by the Secretary as a bed replacement, except that the value of the bed prior to renovation shall be taken into consideration. To qualify as a bed replacement, the bed being renovated must be at least 10 years old and the renovation or improvements cost must be equal to or greater than the difference between the existing bed value and the value of a new bed. To determine the new adjusted facility age, the number of renovated beds assigned a ''new'' age is determined by dividing the total cost of renovation by the difference between the existing bed value and the value of the new bed.

(E) STARTUP OF GROSS RENTAL SYSTEM.—To start up the fair rental system, each facility's bed values shall be determined by the Secretary based on the age of the facility. The determination shall include setting a value for the original beds with adjustments for any additions, bed replacements, and major renovations.

For determination of bed values for use in determining the initial rate, the procedures described above for determining the values of original beds, additions, and replacements shall be used.

(3) TOTAL CURRENT VALUE.—The Secretary shall multiply the per bed value by the number of beds in the facility to estimate the facility's total current value.

(4) RENTAL FACTOR.—The Secretary shall apply a rental factor to the facility's total current value to estimate its annual gross rental value. The Secretary shall determine the rental factor by using the Treasury Bond Composite Yield (greater than 10 years) as published in the Federal Reserve Bulletin plus a risk premium. A risk premium in the amount of 3 percentage points shall be added to the Treasury Yield. The rental factor is multiplied by the facility's total value, as determined in paragraph (3), to determine the annual gross rental value.

(5) PER DIEM PROPERTY PAYMENT.—The annual gross rental value shall be divided by the Secretary by 90 percent of the facility's annual licensed bed days during the cost report period to arrive at the per diem property payment.

(6) PER RESIDENT DAY RENTAL RATE.—The per resident day rental rate for a newly constructed facility during its first year of operation shall be based on the total annual rental divided by the greater of 50 percent of available resident days or actual annualized resident days up to 90 percent of annual licensed bed days during the first year of operation.

(b) Facilities in operation prior to the effective date of this Act shall receive the per resident day rental or actual costs, as determined in accordance with HCFA-Pub. 15, whichever is greater, except that a nursing facility shall be reimbursed the per resident day rental on and after the earliest of the following dates:

(1) the date upon which the nursing facility changes ownership;

(2) the date the nursing facility accepts the per resident day rental; or

(3) the date of the renegotiation of the lease for the land or buildings, not including the exercise of optional extensions specifically included in the original lease agreement or valid extensions thereof.

SEC. 613. MID-YEAR RATE ADJUSTMENTS.

(a) MID-YEAR ADJUSTMENTS.—The Secretary shall establish by regulation a procedure for granting mid-year

rate adjustments for the nursing service, administrative and general, and fee-for-service ancillary services cost centers.

(b) INDUSTRY-WIDE BASIS.—The mid-year rate adjustment procedure shall require the Secretary to grant adjustments on an industry-wide basis, without the need for nursing facilities to apply for such adjustments, based on the following circumstances:

(1) Statutory or regulatory changes affecting nursing facilities.

(2) Changes to the Federal minimum wage.

(3) General labor shortages with high regional wage impacts.

(c) APPLICATION FOR ADJUSTMENT.—The mid-year rate adjustment procedure shall permit specific facilities or groups of facilities to apply to the Secretary for an adjustment based on the following factors:

(1) Local labor shortages.

(2) Regulatory changes that apply to only a subset of the nursing facility industry.

(3) Economic conditions created by natural disasters or other events outside of the control of the provider.

(4) Other cost producing factors, except case-mix variation, to be specified by the Secretary in regulations.

(d) REQUIREMENTS FOR APPLICATION FOR ADJUSTMENT.—

(1) IN GENERAL.—A nursing facility which applies for a mid-year rate adjustment pursuant to this section shall be required to show that the adjustment will result in a greater than 2 percent deviation in the per diem rate for any individual cost service center or a deviation of greater than $5,000 in the total projected and indexed costs for the rate year, whichever is less.

(2) COST EXPERIENCE DATA.—A nursing facility application for a mid-year rate adjustment must be accompanied by recent cost experience data and budget projections.

SEC. 614. EXCEPTION TO PAYMENT METHODS FOR NEW AND LOW VOLUME NURSING FACILITIES.

(a) DEFINITION OF LOW VOLUME NURSING FACILITY.—In this title, the term ''low volume nursing facility'' means a nursing facility having fewer than 2,500 medicare part A resident days per year.

(b) DEFINITION OF NEW NURSING FACILITY.—In this title, the term ''new nursing facility'' means a newly

constructed, licensed, and certified nursing facility or a nursing facility that is in its first 3 years of operation as a provider of services under part A of the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). A nursing facility that has operated for more than 3 years but has a change of ownership shall not constitute a new facility.

(c) OPTION FOR LOW VOLUME NURSING FACILITIES.—A Low volume nursing facility shall have the option of submitting a cost report to the Secretary to receive retrospective payment for all of the cost centers, other than the property cost center, or accepting a per diem rate which shall be based on the sum of—

(1) the median indexed resident day facility unit value for the appropriate geographic region for the nursing service cost center during the base year as identified in section 608(b)(2) of this title;

(2) the median indexed resident day administrative and general per diem costs of all nursing facilities in the appropriate geographic region as identified in section 609(a)(5)(E) of this title;

(3) the median indexed resident day costs per unit of service for fee-for-service ancillary services obtained using the cost information from the nursing facilities in the appropriate geographic region

during the base year, excluding low volume and new nursing facilities, and based on an array of such costs from lowest to highest; and

(4) the median indexed resident day per diem costs for selected ancillary services and other costs obtained using information from the nursing facilities in the appropriate geographic region during the base year, excluding low volume and new nursing facilities, and based on an array of such costs from lowest to highest.

(d) OPTION FOR NEW NURSING FACILITIES.—New nursing facilities shall have the option of being paid by the Secretary on a retrospective cost pass-through basis for all costs centers, or in accordance with subsection (c).

SEC. 615. APPEAL PROCEDURES.

(a) IN GENERAL.—

(1) APPEAL.—Any person or legal entity aggrieved by a decision of the Secretary under this title, and which results in an amount in controversy of $10,000 or more, shall have the right to appeal such decision directly to the Provider Reimbursement Review Board (in this section referred to as ''the Board'') authorized under section 1878 of the Social Security Act (42 U.S.C. 1395oo).

(2) AMOUNT IN CONTROVERSY.—The $10,000 amount in controversy referred to in paragraph (1) shall be computed in accordance with 42 C.F.R. 405.1839.

(b) HEARINGS.—Any appeals to and any hearings before the Board under this title shall follow the procedures under section 1878 of the Social Security Act (42 U.S.C. 1395oo) and the regulations contained in (42 C.F.R. 405.1841–1889), except to the extent that they conflict with, or are inapplicable on account of, any other provision of this title.

SEC. 616. TRANSITION PERIOD.

The Prospective Payment System described in this title shall be phased in over a 3 year period using the following blended rate:

(1) For the first year that the provisions of this title are in effect, 25 percent of the payment rates will be based on the Prospective Payment System under this title and 75 percent will remain based upon reasonable cost reimbursement.

(2) For the second year that the provisions of this title are in effect, 50 percent of the payment rates will be based on the Prospective Payment System under this title and 50 percent based upon reasonable cost reimbursement.

(3) For the third year that the provisions of this title are in effect, 75 percent of the payment rates will be based on the Prospective Payment System under this title and 25 percent based upon reasonable cost reimbursement.

(4) For the fourth year that the provisions of this title are in effect and for all subsequent years, the payment rates will be based solely on the Prospective Payment System under this title.

SEC. 617. EFFECTIVE DATE; INCONSISTENT PROVISIONS.

(a) EFFECTIVE DATE.—The provisions of this title shall take effect on October 1, 1998.

(b) INCONSISTENT PROVISIONS.—The provisions contained in this title shall supersede any other provisions of title XVIII or XIX of the Social Security Act (42 U.S.C. 1395 et seq. 1396 et seq.) which are inconsistent with such provisions.

TITLE VII—TELEMEDICINE

SEC. 701. INTERNET ACCESS FOR HEALTH CARE PROVIDERS FOR RURAL AREAS.

(a) IN GENERAL.—Paragraph (1) of section 254(h) of the Communications Act of 1934 (47 U.S.C. 254(h)) is amended by adding at the end the following:

"(C) INTERNET ACCESS FOR HEALTH CARE PROVIDERS FOR RURAL AREAS.—In order

to meet the objective of providing health care services in rural areas, the Commission shall adopt rules to require that telecommunications carriers provide access to the Internet or other interactive computer service which is necessary for the provision of health care services described in subparagraph (A) at rates as described in that subparagraph. Such access shall include the infrastructure and bandwidth necessary for the provision of such services. In adopting such rules, the Commission shall permit a telecommunications carrier to reduce the amount of its contribution to the mechanism to preserve and advance universal service by the amount, if any, by which the rates for providing access under this subparagraph are exceeded by the rates for similar access provided to other customers in comparable rural areas in the State concerned.''.

(b) DEFINITIONS.—Paragraph (5) of such section is amended by adding at the end the following:

''(D) INTERNET.—The term 'Internet' has the meaning given to it in section 230(e)(1).

''(E) INTERACTIVE COMPUTER SERVICE.—The term 'interactive computer service' has the meaning given to it in section 230(e)(2).''.

(c) CONFORMING AMENDMENT.—The subsection heading of such section is amended to read as follows:

''(h) TELECOMMUNICATIONS SERVICES AND INTERNET ACCESS FOR CERTAIN PROVIDERS.—''.

SEC. 702. COMMISSION ON TELEMEDICINE.

(a) ESTABLISHMENT OF COMMISSION.—

(1) ESTABLISHMENT.—There is established a commission to be known as the Commission on Telemedicine (in this section referred to as the ''Commission'').

(2) MEMBERSHIP.—

(A) COMPOSITION.—The Commission shall be composed of 15 members of whom—

(i) 12 shall be appointed by the Secretary, subject to subparagraph (B); and

(ii) 3 shall be appointed by the Secretary from among employees within appropriate divisions of the Department of Health and Human Services.

(B) PROHIBITION.—The members of the Commission appointed under subparagraph

(A)(i) may not be employees of the Federal Government.

(C) DATE.—The appointments of the members of the Commission shall be made not later than 90 days after the date of enactment of this Act.

(3) PERIOD OF APPOINTMENT; VACANCIES.—Members shall be appointed for the life of the Commission. Any vacancy in the Commission shall not affect its powers, but shall be filled in the same manner as the original appointment.

(4) INITIAL MEETING.—Not later than 30 days after the date on which all members of the Commission have been appointed, the Commission shall hold its first meeting.

(5) MEETINGS.—The Commission shall meet at the call of the Chairperson.

(6) QUORUM.—A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.

(7) CHAIRPERSON AND VICE CHAIRPERSON.—The Commission shall select a Chairperson and Vice Chairperson from among its members.

(b) DUTIES OF THE COMMISSION.—

(1) STUDY AND RECOMMENDATIONS.—The Commission shall conduct a thorough study of and develop recommendations on all matters relating to which telemedicine services should be covered under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(2) REPORT.—Not later than 1 year after the date of enactment of this Act, the Commission shall submit a report to the President and Congress containing a detailed statement of the findings and conclusions of the Commission, together with the Commission's recommendations for such legislation and administrative actions as the Commission considers appropriate.

(c) POWERS OF THE COMMISSION.—

(1) HEARINGS.—The Commission may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Commission considers advisable to carry out the purposes of this section.

(2) INFORMATION FROM FEDERAL AGENCIES.—The Commission may secure directly from any Federal department or agency such information as the Commission considers necessary to carry out the

provisions of this section. Upon request of the Chairperson of the Commission, the head of that department or agency shall furnish that information to the Commission.

(3) POSTAL SERVICES.—The Commission may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

(4) GIFTS.—The Commission may accept, use, and dispose of gifts or donations of services or property.

(d) COMMISSION PERSONNEL MATTERS.—

(1) COMPENSATION.—Members of the Commission shall receive no additional compensation by reason of their service on the Commission.

(2) TRAVEL EXPENSES.—The members of the Commission shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Commission.

(3) STAFF.—

(A) IN GENERAL.—The Chairperson of the Commission may, without regard to the civil

service laws and regulations, appoint and terminate an executive director and such other additional personnel as may be necessary to enable the Commission to perform its duties. The employment of an executive director shall be subject to confirmation by the Commission.

(B) COMPENSATION.—The Chairperson of the Commission may fix the compensation of the executive director and other personnel without regard to the provisions of chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates, except that the rate of pay for the executive director and other personnel may not exceed the rate payable for level V of the Executive Schedule under section 5316 of that title.

(4) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Commission without additional reimbursement (other than the employees regular compensation), and that detail shall be without interruption or loss of civil service status or privilege.

(5) PROCUREMENT OF TEMPORARY AND INTERMITTENT SERVICES.—The Chairperson of the Commission may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of that title.

(e) TERMINATION OF THE COMMISSION.—The Commission shall terminate 90 days after the date on which the Commission submits its report under subsection (b)(2).

(f) APPROPRIATIONS.—The Secretary shall provide to the Commission, out of funds otherwise available to the Secretary, such sums as are necessary to carry out the purposes of the Commission.

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