

"(1) IN GENERAL.—For purposes of subsection (a)(2), the percentage determined under this subsection for a teaching hospital is the mean average of the respective percentages determined under paragraph (3) for each fiscal year of the applicable period (as defined in paragraph (2)), adjusted by the Secretary (upward or downward, as the case may be) on a pro rata basis to the extent necessary to ensure that the sum of the percentages determined under this paragraph for all teaching hospitals is equal to 100 percent. The preceding sentence is subject to sections 2222 and 2223.

"(2) APPLICABLE PERIOD REGARDING RELEVANT DATA; FISCAL YEARS 1992 THROUGH 1994.—For purposes of this part, the term 'applicable period' means the period beginning on the first day of fiscal year 1992 and continuing through the end of fiscal year 1994.

"(3) RESPECTIVE DETERMINATIONS FOR FISCAL YEARS OF APPLICABLE PERIOD.—For purposes of paragraph (1), the percentage determined under this paragraph for a teaching hospital for a fiscal year of the applicable period is the percentage constituted by the ratio of—

"(A) the total amount of payments received by the hospital under section 1886(d)(5)(B) for discharges occurring during the fiscal year involved; to

"(B) the sum of the respective amounts determined under subparagraph (A) for the fiscal year for all teaching hospitals.

"(c) AVAILABILITY OF DATA.—If a teaching hospital received the payments specified in subsection (b)(3)(A) during the applicable period but a complete set of the relevant data is not available to the Secretary for purposes of determining an amount under such subsection for the fiscal year involved, the Secretary shall for purposes of such subsection make an estimate on the basis of such data as is available to the Secretary for the applicable period.

"SEC. 2222. INDIRECT COSTS; SPECIAL RULES REGARDING DETERMINATION OF HOSPITAL-SPECIFIC PERCENTAGE.

"(a) SPECIAL RULE REGARDING FISCAL YEARS 1995 AND 1996.—

"(1) IN GENERAL.—In the case of a teaching hospital whose first payments under 1886(d)(5)(B) were for discharges occurring in fiscal year 1995 or in fiscal year 1996 (referred to in this subsection individually as a 'first payment year'), the percentage determined under paragraph (2) for the hospital is deemed to be the percentage applicable under section 2221(b) to the hospital, except that the percentage under paragraph (2) shall be adjusted in accordance with section 2221(b)(1) to the extent determined by the Secretary to be necessary with respect to a sum that equals 100 percent.

"(2) DETERMINATION OF PERCENTAGE.—For purposes of paragraph (1), the percentage determined under this paragraph for a teaching hospital is the percentage constituted by the ratio of the amount determined under subparagraph (A) to the amount determined under subparagraph (B), as follows:

"(A)(i) If the first payment year for the hospital is fiscal year 1995, the amount determined under this subparagraph is the total amount of payments received by the hospital under section 1886(d)(5)(B) for discharges occurring during fiscal year 1995.

"(ii) If the first payment year for the hospital is fiscal year 1996, the amount determined under this subparagraph is an amount equal to an estimate by the Secretary of the total amount of payments that would have been paid to the hospital under section 1886(d)(5)(B) for discharges occurring during fiscal year 1995 if such section, as in effect for fiscal year 1996, had applied to the hospital for discharges occurring during fiscal year 1995.

"(B)(i) If the first payment year for the hospital is fiscal year 1995, the amount determined under this subpara-

graph is the aggregate total of the payments received by teaching hospitals under section 1886(d)(5)(B) for discharges occurring during fiscal year 1995.

"(ii) If the first payment year for the hospital is fiscal year 1996—

"(I) the Secretary shall make an estimate in accordance with subparagraph (A)(ii) for all teaching hospitals; and

"(II) the amount determined under this subparagraph is the sum of the estimates made by the Secretary under subclause (I).

"(b) NEW TEACHING HOSPITALS.—

"(1) IN GENERAL.—In the case of a teaching hospital that did not receive payments under section 1886(d)(5)(B) for any of the fiscal years 1992 through 1996, the percentage determined under paragraph (3) for the hospital is deemed to be the percentage applicable under section 2221(b) to the hospital, except that the percentage under paragraph (3) shall be adjusted in accordance with section 2221(b)(1) to the extent determined by the Secretary to be necessary with respect to a sum that equals 100 percent.

"(2) DESIGNATED FISCAL YEAR REGARDING DATA.—The determination under paragraph (3) of a percentage for a teaching hospital described in paragraph (1) shall be made for the most recent fiscal year for which the Secretary has sufficient data to make the determination (referred to in this subsection as the 'designated fiscal year').

"(3) DETERMINATION OF PERCENTAGE.—For purposes of paragraph (1), the percentage determined under this paragraph for the teaching hospital involved is the percentage constituted by the ratio of the amount determined under subparagraph (A) to the amount determined under subparagraph (B), as follows:

"(A) The amount determined under this subparagraph is an amount equal to an estimate by the Secretary of the total amount of payments that would have been paid to the hospital under section 1886(d)(5)(B) for the designated fiscal year if such section, as in effect for the first fiscal year for which payments pursuant to this subsection are to be made to the hospital, had applied to the hospital for the designated fiscal year.

"(B) The Secretary shall make an estimate in accordance with subparagraph (A) for all teaching hospitals. The amount determined under this subparagraph is the sum of the estimates made by the Secretary under the preceding sentence.

"(c) CONSOLIDATIONS AND MERGERS.—In the case of two or more teaching hospitals that have each received payments pursuant to section 2221 for one or more fiscal years and that undergo a consolidation or merger, the percentage applicable to the resulting teaching hospital for purposes of section 2221(b) is the sum of the respective percentages that would have applied pursuant to such section if the hospitals had not undergone the consolidation or merger.

"SEC. 2223. INDIRECT COSTS; ALTERNATIVE PAYMENTS REGARDING TEACHING HOSPITALS IN CERTAIN STATES.

"(a) IN GENERAL.—In the case of a teaching hospital in a State for which a demonstration project under section 1814(b)(3) is in effect, this section applies in lieu of section 2221. For purposes of section 2211(a)(1), the amount determined for a teaching hospital for a fiscal year is the product of—

"(1) the amount in the Indirect-Costs Medical Education Account for the fiscal year pursuant to the allocation under section 2201(d)(3)(A) for the year; and

"(2) the percentage determined under subsection (b) for the hospital.

"(b) DETERMINATION OF PERCENTAGE.—For purposes of subsection (a)(2):

"(1) The Secretary shall make an estimate of the total amount of payments that would have been received under section 1886(d)(5)(B) by the hospital involved with respect to each of the fiscal years of the applicable period if such section (as in effect for such fiscal years) had applied to the hospital for such years.

"(2) The percentage determined under this subsection for the hospital for a fiscal year is a mean average percentage determined for the hospital in accordance with the methodology of section 2221(b)(1), except that the estimate made by the Secretary under paragraph (1) of this subsection for a fiscal year of the applicable period is deemed to be the amount that applies for purposes of section 2221(b)(3)(A) for such year.

"(c) RULE REGARDING PAYMENTS FROM CERTAIN AMOUNTS.—In the case of a teaching hospital in a State for which a demonstration project under section 1814(b)(3) is in effect, this section does not provide any payment to the hospital from amounts transferred to the Fund under section 1886(j).

"(d) ADJUSTMENT REGARDING PAYMENTS TO OTHER HOSPITALS.—In the case of a fiscal year for which payments pursuant to subsection (a) are made to one or more teaching hospitals, the following applies:

"(1) The Secretary shall determine a percentage equal to the sum of the respective percentages determined for the hospitals under subsection (b).

"(2) The Secretary shall determine an amount equal to the product of—

"(A) the percentage determined under paragraph (1); and

"(B) the amount in the Indirect-Costs Medical Education Account for the fiscal year pursuant to the transfer under section 1886(j)(1).

"(3) The Secretary shall, for each hospital (other than hospitals described in subsection (a)), make payments to the hospital whose sum is equal to the product of—

"(A) the amount determined under paragraph (2); and

"(B) the percentage that applies to the hospital for purposes of section 2221(b).

"Subpart 3—Amount Relating to Direct Costs of Graduate Medical Education

"SEC. 2231. DETERMINATION OF AMOUNT RELATING TO DIRECT COSTS.

"(a) IN GENERAL.—For purposes of section 2211(a)(2), the amount determined under this section for a teaching hospital for a fiscal year is the sum of—

"(1) the amount determined under subsection (b) (relating to the General Direct-Costs Medical Education Account); and

"(2) the amount determined under subsection (c) (relating to the Medicare Direct-Costs Medical Education Account).

"(b) PAYMENT FROM GENERAL ACCOUNT.—

"(1) IN GENERAL.—For purposes of subsection (a)(1), the amount determined under this subsection for a teaching hospital for a fiscal year is the product of—

"(A) the amount in the General Direct-Costs Medical Education Account on the applicable date under section 2201(d) (once the appropriation under such section is made); and

"(B) the percentage determined for the hospital under paragraph (2).

"(2) HOSPITAL-SPECIFIC PERCENTAGE.—

"(A) IN GENERAL.—For purposes of paragraph (1)(B), the percentage determined under this paragraph for a teaching hospital is the mean average of the respective

percentages determined under subparagraph (B) for each fiscal year of the applicable period (as defined in section 2221(b)(2)), adjusted by the Secretary (upward or downward, as the case may be) on a pro rata basis to the extent necessary to ensure that the sum of the percentages determined under this subparagraph for all teaching hospitals is equal to 100 percent. The preceding sentence is subject to sections 2232 through 2234.

"(B) RESPECTIVE DETERMINATIONS FOR FISCAL YEARS OF APPLICABLE PERIOD.—For purposes of subparagraph (A), the percentage determined under this subparagraph for a teaching hospital for a fiscal year of the applicable period is the percentage constituted by the ratio of—

"(i) the total amount of payments received by the hospital under section 1886(h) for cost reporting periods beginning during the fiscal year involved; to

"(ii) the sum of the respective amounts determined under clause (i) for the fiscal year for all teaching hospitals.

"(3) AVAILABILITY OF DATA.—If a teaching hospital received the payments specified in paragraph (2)(B)(i) during the applicable period but a complete set of the relevant data is not available to the Secretary for purposes of determining an amount under such paragraph for the fiscal year involved, the Secretary shall for purposes of such paragraph make an estimate on the basis of such data as is available to the Secretary for the applicable period.

"(c) PAYMENT FROM MEDICARE ACCOUNT.—

"(1) IN GENERAL.—For purposes of subsection (a)(2), the amount determined under this subsection for a teaching hospital for a fiscal year is the product of—

"(A) the amount in the Medicare Direct-Costs Medical Education Account on the applicable date under section 2201(d) (once the appropriation under such section is made); and

"(B) the percentage determined for the hospital under paragraph (2).

"(2) HOSPITAL-SPECIFIC PERCENTAGE.—For purposes of paragraph (1)(B), the percentage determined under this subsection for a teaching hospital for a fiscal year is the percentage constituted by the ratio of—

"(A) the estimate made by the Secretary for the hospital for the fiscal year under section 1886(j)(2)(B); to

"(B) the sum of the respective estimates referred to in subparagraph (A) for all teaching hospitals.

"SEC. 2232. DIRECT COSTS; SPECIAL RULES REGARDING DETERMINATION OF HOSPITAL-SPECIFIC PERCENTAGE.

"(a) SPECIAL RULE REGARDING FISCAL YEARS 1995 AND 1996.—

"(1) IN GENERAL.—In the case of a teaching hospital whose first payments under 1886(h) were for cost reporting period beginning in fiscal year 1995 or in fiscal year 1996 (referred to in this subsection individually as a 'first payment year'), the percentage determined under paragraph (2) for the hospital is deemed to be the percentage applicable under section 2231(b)(2) to the hospital, except that the percentage under paragraph (2) shall be adjusted in accordance with section 2231(b)(2)(A) to the extent determined by the Secretary to be necessary with respect to a sum that equals 100 percent.

"(2) DETERMINATION OF PERCENTAGE.—For purposes of paragraph (1), the percentage determined under this paragraph for a teaching hospital is the percentage constituted by the ratio of the amount determined under subparagraph (A) to the amount determined under subparagraph (B), as follows:

"(A)(i) If the first payment year for the hospital is fiscal year 1995, the amount determined under this subparagraph is the total amount of payments received by the hos-

pital under section 1886(h) for cost reporting periods beginning in fiscal year 1995.

"(ii) If the first payment year for the hospital is fiscal year 1996, the amount determined under this subparagraph is an amount equal to an estimate by the Secretary of the total amount of payments that would have been paid to the hospital under section 1886(h) for cost reporting periods beginning in fiscal year 1995 if such section, as in effect for fiscal year 1996, had applied to the hospital for fiscal year 1995.

"(B)(i) If the first payment year for the hospital is fiscal year 1995, the amount determined under this subparagraph is the aggregate total of the payments received by teaching hospitals under section 1886(h) for cost reporting periods beginning in fiscal year 1995.

"(ii) If the first payment year for the hospital is fiscal year 1996—

"(I) the Secretary shall make an estimate in accordance with subparagraph (A)(ii) for all teaching hospitals; and

"(II) the amount determined under this subparagraph is the sum of the estimates made by the Secretary under subclause (I).

"(b) NEW TEACHING HOSPITALS.—

"(1) IN GENERAL.—In the case of a teaching hospital that did not receive payments under section 1886(h) for any of the fiscal years 1992 through 1996, the percentage determined under paragraph (3) for the hospital is deemed to be the percentage applicable under section 2231(b)(2) to the hospital, except that the percentage under paragraph (3) shall be adjusted in accordance with section 2231(b)(2)(A) to the extent determined by the Secretary to be necessary with respect to a sum that equals 100 percent.

"(2) DESIGNATED FISCAL YEAR REGARDING DATA.—The determination under paragraph (3) of a percentage for a teaching hospital described in paragraph (1) shall be made for the most recent fiscal year for which the Secretary has sufficient data to make the determination (referred to in this subsection as the 'designated fiscal year').

"(3) DETERMINATION OF PERCENTAGE.—For purposes of paragraph (1), the percentage determined under this paragraph for the teaching hospital involved is the percentage constituted by the ratio of the amount determined under subparagraph (A) to the amount determined under subparagraph (B), as follows:

"(A) The amount determined under this subparagraph is an amount equal to an estimate by the Secretary of the total amount of payments that would have been paid to the hospital under section 1886(h) for the designated fiscal year if such section, as in effect for the first fiscal year for which payments pursuant to this subsection are to be made to the hospital, had applied to the hospital for cost reporting periods beginning in the designated fiscal year.

"(B) The Secretary shall make an estimate in accordance with subparagraph (A) for all teaching hospitals. The amount determined under this subparagraph is the sum of the estimates made by the Secretary under the preceding sentence.

"(c) CONSOLIDATIONS AND MERGERS.—In the case of two or more teaching hospitals that have each received payments pursuant to section 2231 for one or more fiscal years and that undergo a consolidation or merger, the percentage applicable to the resulting teaching hospital for purposes of section 2231(b) is the sum of the respective percentages that would have applied pursuant to such section if the hospitals had not undergone the consolidation or merger.

"SEC. 2233. DIRECT COSTS; AUTHORITY FOR PAYMENTS TO CONSORTIA OF PROVIDERS.

"(a) IN GENERAL.—In lieu of making payments to teaching hospitals pursuant to section 2231, the Secretary may make payments under this section to consortia that meet the requirements of subsection (b).

"(b) QUALIFYING CONSORTIUM.—For purposes of subsection (a), a consortium meets the requirements of this subsection if the consortium is in compliance with the following:

"(1) The consortium consists of an approved medical residency training program of a teaching hospital and one or more of the following entities:

"(A) Schools of medicine or osteopathic medicine.

"(B) Other teaching hospitals (or the approved medical residency training programs of the hospitals).

"(C) Community health centers (under section 330 of the Public Health Service Act).

"(D) Medical group practices.

"(E) Managed care entities.

"(F) Entities furnishing outpatient services.

"(G) Such other entities as the Secretary determines to be appropriate.

"(2) The members of the consortium have agreed to participate in the programs of graduate medical education that are operated by the teaching hospitals of the consortium.

"(3) With respect to the receipt by the consortium of payments made pursuant to this section, the members of the consortium have agreed on a method for allocating the payments among the members.

"(4) The consortium meets such additional requirements as the Secretary may establish.

"(c) PAYMENTS FROM ACCOUNTS.—

"(1) IN GENERAL.—Subject to subsection (d), the total of payments to a qualifying consortium for a fiscal year pursuant to subsection (a) shall be the sum of—

"(1) the aggregate amount determined for the teaching hospitals of the consortium pursuant to paragraph (1) of section 2231(a); and

"(2) an amount determined in accordance with the methodology that applies pursuant to paragraph (2) of such section, except that the estimate used for purposes of subsection (c)(2)(A) of such section shall be the estimate made for the consortium under section 1886(j)(2)(C)(ii).

"(d) LIMITATION ON AGGREGATE TOTAL OF PAYMENTS TO CONSORTIA.—The aggregate total of the amounts paid under subsection (c)(2) to qualifying consortia for a fiscal year may not exceed the sum of—

"(1) the aggregate total of the amounts that would have been paid under section 2231(c) for the fiscal year to the teaching hospitals of the consortia if the hospitals had not been participants in the consortia; and

"(2) an amount equal to 1 percent of the amount that applies under paragraph (1)(A) of such section for the fiscal year (relating to the Medicare Direct-Costs Medical Education Account).

"(e) DEFINITION.—For purposes of this title, the term 'qualifying consortium' means a consortium that meets the requirements of subsection (b).

"SEC. 2234. DIRECT COSTS; ALTERNATIVE PAYMENTS REGARDING TEACHING HOSPITALS IN CERTAIN STATES.

"(a) IN GENERAL.—In the case of a teaching hospital in a State for which a demonstration project under section 1814(b)(3) is in effect, this section applies in lieu of section 2231. For purposes of section 2211(a)(2), the amount determined for a teaching hospital for a fiscal year is the product of—

"(1) the amount in the General Direct-Costs Medical Education Account on the applicable date under section 2201(d) (once the appropriation under such section is made); and

"(2) the percentage determined under subsection (b) for the hospital.

"(b) DETERMINATION OF PERCENTAGE.—For purposes of subsection (a)(2):

"(1) The Secretary shall make an estimate of the total amount of payments that would have been received under section 1886(h) by the hospital involved with respect to each of the fiscal years of the applicable period if such section (as in effect for such fiscal years) had applied to the hospital for such years.

"(2) The percentage determined under this subsection for the hospital for a fiscal year is a mean average percentage determined for the hospital in accordance with the methodology of section 2231(b)(2)(A), except that the estimate made by the Secretary under paragraph (1) of this subsection for a fiscal year of the applicable period is deemed to be the amount that applies for purposes of section 2231(b)(2)(B)(i) for such year.

"(c) RULE REGARDING PAYMENTS FROM CERTAIN AMOUNTS.—In the case of a teaching hospital in a State for which a demonstration project under section 1814(b)(3) is in effect, this section does not provide any payment to the hospital from amounts transferred to the Fund under section 1886(j).

"Subpart 4—General Provisions

"SEC. 2241. ADJUSTMENTS IN PAYMENT AMOUNTS.

"(a) COLLECTION OF DATA ON ACCURACY OF ESTIMATES.—The Secretary shall collect data on whether the estimates made by the Secretary under section 1886(j) for a fiscal year were substantially accurate.

"(b) ADJUSTMENTS.—If the Secretary determines under subsection (a) that an estimate for a fiscal year was not substantially accurate, the Secretary shall, for the first fiscal year beginning after the Secretary makes the determination—

"(1) make adjustments accordingly in transfers to the Fund under section 1886(j); and

"(2) make adjustments accordingly in the amount of payments to teaching hospitals pursuant to 2231(c) (or, as applicable, to qualifying consortia pursuant to section 2232(c)(2))."

PART 2—AMENDMENTS TO MEDICARE PROGRAM

SEC. 15411. TRANSFERS TO TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND.

Section 1886 (42 U.S.C. 1395ww) is amended—

(1) in subsection (d)(5)(B), in the matter preceding clause (i), by striking "The Secretary shall provide" and inserting the following: "For discharges occurring on or before September 30, 1996, the Secretary shall provide";

(2) in subsection (h)—

(A) in paragraph (1), in the first sentence, by striking "the Secretary shall provide" and inserting "the Secretary shall, subject to paragraph (6), provide"; and

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

"(6) LIMITATION.—

"(A) IN GENERAL.—The authority to make payments under this subsection applies only with respect to cost reporting periods ending on or before September 30, 1996, except as provided in subparagraph (B).

"(B) RULE REGARDING PORTION OF LAST COST REPORTING PERIOD.—In the case of a cost reporting period that extends beyond September 30, 1996, payments under this

subsection shall be made with respect to such portion of the period as has lapsed as of such date.

"(C) RULE OF CONSTRUCTION.—This paragraph may not be construed as authorizing any payment under section 1861(v) with respect to graduate medical education."; and

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

"(j) TRANSFERS TO TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND.—

"(1) INDIRECT COSTS OF MEDICAL EDUCATION.—

"(A) IN GENERAL.—From the Federal Hospital Insurance Trust Fund, the Secretary shall, for fiscal year 1997 and each subsequent fiscal year, transfer to the Indirect-Costs Medical Education Account (under section 2201) an amount determined by the Secretary in accordance with subparagraph (B).

"(B) DETERMINATION OF AMOUNTS.—The Secretary shall make an estimate for the fiscal year involved of the nationwide total of the amounts that would have been paid under subsection (d)(5)(B) to hospitals during the fiscal year if such payments had not been terminated for discharges occurring after September 30, 1996. For purposes of subparagraph (A), the amount determined under this subparagraph for the fiscal year is the estimate made by the Secretary under the preceding sentence.

"(2) DIRECT COSTS OF MEDICAL EDUCATION.—

"(A) IN GENERAL.—From the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, the Secretary shall, for fiscal year 1997 and each subsequent fiscal year, transfer to the Medicare Direct-Costs Medical Education Account (under section 2201) the sum of—

"(i) an amount determined by the Secretary in accordance with subparagraph (B); and

"(ii) as applicable, an amount determined by the Secretary in accordance with subparagraph (C)(ii).

"(B) DETERMINATION OF AMOUNTS.—For each hospital (other than a hospital that is a member of a qualifying consortium referred to in subparagraph (C)), the Secretary shall make an estimate for the fiscal year involved of the amount that would have been paid under subsection (h) to the hospital during the fiscal year if such payments had not been terminated for cost reporting periods ending on or before September 30, 1996. For purposes of subparagraph (A)(i), the amount determined under this subparagraph for the fiscal year is the sum of all estimates made by the Secretary under the preceding sentence.

"(C) ESTIMATES REGARDING QUALIFYING CONSORTIA.—If the Secretary elects to authorize one or more qualifying consortia for purposes of section 2233(a), the Secretary shall carry out the following:

"(i) The Secretary shall establish a methodology for making payments to qualifying consortia with respect to the reasonable direct costs of such consortia in carrying out programs of graduate medical education. The methodology shall be the methodology established in subsection (h), modified to the extent necessary to take into account the participation in such programs of entities other than hospitals.

"(ii) For each qualifying consortium, the Secretary shall make an estimate for the fiscal year involved of the amount that would have been paid to the consortium during the fiscal year if, using the methodology under clause (i), payments had been made to the consortium for the fiscal year as reimbursements with respect to cost reporting periods. For purposes of sub-

paragraph (A)(ii), the amount determined under this clause for the fiscal year is the sum of all estimates made by the Secretary under the preceding sentence.

"(D) ALLOCATION BETWEEN FUNDS.—In providing for a transfer under subparagraph (A) for a fiscal year, the Secretary shall provide for an allocation of the amounts involved between part A and part B (and the trust funds established under the respective parts) as reasonably reflects the proportion of direct graduate medical education costs of hospitals associated with the provision of services under each respective part.

"(3) APPLICABILITY OF CERTAIN AMENDMENTS.—Amendments made to subsection (d)(5)(B) and subsection (h) that are effective on or after October 1, 1996, apply only for purposes of estimates under paragraphs (1) and (2) and for purposes of determining the amount of payments under 2211. Such amendments do not require any adjustment to amounts paid under subsection (d)(5)(B) or (h) with respect to fiscal year 1996 or any prior fiscal year.

"(4) RELATIONSHIP TO CERTAIN DEMONSTRATION PROJECTS.—In the case of a State for which a demonstration project under section 1814(b)(3) is in effect, the Secretary, in making determinations of the rates of increase under such section, shall include all amounts transferred under this subsection. Such amounts shall be so included to the same extent and in the same manner as amounts determined under subsections (d)(5)(B) and (h) were included in such determination under the provisions of this title in effect on September 30, 1996."

SEC. 16412. MODIFICATION IN PAYMENT POLICIES REGARDING GRADUATE MEDICAL EDUCATION.

(a) INDIRECT COSTS OF MEDICAL EDUCATION; APPLICABLE PERCENTAGE.—

(1) MODIFICATION REGARDING 5.6 PERCENT.—Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended—

(A) by striking "on or after October 1, 1988," and inserting "on or after October 1, 1999,"; and

(B) by striking "1.89" and inserting "1.38".

(2) SPECIAL RULE REGARDING FISCAL YEARS 1996 THROUGH 1998; MODIFICATION REGARDING 6 PERCENT.—Section 1886(d)(5)(B)(ii), as amended by paragraph (1), is amended by adding at the end the following: "In the case of discharges occurring on or after October 1, 1995, and before October 1, 1999, the preceding sentence applies to the same extent and in the same manner as the sentence applies to discharges occurring on or after October 1, 1999, except that the term '1.38' is deemed to be '1.48'."

(b) DIRECT COSTS OF MEDICAL EDUCATION.—

(1) LIMITATION ON NUMBER OF FULL-TIME-EQUIVALENT RESIDENTS.—Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) is amended by adding at the end the following new subparagraph:

"(F) LIMITATION ON NUMBER OF RESIDENTS FOR CERTAIN FISCAL YEARS.—Such rules shall provide that for purposes of a cost reporting period beginning on or after October 1, 1995, and on or before September 30, 2002, the number of full-time-equivalent residents determined under this paragraph with respect to an approved medical residency training program may not exceed the number of full-time-equivalent residents with respect to the program as of August 1, 1995 (except that this subparagraph does not apply to any nonphysician postgraduate training program that, under paragraph (5)(A), is an approved medical residency training program)."

(2) **EXCLUSION OF RESIDENTS AFTER INITIAL RESIDENCY PERIOD.**—Section 1886(h)(4)(C) (42 U.S.C. 1395ww(h)(4)(C)) is amended to read as follows:

“(C) **WEIGHTING FACTORS FOR RESIDENTS.**—Effective for cost reporting periods beginning on or after October 1, 1997, such rules shall provide that, in the calculation of the number of full-time-equivalent residents in an approved residency program, the weighting factor for a resident who is in the initial residency period (as defined in paragraph (5)(F)) is 1.0 and the weighting factor for a resident who has completed such period is 0.0. (In the case of cost reporting periods beginning before October 1, 1997, the weighting factors that apply in such calculation are the weighting factors that were applicable under this subparagraph on the day before the date of the enactment of the Medicare Preservation Act of 1995.)”.

(3) **REDUCTIONS IN PAYMENTS FOR ALIEN RESIDENTS.**—Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)), as amended by paragraph (1), is amended by adding at the end the following new subparagraph:

“(G) **SPECIAL RULES FOR ALIEN RESIDENTS.**—In the case of individuals who are not citizens or nationals of the United States, in the calculation of the number of full-time-equivalent residents in an approved medical residency program, the following rules shall apply with respect to such individuals who are residents in the program:

“(i) For a cost reporting period beginning during fiscal year 1996, for each such individual the Secretary shall apply a weighting factor of .75.

“(ii) For a cost reporting period beginning during fiscal year 1997, for each such individual the Secretary shall apply a weighting factor of .50.

“(iii) For a cost reporting period beginning during fiscal year 1998, for each such individual the Secretary shall apply a weighting factor of .25.

“(iv) For a cost reporting period beginning during fiscal year 1999 or any subsequent fiscal year, such individuals shall be excluded from the calculation of the number of full-time-equivalent residents in an approved medical residency program under this paragraph.”.

(c) **EFFECTIVE DATE.**—Except as provided otherwise in this section (or in the amendments made by this section), the amendments made by this section apply to hospital cost reporting periods beginning on or after October 1, 1995.

PART 3—REFORM OF FEDERAL POLICIES REGARDING TEACHING HOSPITALS AND GRADUATE MEDICAL EDUCATION

SEC. 15421. ESTABLISHMENT OF ADVISORY PANEL FOR RECOMMENDING POLICIES.

Title XXII of the Social Security Act, as added by section 15401, is amended by adding at the end the following part:

“PART C—OTHER MATTERS

“SEC. 2251. ADVISORY PANEL ON REFORM IN FINANCING OF TEACHING HOSPITALS AND GRADUATE MEDICAL EDUCATION.

“(a) **ESTABLISHMENT.**—The Chair of the Medicare Payment Review Commission under section 1806 shall establish a temporary advisory panel to be known as the Advisory Panel on Financing for Teaching Hospitals and Graduate Medical Education (in this section referred to as the ‘Panel’).

“(b) **DUTIES.**—The Panel shall develop recommendations on whether and to what extent Federal policies regarding teaching

hospitals and graduate medical education should be reformed, including recommendations regarding the following:

"(1) The financing of graduate medical education, including consideration of alternative broad-based sources of funding for such education.

"(2) The financing of teaching hospitals, including consideration of the difficulties encountered by such hospitals as competition among health care entities increases. Matters considered under this paragraph shall include consideration of the effects on teaching hospitals of the method of financing used for the program under part C of title XVIII (relating to MedicarePlus).

"(3) The methodology for making payments for graduate medical education, and the selection of entities to receive the payments. Matters considered under this paragraph shall include the following:

"(A) The methodology under part B for making payments from the Fund, including the use of data from the fiscal years 1992 through 1994, and including the methodology that applies with respect to consolidations and mergers of participants in the program under such part and with respect to the inclusion of additional participants in the program.

"(B) Issues regarding children's hospitals, and approved medical residency training programs in pediatrics.

"(C) Whether and to what extent payments are being made (or should be made) for graduate training in the various nonphysician health professions.

"(4) Federal policies regarding international medical graduates.

"(5) The dependence of schools of medicine on service-generated income.

"(6) The effects of the amendments made by section 15412 of the Medicare Preservation Act of 1995, including adverse effects on teaching hospitals that result from modifications in policies regarding international medical graduates.

"(7) The feasibility and desirability of reducing payments for graduate medical education for high-cost residency programs under section 1886(h)(2)(D)(iii).

"(c) COMPOSITION.—Not later than three months after being designated as the initial chairman of the Medicare Payment Review Commission, the chairman of the Commission shall appoint to the Panel 19 individuals who are not members of the Commission, who are not officers or employees of the United States, and who possess expertise on matters on which the Panel is to make recommendations under subsection (b). Such individuals shall include the following:

"(1) Deans from allopathic and osteopathic schools of medicine.

"(2) Chief executive officers (or equivalent administrative heads) from academic health centers, integrated health care systems, and approved medical residency training programs.

"(3) Chairs of departments or divisions from allopathic and osteopathic schools of medicine, schools of dentistry, and approved medical residency training programs in oral surgery.

"(4) Individuals with leadership experience from each of the fields of advanced practice nursing, physician assistants, and podiatric medicine.

"(5) Individuals with substantial experience in the study of issues regarding the composition of the health care workforce of the United States.

"(6) Individuals with expertise on the financing of health care.

"(7) Representatives from health insurance organizations and health plan organizations.

"(d) **RELATIONSHIP OF PANEL TO MEDICARE PAYMENT REVIEW COMMISSION.**—From amounts appropriated under subsection (n), the Medicare Review Payment Commission shall provide for the Panel such staff and administrative support (including quarters for the Panel) as may be necessary for the Panel to carry out the duties under subsection (b).

"(e) **CHAIR.**—The Panel shall designate a member of the Panel to serve as the Chair of the Panel.

"(f) **MEETINGS.**—The Panel shall meet at the call of the Chair or a majority of the members, except that the first meeting of the Panel shall be held not later than three months after the date on which appointments under subsection (c) are completed.

"(g) **TERMS.**—The term of a member of the Panel is the duration of the Panel.

"(h) **VACANCIES.**—

"(1) **IN GENERAL.**—A vacancy in the membership of the Panel does not affect the power of the remaining members to carry out the duties under subsection (b). A vacancy in the membership of the Panel shall be filled in the manner in which the original appointment was made.

"(2) **INCOMPLETE TERM.**—If a member of the Panel does not serve the full term applicable to the member, the individual appointed to fill the resulting vacancy shall be appointed for the remainder of the term of the predecessor of the individual.

"(i) **COMPENSATION; REIMBURSEMENT OF EXPENSES.**—

"(1) **COMPENSATION.**—Members of the Panel shall receive compensation for each day (including traveltime) engaged in carrying out the duties of the Committee. Such compensation may not be in an amount in excess of the daily equivalent of the annual maximum rate of basic pay payable under the General Schedule (under title 5, United States Code) for positions above GS-15.

"(2) **REIMBURSEMENT.**—Members of the Panel may, in accordance with chapter 57 of title 5, United States Code, be reimbursed for travel, subsistence, and other necessary expenses incurred in carrying out the duties of the Panel.

"(j) **CONSULTANTS.**—The Panel may procure such temporary and intermittent services of consultants under section 3109(b) of title 5, United States Code, as the Panel may determine to be useful in carrying out the duties under section 3. The Panel may not procure services under this subsection at any rate in excess of the daily equivalent of the maximum annual rate of basic pay payable under the General Schedule for positions above GS-15. Consultants under this subsection may, in accordance with chapter 57 of title 5, United States Code, be reimbursed for travel, subsistence, and other necessary expenses incurred for activities carried out on behalf of the Panel pursuant to section 3.

"(k) **POWERS.**—

"(1) **IN GENERAL.**—For the purpose of carrying out the duties of the Panel under subsection (b), the Panel may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Panel considers appropriate.

"(2) **OBTAINING OFFICIAL INFORMATION.**—Upon the request of the Panel, the heads of Federal agencies shall furnish directly to the Panel information necessary for the Panel to carry out the duties under subsection (b).

"(3) **USE OF MAILS.**—The Panel may use the United States mails in the same manner and under the same conditions as Federal agencies.

"(l) **REPORTS.**—

"(1) **FIRST INTERIM REPORT.**—Not later than one year after the date of the enactment of the Medicare Preservation Act of 1995, the Panel shall submit to the Congress a report providing the recommendations of the Panel regarding the matters specified in paragraphs (1) through (4) of subsection (b).

"(III) For discharges occurring on or after October 1, 1997, and on or before September 30, 1998, by 20 percent.

"(IV) For discharges occurring on or after October 1, 1998, and on or before September 30, 1999, by 20 percent.

"(V) For discharges occurring on or after October 1, 1999, and on or before September 30, 2000, by 25 percent.

"(VI) For discharges occurring on or after October 1, 2000, and on or before September 30, 2001, by 30 percent.

"(VII) For discharges occurring on or after October 1, 2001, by 30 percent."

SEC. 15503. PAYMENTS FOR CAPITAL-RELATED COSTS FOR INPATIENT HOSPITAL SERVICES.

(a) REDUCTION IN PAYMENTS FOR PPS HOSPITALS.—

(1) CONTINUATION OF CURRENT REDUCTIONS.—Section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)) is amended in the second sentence—

(A) by striking "through 1995" and inserting "through 2002"; and

(B) by inserting after "reduction" the following: "(or a 15 percent reduction in the case of payments during fiscal years 1996 through 2002)".

(2) REDUCTION IN BASE PAYMENT RATES.—Section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)) is amended by adding at the end the following new sentence: "In addition to the reduction described in the preceding sentence, for discharges occurring after September 30, 1995, the Secretary shall reduce by 7.47 percent the unadjusted standard Federal capital payment rate (as described in 42 CFR 412.308(c), as in effect on the date of the enactment of the Medicare Preservation Act of 1995) and shall reduce by 8.27 percent the unadjusted hospital-specific rate (as described in 42 CFR 412.328(e)(1), as in effect on such date of enactment)."

(b) REDUCTION IN PAYMENTS FOR PPS-EXEMPT HOSPITALS.—Section 1886(g) (42 U.S.C. 1395ww(g)) is amended by adding at the end the following new paragraph:

"(4)(A) Except as provided in subparagraph (B), in determining the amount of the payments that may be made under this title with respect to all the capital-related costs of inpatient hospital services furnished during fiscal years 1996 through 2002 of a hospital which is not a subsection (d) hospital or a subsection (d) Puerto Rico hospital, the Secretary shall reduce the amounts of such payments otherwise determined under this title by 15 percent.

"(B) Subparagraph (A) shall not apply to payments with respect to the capital-related costs of any hospital that is a sole community hospital (as defined in subsection (d)(5)(D)(iii)) or a rural primary care hospital (as defined in section 1861(mm)(1))."

(c) HOSPITAL-SPECIFIC ADJUSTMENT FOR CAPITAL-RELATED TAX COSTS.—Section 1886(g)(1) (42 U.S.C. 1395ww(g)(1)) is amended—

(1) by redesignating subparagraph (C) as subparagraph (D), and

(2) by inserting after subparagraph (B) the following:

"(C)(i) For discharges occurring after September 30, 1995, such system shall provide for an adjustment in an amount equal to the amount determined under clause (iv) for capital-related tax costs for each hospital that is eligible for such adjustment.

"(ii) Subject to clause (iii), a hospital is eligible for an adjustment under this subparagraph, with respect to discharges occurring in a fiscal year, if the hospital—

"(I) is a hospital that may otherwise receive payments under this subsection,

"(II) is not a public hospital, and

"(III) incurs capital-related tax costs for the fiscal year.

"(iii)(I) In the case of a hospital that first incurs capital-related tax costs in a fiscal year after fiscal year 1992

because of a change from nonproprietary to proprietary status or because the hospital commenced operation after such fiscal year, the first fiscal year for which the hospital shall be eligible for such adjustment is the second full fiscal year following the fiscal year in which the hospital first incurs such costs.

"(II) In the case of a hospital that first incurs capital-related tax costs in a fiscal year after fiscal year 1992 because of a change in State or local tax laws, the first fiscal year for which the hospital shall be eligible for such adjustment is the fourth full fiscal year following the fiscal year in which the hospital first incurs such costs.

"(iv) The per discharge adjustment under this clause shall be equal to the hospital-specific capital-related tax costs per discharge of a hospital for fiscal year 1992 (or, in the case of a hospital that first incurs capital-related tax costs for a fiscal year after fiscal year 1992, for the first full fiscal year for which such costs are incurred), updated to the fiscal year to which the adjustment applies. Such per discharge adjustment shall be added to the Federal capital rate, after such rate has been adjusted as described in 42 CFR 412.312 (as in effect on the date of the enactment of the Medicare Preservation Act of 1995), and before such rate is multiplied by the applicable Federal rate percentage.

"(v) For purposes of this subparagraph, capital-related tax costs include—

"(I) the costs of taxes on land and depreciable assets owned by a hospital (or related organization) and used for patient care,

"(II) payments in lieu of such taxes (made by hospitals that are exempt from taxation), and

"(III) the costs of taxes paid by a hospital (or related organization) as lessee of land, buildings, or fixed equipment from a lessor that is unrelated to the hospital (or related organization) under the terms of a lease that requires the lessee to pay all expenses (including mortgage, interest, and amortization) and leaves the lessor with an amount free of all claims (sometimes referred to as a 'net net net' or 'triple net' lease).

In determining the adjustment required under clause (i), the Secretary shall not take into account any capital-related tax costs of a hospital to the extent that such costs are based on tax rates and assessments that exceed those for similar commercial properties.

"(vi) The system shall provide that the Federal capital rate for any fiscal year after September 30, 1995, shall be reduced by a percentage sufficient to ensure that the adjustments required to be paid under clause (i) for a fiscal year neither increase nor decrease the total amount that would have been paid under this system but for the payment of such adjustments for such fiscal year."

(d) REVISION OF EXCEPTIONS PROCESS UNDER PROSPECTIVE PAYMENT SYSTEM FOR CERTAIN PROJECTS.—

(1) IN GENERAL.—Section 1886(g)(1) (42 U.S.C. 1395ww(g)(1)), as amended by subsection (c), is amended—

(1) by redesignating subparagraph (D) as subparagraph (E), and

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

"(D) The exceptions under the system provided by the Secretary under subparagraph (B)(iii) shall include the provision of exception payments under the special exceptions process provided under 42 CFR 412.348(g) (as in effect on September 1, 1995), except that the Secretary shall revise such process as follows:

"(i) A hospital with at least 100 beds which is located in an urban area shall be eligible under such process without regard to its disproportionate patient percentage under subsection (d)(5)(F) or whether it qualifies for additional payment amounts under such subsection.

"(ii) The minimum payment level for qualifying hospitals shall be 85 percent.

"(iii) A hospital shall be considered to meet the requirement that it completes the project involved no later than the end of the hospital's last cost reporting period beginning after October 1, 2001, if—

"(I) the hospital has obtained a certificate of need for the project approved by the State or a local planning authority, and

"(II) by September 1, 1995, the hospital has expended on the project at least \$750,000 or 10 percent of the estimated cost of the project.

"(iv) The amount of the exception payment made shall not be reduced by any offsetting amounts."

(2) CONFORMING AMENDMENT.—Section 1886(g)(1)(B) (42 U.S.C. 1395ww(g)(1)(B)) is amended by striking "may provide" and inserting "shall provide (in accordance with subparagraph (D))".

SEC. 16604. REDUCTION IN ADJUSTMENT FOR INDIRECT MEDICAL EDUCATION.

For provisions modifying medicare payment policies regarding graduate medical education, see part 2 of subtitle E.

SEC. 16606. TREATMENT OF PPS-EXEMPT HOSPITALS.

(a) UPDATES.—Section 1886(b)(3)(B)(ii)(V) (42 U.S.C. 1395ww(b)(3)(B)(ii)(V)) is amended by striking "through 1997" and inserting "through 2002".

(b) REBASING FOR CERTAIN LONG-TERM CARE HOSPITALS.—

(1) IN GENERAL.—Section 1886(b)(3) (42 U.S.C. 1395ww(b)(3)) is amended—

(A) in subparagraph (A), by striking "and (E)" and inserting "(E), and (F)";

(B) in subparagraph (B)(ii), by striking "(A) and (E)" and inserting "(A), (E), and (F)"; and

(C) by adding at the end the following new subparagraph:

"(F)(i) In the case of a qualified long-term care hospital (as defined in clause (ii)), the term 'target amount' means—

"(I) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital, the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital for the 12-month cost reporting period beginning during fiscal year 1991; or

"(II) with respect to a later cost reporting period, the target amount for the preceding cost reporting period, increase by the applicable percentage increase under subparagraph (B)(ii) for that later cost reporting period.

"(ii) In clause (i), a 'qualified long-term care hospital' means, with respect to a cost reporting period, a hospital described in clause (iv) of subsection (d)(1)(B) during fiscal year 1995 for which the hospital's allowable operating costs of inpatient hospital services recognized under this title for each of the two most recent previous 12-month cost reporting periods exceeded the hospital's target amount determined under this paragraph for such cost reporting periods, if the hospital—

"(I) has a disproportionate patient percentage during such cost reporting period (as determined by the Secretary under subsection (d)(5)(F)(vi) as if the hospital were a subsection (d) hospital) of at least 25 percent, or

"(II) is located in a State for which no payment is made under the State plan under title XIX for days of inpatient hos-

pital services furnished to any individual in excess of the limit on the number of days of such services furnished to the individual for which payment may be made under this title."

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1) shall apply to discharges occurring during cost reporting periods beginning on or after October 1, 1995.

(c) TREATMENT OF CERTAIN UNITS LOCATED WITHIN OTHER HOSPITALS.—

(1) **IN GENERAL.**—Section 1886(d)(1)(B) (42 U.S.C. 1395ww(d)(1)(B)) is amended in the matter following clause (v) by striking the period and inserting the following: ", or a long-term care unit of the hospital if such unit was not treated as a subsection (d) hospital with respect to discharges occurring on or before September 30, 1995."

(2) **STUDY BY REVIEW COMMISSION.**—Not later than 12 months after the date a majority of the members of the Medicare Payment Review Commission are first appointed, the Commission shall submit a report to Congress containing recommendations for appropriate revisions in the treatment of distinct units of hospitals for purposes of section 1886 of the Social Security Act.

SEC. 15506. REDUCTION IN PAYMENTS TO HOSPITALS FOR ENROLLEES' BAD DEBTS.

(a) **IN GENERAL.**—Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)) is amended by adding at the end the following new subparagraph:

"(T) In determining such reasonable costs for hospitals, the amount of bad debts otherwise treated as allowable costs which are attributable to the deductibles and coinsurance amounts under this title shall be reduced by—

"(i) 75 percent for cost reporting periods beginning during fiscal year 1996,

"(ii) 60 percent for cost reporting periods beginning during fiscal year 1997, and

"(iii) 50 percent for subsequent cost reporting periods."

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to hospital cost reporting periods beginning on or after October 1, 1995.

SEC. 15507. PERMANENT EXTENSION OF HEMOPHILIA PASS-THROUGH.

Effective as if included in the enactment of OBRA-1989, section 6011(d) of such Act (as amended by section 13505 of OBRA-1993) is amended by striking "and shall expire September 30, 1994".

SEC. 15508. CONFORMING AMENDMENT TO CERTIFICATION OF CHRISTIAN SCIENCE PROVIDERS.

(a) **HOSPITALS.**—Section 1861(e) (42 U.S.C. 1395x(e)) is amended in the sixth sentence by inserting after "Massachusetts," the following: "or by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.,".

(b) **SKILLED NURSING FACILITIES.**—Section 1861(y)(1) is amended by inserting after "Massachusetts," the following: "or by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.,".

Subpart B—Provisions Relating to Rural Hospitals

SEC. 15511. SOLE COMMUNITY HOSPITALS.

(a) **UPDATE.**—Section 1886(b)(3)(B)(iv) (42 U.S.C. 1395ww(b)(3)(B)(iv)) is amended—

(A) in subclause (III), by striking "and" at the end; and

(B) by striking subclause (IV) and inserting the following:

"(IV) for each of the fiscal years 1996 through 2000, the market basket percentage increase minus 1 percentage points, and

"(V) for fiscal year 2001 and each subsequent fiscal year, the applicable percentage increase under clause (i)."

(b) **STUDY OF IMPACT OF SOLE COMMUNITY HOSPITAL DESIGNATIONS.—**

(1) **STUDY.**—The Medicare Payment Review Commission shall conduct a study of the impact of the designation of hospitals as sole community hospitals under the medicare program on the delivery of health care services to individuals in rural areas, and shall include in the study an analysis of the characteristics of the hospitals designated as such sole community hospitals under the program.

(2) **REPORT.**—Not later than 12 months after the date a majority of the members of the Commission are first appointed, the Commission shall submit to Congress a report on the study conducted under paragraph (1).

SEC. 15512. CLARIFICATION OF TREATMENT OF EAC AND RPC HOSPITALS.

Paragraphs (1)(A) and (2)(A) of section 1820(i) (42 U.S.C. 1395i-4(i)) are each amended by striking the semicolon at the end and inserting the following: ", or in a State which the Secretary finds would receive a grant under such subsection during a fiscal year if funds were appropriated for grants under such subsection for the fiscal year,".

SEC. 15513. RURAL EMERGENCY ACCESS CARE HOSPITALS.

(a) **ESTABLISHMENT OF PROGRAM.**—

(1) **IN GENERAL.**—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

"Rural Emergency Access Care Hospital; Rural Emergency Access Care Hospital Services

"(oo)(1) The term 'rural emergency access care hospital' means, for a fiscal year, a facility with respect to which the Secretary finds the following:

"(A) The facility is located in a rural area (as defined in section 1886(d)(2)(D)).

"(B) The facility was a hospital under this title at any time during the 5-year period that ends on the date of the enactment of this subsection.

"(C) The facility is in danger of closing due to low inpatient utilization rates and negative operating losses, and the closure of the facility would limit the access of individuals residing in the facility's service area to emergency services.

"(D) The facility has entered into (or plans to enter into) an agreement with a hospital with a participation agreement in effect under section 1866(a), and under such agreement the hospital shall accept patients transferred to the hospital from the facility and receive data from and transmit data to the facility.

"(E) There is a practitioner who is qualified to provide advanced cardiac life support services (as determined by the State in which the facility is located) on-site at the facility on a 24-hour basis.

"(F) A physician is available on-call to provide emergency medical services on a 24-hour basis.

"(G) The facility is a member of a community rural health network under section 104 of the Rural Health Development Act.

"(H) The facility meets such staffing requirements as would apply under section 1861(e) to a hospital located in a rural area, except that—

"(i) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open, except insofar as the facility is required to provide emergency care on a 24-hour basis under subparagraphs (E) and (F); and

"(ii) the facility may provide any services otherwise required to be provided by a full-time, on-site dietician, pharmacist, laboratory technician, medical technologist, or radiological technologist on a part-time, off-site basis.

"(I) The facility meets the requirements applicable to clinics and facilities under subparagraphs (C) through (J) of paragraph (2) of section 1861(aa) and of clauses (ii) and (iv) of the second sentence of such paragraph (or, in the case of the requirements of subparagraph (E), (F), or (J) of such paragraph, would meet the requirements if any reference in such subparagraph to a 'nurse practitioner' or to 'nurse practitioners' was deemed to be a reference to a 'nurse practitioner or nurse' or to 'nurse practitioners or nurses'); except that in determining whether a facility meets the requirements of this subparagraph, subparagraphs (E) and (F) of that paragraph shall be applied as if any reference to a 'physician' is a reference to a physician as defined in section 1861(r)(1).

"(2) The term 'rural emergency access care hospital services' means the following services provided by a rural emergency access care hospital:

"(A) An appropriate medical screening examination (as described in section 1867(a)).

"(B) Necessary stabilizing examination and treatment services for an emergency medical condition and labor (as described in section 1867(b)).

"(3) The term 'inpatient rural emergency access care hospital services' means services described in paragraph (2), furnished to an individual over a continuous period not to exceed 24 hours (except that such services may be furnished over a longer period in the case of an individual who is unable to leave the hospital because of inclement weather) that would be inpatient hospital services if furnished to an inpatient of a hospital by a hospital."

(2) **REQUIRING RURAL EMERGENCY ACCESS CARE HOSPITALS TO MEET HOSPITAL ANTI-DUMPING REQUIREMENTS.**—Section 1867(e)(5) (42 U.S.C. 1395dd(e)(5)) is amended by striking "1861(mm)(1)" and inserting "1861(mm)(1) and a rural emergency access care hospital (as defined in section 1861(oo)(1))".

(b) **COVERAGE OF AND PAYMENT FOR SERVICES UNDER PART A.**—

(1) **COVERAGE.**—Section 1812(a)(1) (42 U.S.C. 1395d(a)(1)) is amended by striking "or inpatient rural primary care hospital services" and inserting "inpatient rural primary care hospital services, or inpatient rural emergency access care hospital services".

(2) **APPLICATION OF DEDUCTIBLE AND COINSURANCE.**—(A) Sections 1813(a) and 1813(b)(3)(A) (42 U.S.C. 1395e(a), 1395e(b)(3)(A)) are each amended by striking "services or inpatient rural primary care hospital services" each place it appears and inserting "services, inpatient rural primary care hospital services, or inpatient rural emergency access care hospital services".

(B) Section 1813(b)(3)(B) (42 U.S.C. 1395e(b)(3)(B)) is amended by inserting ", inpatient rural emergency access care hospital services," after "inpatient rural primary care hospital services".

(3) **PAYMENT BASED ON REASONABLE COSTS.**—Section 1814 (42 U.S.C. 1395f) is amended by adding at the end the following new subsection:

"Payment for Inpatient Rural Emergency Access Care Hospital Services

"(m) The amount of payment under this part for inpatient rural primary care hospital services shall be equal to the reasonable cost of such services (as determined under section 1861(v)), less the amount the hospital may charge as described in clause (ii)

of section 1866(a)(2)(A), but in no case may the payment for such services exceed 80 percent of such reasonable cost."

(4) APPLICATION OF SPELL OF ILLNESS.—Section 1861(a) (42 U.S.C. 1395x(a)) is amended—

(A) in paragraph (1), by inserting ", inpatient rural emergency access care hospital services," after "inpatient rural primary care hospital services"; and

(B) in paragraph (2), by striking "hospital or rural primary care hospital" and inserting "hospital, rural primary care hospital, or rural emergency access care hospital".

(c) REFERENCE TO PAYMENT PROVISIONS UNDER PART B.—For provisions relating to payment for inpatient rural emergency access care hospital services under part B, see section 15607.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to fiscal years beginning on or after October 1, 1995.

SEC. 15514. CLASSIFICATION OF RURAL REFERRAL CENTERS.

(a) PROHIBITING DENIAL OF REQUEST FOR RECLASSIFICATION ON BASIS OF COMPARABILITY OF WAGES.—

(1) IN GENERAL.—Section 1886(d)(10)(D) (42 U.S.C. 1395ww(d)(10)(D)) is amended—

(A) by redesignating clause (iii) as clause (iv); and

(B) by inserting after clause (ii) the following new clause:

"(iii) Under the guidelines published by the Secretary under clause (i), in the case of a hospital which is classified by the Secretary as a rural referral center under paragraph (5)(C), the Board may not reject the application of the hospital under this paragraph on the basis of any comparison between the average hourly wage of the hospital and the average hourly wage of hospitals in the area in which it is located."

(2) EFFECTIVE DATE.—Notwithstanding section 1886(d)(10)(C)(ii) of the Social Security Act, a hospital may submit an application to the Medicare Geographic Classification Review Board during the 30-day period beginning on the date of the enactment of this Act requesting a change in its classification for purposes of determining the area wage index applicable to the hospital under section 1886(d)(3)(D) of such Act for fiscal year 1997, if the hospital would be eligible for such a change in its classification under the standards described in section 1886(d)(10)(D) (as amended by paragraph (1)) but for its failure to meet the deadline for applications under section 1886(d)(10)(C)(ii).

(b) CONTINUING TREATMENT OF PREVIOUSLY DESIGNATED CENTERS.—Any hospital classified as a rural referral center by the Secretary of Health and Human Services under section 1886(d)(5)(C) of the Social Security Act for fiscal year 1994 shall be classified as such a rural referral center for fiscal year 1996 and each subsequent fiscal year.

SEC. 15515. FLOOR ON AREA WAGE INDEX.

(a) IN GENERAL.—For purposes of section 1886(d)(3)(E) of the Social Security Act for discharges occurring on or after October 1, 1995, the area wage index applicable under such section to any hospital which is not located in a rural area (as defined in section 1886(d)(2)(D) of such Act) may not be less than the average of the area wage indices applicable under such section to hospitals located in rural areas in the State in which the hospital is located.

(b) BUDGET-NEUTRALITY IN IMPLEMENTATION.—The Secretary of Health and Human Services shall make any adjustments required under subsection (a) in a manner which assures that the aggregate payments made under section 1886(d) of the Social Security Act in a fiscal year for the operating costs of inpatient hospital services are not greater or less than those which would have been made in the year without such adjustments.

PART 2—PAYMENTS TO SKILLED NURSING FACILITIES

SEC. 16621. PAYMENTS FOR ROUTINE SERVICE COSTS.

(a) **CLARIFICATION OF DEFINITION OF ROUTINE SERVICE COSTS.**—Section 1888 (42 U.S.C. 1395yy) is amended by adding at the end the following new subsection:

“(e) For purposes of this section, the ‘routine service costs’ of a skilled nursing facility are all costs which are attributable to nursing services, room and board, administrative costs, other overhead costs, and all other ancillary services (including supplies and equipment), excluding costs attributable to covered non-routine services subject to payment limits under section 1888A.”.

(b) **CONFORMING AMENDMENT.**—Section 1888 (42 U.S.C. 1395yy) is amended in the heading by inserting “AND CERTAIN ANCILLARY” after “SERVICE”.

SEC. 16622. INCENTIVES FOR COST EFFECTIVE MANAGEMENT OF COVERED NON-ROUTINE SERVICES.

(a) **IN GENERAL.**—Title XVIII is amended by inserting after section 1888 the following new section:

“INCENTIVES FOR COST-EFFECTIVE MANAGEMENT OF COVERED NON-ROUTINE SERVICES OF SKILLED NURSING FACILITIES

“SEC. 1888A. (a) **DEFINITIONS.**—For purposes of this section:

“(1) **COVERED NON-ROUTINE SERVICES.**—The term ‘covered non-routine services’ means post-hospital extended care services consisting of any of the following:

“(A) Physical or occupational therapy or speech-language pathology services, or respiratory therapy.

“(B) Prescription drugs.

“(C) Complex medical equipment.

“(D) Intravenous therapy and solutions (including enteral and parenteral nutrients, supplies, and equipment).

“(E) Radiation therapy.

“(F) Diagnostic services, including laboratory, radiology (including computerized tomography services and imaging services), and pulmonary services.

“(2) **SNF MARKET BASKET PERCENTAGE INCREASE.**—The term ‘SNF market basket percentage increase’ for a fiscal year means a percentage equal to the percentage increase in routine service cost limits for the year under section 1888(a).

“(3) **STAY.**—The term ‘stay’ means, with respect to an individual who is a resident of a skilled nursing facility, a period of continuous days during which the facility provides extended care services for which payment may be made under this title to the individual during the individual’s spell of illness.

“(b) **NEW PAYMENT METHOD FOR COVERED NON-ROUTINE SERVICES.**—

“(1) **IN GENERAL.**—Subject to subsection (c), a skilled nursing facility shall receive interim payments under this title for covered non-routine services furnished to an individual during a cost reporting period beginning during a fiscal year (after fiscal year 1996) in an amount equal to the reasonable cost of providing such services in accordance with section 1861(v). The Secretary may adjust such payments if the Secretary determines (on the basis of such estimated information as the Secretary considers appropriate) that payments to the facility under this paragraph for a cost reporting period would substantially exceed the cost reporting period limit determined under subsection (c)(1)(B).

“(2) **RESPONSIBILITY OF SKILLED NURSING FACILITY TO MANAGE BILLINGS.**—

“(A) **CLARIFICATION RELATING TO PART A BILLING.**—In the case of a covered non-routine service furnished to an individual who (at the time the service is furnished) is a

resident of a skilled nursing facility who is entitled to coverage under section 1812(a)(2) for such service, the skilled nursing facility shall submit a claim for payment under this title for such service under part A (without regard to whether or not the item or service was furnished by the facility, by others under arrangement with them made by the facility, under any other contracting or consulting arrangement, or otherwise).

"(B) PART B BILLING.—In the case of a covered non-routine service furnished to an individual who (at the time the service is furnished) is a resident of a skilled nursing facility who is not entitled to coverage under section 1812(a)(2) for such service but is entitled to coverage under part B for such service, the skilled nursing facility shall submit a claim for payment under this title for such service under part B (without regard to whether or not the item or service was furnished by the facility, by others under arrangement with them made by the facility, under any other contracting or consulting arrangement, or otherwise).

"(C) MAINTAINING RECORDS ON SERVICES FURNISHED TO RESIDENTS.—Each skilled nursing facility receiving payments for extended care services under this title shall document on the facility's cost report all covered non-routine services furnished to all residents of the facility to whom the facility provided extended care services for which payment was made under part A during a fiscal year (beginning with fiscal year 1996) (without regard to whether or not the services were furnished by the facility, by others under arrangement with them made by the facility, under any other contracting or consulting arrangement, or otherwise).

"(c) RECONCILIATION OF AMOUNTS.—

"(1) LIMIT BASED ON PER STAY LIMIT AND NUMBER OF STAYS.—

"(A) IN GENERAL.—If a skilled nursing facility has received aggregate payments under subsection (b) for covered non-routine services during a cost reporting period beginning during a fiscal year in excess of an amount equal to the cost reporting period limit determined under subparagraph (B), the Secretary shall reduce the payments made to the facility with respect to such services for cost reporting periods beginning during the following fiscal year in an amount equal to such excess. The Secretary shall reduce payments under this subparagraph at such times and in such manner during a fiscal year as the Secretary finds necessary to meet the requirement of this subparagraph.

"(B) COST REPORTING PERIOD LIMIT.—The cost reporting period limit determined under this subparagraph is an amount equal to the product of—

"(i) the per stay limit applicable to the facility under subsection (d) for the period; and

"(ii) the number of stays beginning during the period for which payment was made to the facility for such services.

"(C) PROSPECTIVE REDUCTION IN PAYMENTS.—In addition to the process for reducing payments described in subparagraph (A), the Secretary may reduce payments made to a facility under this section during a cost reporting period if the Secretary determines (on the basis of such estimated information as the Secretary considers appropriate) that payments to the facility under this section for the period will substantially exceed the cost reporting period limit for the period determined under this paragraph.

"(2) INCENTIVE PAYMENTS.—

"(A) IN GENERAL.—If a skilled nursing facility has received aggregate payments under subsection (b) for covered non-routine services during a cost reporting period beginning during a fiscal year in an amount that is less than the amount determined under paragraph (1)(B), the Secretary shall pay the skilled nursing facility in the following fiscal year an incentive payment equal to 50 percent of the difference between such amounts, except that the incentive payment may not exceed 5 percent of the aggregate payments made to the facility under subsection (b) for the previous fiscal year (without regard to subparagraph (B)).

"(B) INSTALLMENT INCENTIVE PAYMENTS.—The Secretary may make installment payments during a fiscal year to a skilled nursing facility based on the estimated incentive payment that the facility would be eligible to receive with respect to such fiscal year.

"(d) DETERMINATION OF FACILITY PER STAY LIMIT.—

"(1) LIMIT FOR FISCAL YEAR 1997.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the Secretary shall establish separate per stay limits for hospital-based and freestanding skilled nursing facilities for the 12-month cost reporting period beginning during fiscal year 1997 that are equal to the sum of—

"(i) 50 percent of the facility-specific stay amount for the facility (as determined under subsection (e)) for the last 12-month cost reporting period ending on or before September 30, 1994, increased (in a compounded manner) by the SNF market basket percentage increase for fiscal years 1995 through 1997; and

"(ii) 50 percent of the average of all facility-specific stay amounts for all hospital-based facilities or all freestanding facilities (whichever is applicable) during the cost reporting period described in clause (i), increased (in a compounded manner) by the SNF market basket percentage increase for fiscal years 1995 through 1997.

"(B) FACILITIES NOT HAVING 1994 COST REPORTING PERIOD.—In the case of a skilled nursing facility for which payments were not made under this title for covered non-routine services for the last 12-month cost reporting period ending on or before September 30, 1994, the per stay limit for the 12-month cost reporting period beginning during fiscal year 1997 shall be twice the amount determined under subparagraph (A)(ii).

"(2) LIMIT FOR SUBSEQUENT FISCAL YEARS.—The per stay limit for a skilled nursing facility for a 12-month cost reporting period beginning during a fiscal year after fiscal year 1997 is equal to the per stay limit established under this subsection for the 12-month cost reporting period beginning during the previous fiscal year, increased by the SNF market basket percentage increase for such subsequent fiscal year minus 2 percentage points.

"(3) REBASING OF AMOUNTS.—

"(A) IN GENERAL.—The Secretary shall provide for an update to the facility-specific amounts used to determine the per stay limits under this subsection for cost reporting periods beginning on or after October 1, 1999, and every 2 years thereafter.

"(B) TREATMENT OF FACILITIES NOT HAVING REBASED COST REPORTING PERIODS.—Paragraph (1)(B) shall apply with respect to a skilled nursing facility for which payments were not made under this title for covered non-routine services for the 12-month cost reporting period used by the Secretary to update facility-specific amounts under subparagraph (A) in the same manner as such paragraph

applies with respect to a facility for which payments were not made under this title for covered non-routine services for the last 12-month cost reporting period ending on or before September 30, 1994.

"(e) DETERMINATION OF FACILITY-SPECIFIC STAY AMOUNTS.—The 'facility-specific stay amount' for a skilled nursing facility for a cost reporting period is the sum of—

"(1) the average amount of payments made to the facility under part A during the period which are attributable to covered non-routine services furnished during a stay (as determined on a per diem basis); and

"(2) the Secretary's best estimate of the average amount of payments made under part B during the period for covered non-routine services furnished to all residents of the facility to whom the facility provided extended care services for which payment was made under part A during the period (without regard to whether or not the services were furnished by the facility, by others under arrangement with them made by the facility, under any other contracting or consulting arrangement, or otherwise), as estimated by the Secretary.

"(f) INTENSIVE NURSING OR THERAPY NEEDS.—

"(1) IN GENERAL.—In applying subsection (b) to covered non-routine services furnished during a stay beginning during a cost reporting period beginning during a fiscal year (beginning with fiscal years after fiscal year 1997) to a resident of a skilled nursing facility who requires intensive nursing or therapy services, the per stay limit for such resident shall be the per stay limit developed under paragraph (2) instead of the per stay limit determined under subsection (d)(1)(A).

"(2) PER STAY LIMIT FOR INTENSIVE NEED RESIDENTS.—Not later than June 30, 1997, the Secretary, after consultation with the Medicare Payment Review Commission and skilled nursing facility experts, shall develop and publish a per stay limit for residents of a skilled nursing facility who require intensive nursing or therapy services.

"(3) BUDGET NEUTRALITY.—The Secretary shall adjust payments under subsection (b) in a manner that ensures that total payments for covered non-routine services under this section are not greater or less than total payments for such services would have been but for the application of paragraph (1).

"(g) SPECIAL TREATMENT FOR SMALL SKILLED NURSING FACILITIES.—This section shall not apply with respect to a skilled nursing facility for which payment is made for routine service costs during a cost reporting period on the basis of prospective payments under section 1888(d).

"(h) EXCEPTIONS AND ADJUSTMENTS TO LIMITS.—

"(1) IN GENERAL.—The Secretary may make exceptions and adjustments to the cost reporting limits applicable to a skilled nursing facility under subsection (c)(1)(B) for a cost reporting period, except that the total amount of any additional payments made under this section for covered non-routine services during the cost reporting period as a result of such exceptions and adjustments may not exceed 5 percent of the aggregate payments made to all skilled nursing facilities for covered non-routine services during the cost reporting period (determined without regard to this paragraph).

"(2) BUDGET NEUTRALITY.—The Secretary shall adjust payments under subsection (b) in a manner that ensures that total payments for covered non-routine services under this section are not greater or less than total payments for such services would have been but for the application of paragraph (1).

"(i) SPECIAL RULE FOR X-RAY SERVICES.—Before furnishing a covered non-routine service consisting of an X-ray service for which payment may be made under part A or part B to a resident, a skilled nursing facility shall consider whether furnishing the service through a provider of portable X-ray service services would be

appropriate, taking into account the cost effectiveness of the service and the convenience to the resident."

(b) CONFORMING AMENDMENT.—Section 1814(b) (42 U.S.C. 1395ff(b)) is amended in the matter preceding paragraph (1) by striking "1813 and 1886" and inserting "1813, 1886, 1888, and 1888A".

SEC. 15523. PAYMENTS FOR ROUTINE SERVICE COSTS.

(a) MAINTAINING SAVINGS RESULTING FROM TEMPORARY FREEZE ON PAYMENT INCREASES.—

(1) BASING UPDATES TO PER DIEM COST LIMITS ON LIMITS FOR FISCAL YEAR 1993.—

(A) IN GENERAL.—The last sentence of section 1888(a) (42 U.S.C. 1395yy(a)) is amended by adding at the end the following: "(except that such updates may not take into account any changes in the routine service costs of skilled nursing facilities occurring during cost reporting periods which began during fiscal year 1994 or fiscal year 1995)."

(B) NO EXCEPTIONS PERMITTED BASED ON AMENDMENT.—The Secretary of Health and Human Services shall not consider the amendment made by subparagraph (A) in making any adjustments pursuant to section 1888(c) of the Social Security Act.

(2) PAYMENTS DETERMINED ON PROSPECTIVE BASIS.—Any change made by the Secretary of Health and Human Services in the amount of any prospective payment paid to a skilled nursing facility under section 1888(d) of the Social Security Act for cost reporting periods beginning on or after October 1, 1995, may not take into account any changes in the costs of services occurring during cost reporting periods which began during fiscal year 1994 or fiscal year 1995.

(b) ESTABLISHMENT OF SCHEDULE FOR MAKING ADJUSTMENTS TO LIMITS.—Section 1888(c) (42 U.S.C. 1395yy(c)) is amended by striking the period at the end of the second sentence and inserting ", and may only make adjustments under this subsection with respect to a facility which applies for an adjustment during an annual application period established by the Secretary."

(c) LIMITATION ON AGGREGATE INCREASE IN PAYMENTS RESULTING FROM ADJUSTMENTS TO LIMITS.—Section 1888(c) (42 U.S.C. 1395yy(c)) is amended—

(1) by striking "(c) The Secretary" and inserting "(c)(1) Subject to paragraph (2), the Secretary"; and

(2) by adding at the end the following new paragraph:

"(2) The Secretary may not make any adjustments under this subsection in the limits set forth in subsection (a) for a cost reporting period beginning during a fiscal year to the extent that the total amount of the additional payments made under this title as a result of such adjustments is greater than an amount equal to—

"(A) for cost reporting periods beginning during fiscal year 1997, the total amount of the additional payments made under this title as a result of adjustments under this subsection for cost reporting periods beginning during fiscal year 1996 increased by the SNF market basket percentage increase (as defined in section 1888A(e)(3)) for fiscal year 1997; and

"(B) for cost reporting periods beginning during a subsequent fiscal year, the amount determined under this paragraph for the previous fiscal year increased by the SNF market basket percentage increase for such subsequent fiscal year."

(d) IMPOSITION OF LIMITS FOR ALL COST REPORTING PERIODS.—Section 1888(a) (42 U.S.C. 1395yy(a)) is amended in the matter preceding paragraph (1) by inserting after "extended care services" the following: "(for any cost reporting period for which payment is made under this title to the skilled nursing facility for such services)".

SEC. 15524. REDUCTIONS IN PAYMENT FOR CAPITAL-RELATED COSTS.

Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)), as amended by section 15506, is amended by adding at the end the following new subparagraph:

"(U) Such regulations shall provide that, in determining the amount of the payments that may be made under this title with respect to all the capital-related costs of skilled nursing facilities, the Secretary shall reduce the amounts of such payments otherwise established under this title by 15 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1996 through 2002."

SEC. 15525. TREATMENT OF ITEMS AND SERVICES PAID FOR UNDER PART B.

(a) **REQUIRING PAYMENT FOR ALL ITEMS AND SERVICES TO BE MADE TO FACILITY.**—

(1) **IN GENERAL.**—The first sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended—

(A) by striking "and (D)" and inserting "(D)"; and

(B) by striking the period at the end and inserting the following: ", and (E) in the case of an item or service furnished to an individual who (at the time the item or service is furnished) is a resident of a skilled nursing facility, payment shall be made to the facility (without regard to whether or not the item or service was furnished by the facility, by others under arrangement with them made by the facility, or otherwise)."

(2) **EXCLUSION FOR ITEMS AND SERVICES NOT BILLED BY FACILITY.**—Section 1862(a) (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 new paragraph:

"(16) where such expenses are for covered non-routine services (as defined in section 1888A(a)(1)) furnished to an individual who is a resident of a skilled nursing facility and for which the claim for payment under this title is not submitted by the facility."

(3) **CONFORMING AMENDMENT.**—Section 1832(a)(1) (42 U.S.C. 1395k(a)(1)) is amended by striking "(2);" and inserting "(2) and section 1842(b)(6)(E);".

(b) **REDUCTION IN PAYMENTS FOR ITEMS AND SERVICES FURNISHED BY OR UNDER ARRANGEMENTS WITH FACILITIES.**—Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)), as amended by sections 15506 and 15524, is amended by adding at the end the following new subparagraph:

"(V) In the case of an item or service furnished by a skilled nursing facility (or by others under arrangement with them made by a skilled nursing facility) for which payment is made under part B in an amount determined in accordance with section 1833(a)(2)(B), the Secretary shall reduce the reasonable cost for such item or service otherwise determined under clause (i)(I) of such section by 5.8 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1996 through 2002."

SEC. 15526. CERTIFICATION OF FACILITIES MEETING REVISED NURSING HOME REFORM STANDARDS.

(a) **IN GENERAL.**—Section 1819(a)(3) (42 U.S.C. 1395i-3(a)(3)) is amended to read as follows:

"(3)(A) is certified by the Secretary as meeting the standards established under subsection (b), or (B) is a State-certified facility (as defined in subsection (c))."

(b) **REQUIREMENTS DESCRIBED.**—Section 1819 (42 U.S.C. 1395i-3) is amended by striking subsections (b) through (i) and inserting the following:

"(b) **STANDARDS FOR AND CERTIFICATION OF FACILITIES.**—

"(1) STANDARDS FOR FACILITIES.—

"(A) IN GENERAL.—The Secretary shall provide for the establishment and maintenance of standards consistent with the contents described in subparagraph (B) for skilled nursing facilities which furnish services for which payment may be made under this title.

"(B) CONTENTS OF STANDARDS.—The standards established for facilities under this paragraph shall contain provisions relating to the following items:

- "(i)** The treatment of resident medical records.
- "(ii)** Policies, procedures, and bylaws for operation.
- "(iii)** Quality assurance systems.
- "(iv)** Resident assessment procedures, including care planning and outcome evaluation.
- "(v)** The assurance of a safe and adequate physical plant for the facility.
- "(vi)** Qualifications for staff sufficient to provide adequate care.
- "(vii)** Utilization review.
- "(viii)** The protection and enforcement of resident rights described in subparagraph (C).

"(C) RESIDENT RIGHTS DESCRIBED.—The resident rights described in this subparagraph are the rights of residents to the following:

- "(i)** To exercise the individual's rights as a resident of the facility and as a citizen or resident of the United States.
- "(ii)** To receive notice of rights and services.
- "(iii)** To be protected against the misuse of resident funds.
- "(iv)** To be provided privacy and confidentiality.
- "(v)** To voice grievances.
- "(vi)** To examine the results of inspections under the certification program.
- "(vii)** To refuse to perform services for the facility.
- "(viii)** To be provided privacy in communications and to receive mail.
- "(ix)** To have the facility provide immediate access to any resident by any representative of the certification program, the resident's individual physician, the State long term care ombudsman, and any person the resident has designated as a visitor.
- "(x)** To retain and use personal property.
- "(xi)** To be free from abuse, including verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion.
- "(xii)** To be provided with prior written notice of a pending transfer or discharge.

"(D) REQUIRING NOTICE AND COMMENT.—The standards established for facilities under this paragraph may only take effect after the Secretary has provided the public with notice and an opportunity for comment.

"(2) CERTIFICATION PROGRAM.—

"(A) IN GENERAL.—The Secretary shall provide for the establishment and operation of a program consistent with the requirements of subparagraph (B) for the certification of skilled nursing facilities which meet the standards established under paragraph (1) and the decertification of facilities which fail to meet such standards.

"(B) REQUIREMENTS FOR PROGRAM.—In addition to any other requirements the Secretary may impose, in establishing and operating the certification program under subparagraph (A), the Secretary shall ensure the following:

- "(i)** The Secretary shall ensure public access (as defined by the Secretary) to the certification program's evaluations of participating facilities, including compli-

ance records and enforcement actions and other reports by the Secretary regarding the ownership, compliance histories, and services provided by certified facilities.

"(ii) Not less often than every 4 years, the Secretary shall audit its expenditures under the program, through an entity designated by the Secretary which is not affiliated with the program, as designated by the Secretary.

"(c) INTERMEDIATE SANCTION AUTHORITY.—

"(1) AUTHORITY.—In addition to any other authority, where the Secretary determines that a nursing facility which is certified for participation under this title plan no longer substantially meets the requirements for such a facility under this title and further determines that the facility's deficiencies—

"(A) immediately jeopardize the health and safety of its residents, the Secretary shall at least provide for the termination of the facility's certification for participation under this title, or

"(B) do not immediately jeopardize the health and safety of its residents, the Secretary may, in lieu of providing for terminating the facility's certification for participation under the plan, provide lesser sanctions including one that provides that no payment will be made under this title with respect to any individual admitted to such facility after a date specified by the Secretary.

"(2) NOTICE.—The Secretary shall not make such a decision with respect to a facility until the facility has had a reasonable opportunity, following the initial determination that it no longer substantially meets the requirements for such a facility under the plan, to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

"(3) EFFECTIVENESS.—The Secretary's decision to deny payment may be made effective only after such notice to the public and to the facility as may be provided for by the Secretary, and its effectiveness shall terminate (A) when the Secretary finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the requirements for such a facility under this title, or (B) in the case described in paragraph (1)(B), with the end of the eleventh month following the month such decision is made effective, whichever occurs first. If a facility to which clause (B) of the previous sentence applies still fails to substantially meet the provisions of the respective section on the date specified in such clause, the Secretary shall terminate such facility's certification for participation under this title effective with the first day of the first month following the month specified in such clause.

"(c) STATE-CERTIFIED FACILITY DEFINED.—In subsection (a), a 'State-certified facility' means a facility licensed or certified as a skilled nursing facility by the State in which it is located, or a facility which otherwise meets the requirements applicable to providers of nursing facility services under the State plan under title XIX or the MediGrant program under title XXI."

(c) CONFORMING AMENDMENTS.—(1) Section 1861(v)(1)(E) (42 U.S.C. 1395x(v)(1)(E)) is amended by striking the second sentence.

(2) Section 1864 (42 U.S.C. 1395aa) is amended by striking subsection (d).

(3) Section 1866(f)(1) (42 U.S.C. 1395cc(f)(1)) is amended by striking "1819(c)(2)(E)."

(4) Section 1883(f) (42 U.S.C. 1395tt(f)) is amended—

(A) in the second sentence, by striking "such a hospital" and inserting "a hospital which enters into an agreement with the Secretary under this section"; and

(B) by striking the first sentence.

(d) **EFFECTIVE DATE.**—The amendments made by this section shall apply with respect to cost reporting periods beginning on or after October 1, 1995.

SEC. 15527. MEDICAL REVIEW PROCESS.

In order to ensure that medicare beneficiaries are furnished appropriate extended care services, the Secretary of Health and Human Services shall establish and implement a thorough medical review process to examine the effects of the amendments made by this part on the quality of extended care services furnished to medicare beneficiaries. In developing such a medical review process, the Secretary shall place a particular emphasis on the quality of non-routine covered services for which payment is made under section 1888A of the Social Security Act.

SEC. 15528. REPORT BY MEDICARE PAYMENT REVIEW COMMISSION.

Not later than October 1, 1997, the Medicare Payment Review Commission shall submit to Congress a report on the system under which payment is made under the medicare program for extended care services furnished by skilled nursing facilities, and shall include in the report the following:

(1) An analysis of the effect of the methodology established under section 1888A of the Social Security Act (as added by section 15522) on the payments for, and the quality of, extended care services under the medicare program.

(2) An analysis of the advisability of determining the amount of payment for covered non-routine services of facilities (as described in such section) on the basis of the amounts paid for such services when furnished by suppliers under part B of the medicare program.

(3) An analysis of the desirability of maintaining separate limits for hospital-based and freestanding facilities in the costs of extended care services recognized as reasonable under the medicare program.

(4) An analysis of the quality of services furnished by skilled nursing facilities.

(5) An analysis of the adequacy of the process and standards used to provide exceptions to the limits described in paragraph (3).

SEC. 15529. EFFECTIVE DATE.

Except as otherwise provided in this subchapter, the amendments made by this subchapter shall apply to services furnished during cost reporting periods (or portions of cost reporting periods) beginning on or after October 1, 1996.

Subtitle G—Provisions Relating to Medicare Part B

PART 1—PAYMENT REFORMS

SEC. 15601. PAYMENTS FOR PHYSICIANS' SERVICES.

(a) **REPLACEMENT OF VOLUME PERFORMANCE STANDARD WITH SUSTAINABLE GROWTH RATE.**—Section 1848(f)(2) (42 U.S.C. 1395w-4(f)(2)) is amended to read as follows:

“(f) **SUSTAINABLE GROWTH RATE.**—

“(1) **SPECIFICATION OF GROWTH RATE.**—

“(A) **FISCAL YEAR 1996.**—The sustainable growth rate for all physicians' services for fiscal year 1996 shall be equal to the product of—

“(i) 1 plus the Secretary's estimate of the percentage change in the medicare economic index for 1996 (described in the fourth sentence of section 1842(b)(3)) (divided by 100),

“(ii) 1 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than pri-

vate plan enrollees) from fiscal year 1995 to fiscal year 1996,

"(iii) 1 plus the Secretary's estimate of the projected percentage growth in real gross domestic product per capita (divided by 100) from fiscal year 1995 to fiscal year 1996, plus 2 percentage points, and

"(iv) 1 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services in fiscal year 1996 (compared with fiscal year 1995) which will result from changes in law, determined without taking into account estimated changes in expenditures due to changes in the volume and intensity of physicians' services or changes in expenditures resulting from changes in the update to the conversion factor under subsection (d),

minus 1 and multiplied by 100.

"(B) SUBSEQUENT FISCAL YEARS.—The sustainable growth rate for all physicians' services for fiscal year 1997 and each subsequent fiscal year shall be equal to the sustainable growth rate determined under this paragraph for the previous fiscal year, increased by the product of—

"(i) 1 plus the Secretary's estimate of the percentage change in the medicare economic index for the fiscal year involved (described in the fourth sentence of section 1842(b)(3)) (divided by 100),

"(ii) 1 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than private plan enrollees) from the previous fiscal year to the fiscal year involved,

"(iii) 1 plus the Secretary's estimate of the projected percentage growth in real gross domestic product per capita (divided by 100) from the previous fiscal year to the fiscal year involved, plus 2 percentage points, and

"(iv) 1 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services in the fiscal year (compared with the previous fiscal year) which will result from changes in law, determined without taking into account estimated changes in expenditures due to changes in the volume and intensity of physicians' services or changes in expenditures resulting from changes in the update to the conversion factor under subsection (d)(3),

minus 1 and multiplied by 100."

"(2) EXCLUSION OF SERVICES FURNISHED TO PRIVATE PLAN ENROLLEES.—In this subsection, the term 'physicians' services' with respect to a fiscal year does not include services furnished to an individual enrolled under this part who has elected to receive benefits under this title for the fiscal year through a MedicarePlus product offered under part C or through enrollment with an eligible organization with a risk-sharing contract under section 1876."

(b) ESTABLISHING UPDATE TO CONVERSION FACTOR TO MATCH SPENDING UNDER SUSTAINABLE GROWTH RATE.—

(1) IN GENERAL.—Section 1848(d) (42 U.S.C. 1395w-4(d)(3)) is amended—

(A) by striking paragraph (2);

(B) by amending paragraph (3) to read as follows:

"(3) UPDATE.—

"(A) IN GENERAL.—Subject to subparagraph (E), for purposes of this section the update for a year (beginning with 1997) is equal to the product of—

"(i) 1 plus the Secretary's estimate of the percentage increase in the medicare economic index (de-

scribed in the fourth sentence of section 1842(b)(3)) for the year (divided by 100), and

"(ii) 1 plus the Secretary's estimate of the update adjustment factor for the year (divided by 100), minus 1 and multiplied by 100.

"(B) UPDATE ADJUSTMENT FACTOR.—The 'update adjustment factor' for a year is equal to the quotient of—

"(i) the difference between (I) the sum of the allowed expenditures for physicians' services furnished during each of the years 1995 through the year involved and (II) the sum of the amount of actual expenditures for physicians' services furnished during each of the years 1995 through the previous year; divided by

"(ii) the Secretary's estimate of allowed expenditures for physicians' services furnished during the year.

"(C) DETERMINATION OF ALLOWED EXPENDITURES.—For purposes of subparagraph (B), allowed expenditures for physicians' services shall be determined as follows (as estimated by the Secretary):

"(i) In the case of allowed expenditures for 1995, such expenditures shall be equal to actual expenditures for services furnished during the 12-month period ending with June of 1995.

"(ii) In the case of allowed expenditures for 1996 and each subsequent year, such expenditures shall be equal to allowed expenditures for the previous year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during the year.

"(D) DETERMINATION OF ACTUAL EXPENDITURES.—For purposes of subparagraph (B), the amount of actual expenditures for physicians' services furnished during a year shall be equal to the amount of expenditures for such services during the 12-month period ending with June of the previous year.

"(E) RESTRICTION ON VARIATION FROM MEDICARE ECONOMIC INDEX.—Notwithstanding the amount of the update adjustment factor determined under subparagraph (B) for a year, the update in the conversion factor under this paragraph for the year may not be—

"(i) greater than 103 percent of the Secretary's estimate of the percentage increase in the medicare economic index (described in the fourth sentence of section 1842(b)(3)) for the year; or

"(ii) less than 93 percent of the Secretary's estimate of the percentage increase in the medicare economic index (described in the fourth sentence of section 1842(b)(3)) for the year."; and

(C) by adding at the end the following new paragraph:

"(4) REPORTING REQUIREMENTS.—

"(A) IN GENERAL.—Not later than November 1 of each year (beginning with 1996), the Secretary shall transmit to the Congress a report that describes the update in the conversion factor for physicians' services (as defined in subsection (f)(3)(A)) in the following year.

"(B) COMMISSION REVIEW.—The Medicare Payment Review Commission shall review the report submitted under subparagraph (A) for a year and shall submit to the Congress, by not later than December 1 of the year, a report containing its analysis of the conversion factor for the following year."

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to physicians' services furnished on or after January 1, 1997.

(c) ESTABLISHMENT OF SINGLE CONVERSION FACTOR FOR 1996.—

(1) IN GENERAL.—Section 1848(d)(1) (42 U.S.C. 1395w-4(d)(1)) is amended—

(A) by redesignating subparagraph (C) as subparagraph (D); and

(B) by inserting after subparagraph (B) the following new subparagraph:

“(C) SPECIAL RULE FOR 1996.—For 1996, the conversion factor under this subsection shall be \$34.60 for all physicians’ services.”

(2) CONFORMING AMENDMENTS.—Section 1848 (42 U.S.C. 1395w-4) is amended—

(A) by striking “(or factors)” each place it appears in subsection (d)(1)(A) and (d)(1)(C)(ii);

(B) in subsection (d)(1)(A), by striking “or updates”;

(C) in subsection (d)(1)(C)(ii), by striking “(or updates)”;

(D) in subsection (i)(1)(C), by striking “conversion factors” and inserting “the conversion factor”.

SEC. 16402. ELIMINATION OF FORMULA-DRIVEN OVERPAYMENTS FOR CERTAIN OUTPATIENT HOSPITAL SERVICES.

(a) AMBULATORY SURGICAL CENTER PROCEDURES.—Section 1833(i)(3)(B)(i)(II) (42 U.S.C. 1395l(i)(3)(B)(i)(II)) is amended—

(1) by striking “of 80 percent”; and

(2) by striking the period at the end and inserting the following: “, less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).”.

(b) RADIOLOGY SERVICES AND DIAGNOSTIC PROCEDURES.—Section 1833(n)(1)(B)(i)(II) (42 U.S.C. 1395l(n)(1)(B)(i)(II)) is amended—

(1) by striking “of 80 percent”; and

(2) by striking the period at the end and inserting the following: “, less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished during portions of cost reporting periods occurring on or after October 1, 1995.

SEC. 16403. REDUCTION IN UPDATES TO PAYMENT AMOUNTS FOR DURABLE MEDICAL EQUIPMENT.

(a) IN GENERAL.—

(1) FREEZE IN UPDATE FOR COVERED ITEMS.—Section 1834(a)(14) (42 U.S.C. 1395m(a)(14)) is amended—

(A) by striking “and” at the end of subparagraph (A);

(B) in subparagraph (B)—

(i) by striking “a subsequent year” and inserting “1993, 1994, and 1995”, and

(ii) by striking the period at the end and inserting “, and”;

(C) by adding at the end the following:

“(C) for each of the years 1996 through 2002, 0 percentage points; and

“(D) for a subsequent year, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year.”.

(2) UPDATE FOR ORTHOTICS AND PROSTHETICS.—Section 1834(h)(4)(A) (42 U.S.C. 1395m(h)(4)(A)) is amended—

(A) by striking “and” at the end of clause (iii);

(B) by redesignating clause (iv) as clause (v); and

(C) by inserting after clause (iii) the following new clause:

“(iv) for each of the years 1996 through 2002, 1 percent, and”.

(b) OXYGEN AND OXYGEN EQUIPMENT.—Section 1834(a)(9)(C) (42 U.S.C. 1395m(a)(9)(C)) is amended—

- (1) by striking "and" at the end of clause (iii);
- (2) in clause (iv)—
 - (A) by striking "a subsequent year" and inserting "1993, 1994, and 1995", and
 - (B) by striking the period at the end and inserting a semicolon; and
- (3) by adding at the end the following new clauses:
 - "(v) in 1996, is 80 percent of the national limited monthly payment rate computed under subparagraph (B) for the item for the year; and
 - "(vi) in a subsequent year, is the national limited monthly payment rate computed under subparagraph (B) for the item for the year."

SEC. 15604. REDUCTION IN UPDATES TO PAYMENT AMOUNTS FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.

(a) **CHANGE IN UPDATE.**—Section 1833(h)(2)(A)(ii)(IV) (42 U.S.C. 1395l(h)(2)(A)(ii)(IV)) is amended striking "1994 and 1995" and inserting "1994 through 2002".

(b) **LOWERING CAP ON PAYMENT AMOUNTS.**—Section 1833(h)(4)(B) (42 U.S.C. 1395l(h)(4)(B)) is amended—

- (1) in clause (vi), by striking "and" at the end;
- (2) in clause (vii)—
 - (A) by inserting "and before January 1, 1997," after "1995," and
 - (B) by striking the period at the end and inserting "and"; and
- (3) by adding at the end the following new clause:

"(viii) after December 31, 1996, is equal to 65 percent of such median."

SEC. 15605. EXTENSION OF REDUCTIONS IN PAYMENTS FOR COSTS OF HOSPITAL OUTPATIENT SERVICES.

(a) **REDUCTION IN PAYMENTS FOR CAPITAL-RELATED COSTS.**—Section 1861(v)(1)(S)(ii)(I) (42 U.S.C. 1395x(v)(1)(S)(ii)(I)) is amended by striking "through 1998" and inserting "through 2002".

(b) **REDUCTION IN PAYMENTS FOR OTHER COSTS.**—Section 1861(v)(1)(S)(ii)(II) (42 U.S.C. 1395x(v)(1)(S)(ii)(II)) is amended by striking "through 1998" and inserting "through 2002".

SEC. 15606. FREEZE IN PAYMENTS FOR AMBULATORY SURGICAL CENTER SERVICES.

The Secretary of Health and Human Services shall not provide for any inflation update in the payment amounts under subparagraphs (A) and (B) of section 1833(i)(2) of the Social Security Act for any of the fiscal years 1996 through 2002.

SEC. 15607. RURAL EMERGENCY ACCESS CARE HOSPITALS.

(a) **COVERAGE UNDER PART B.**—Section 1832(a)(2) (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 new subparagraph:

"(K) rural emergency access care hospital services (as defined in section 1861(o)(2))."

(b) **PAYMENT BASED ON REASONABLE COSTS.**—Section 1833(a)(2) (42 U.S.C. 1395l(a)(2)), as amended by section 15607(c), is amended—

- (1) by striking "and" at the end of subparagraph (F);
- (2) by adding "and" at the end of subparagraph (G); and
- (3) by adding at the end the following new subparagraph:

"(H) with respect to rural emergency access care hospital services, the reasonable cost of such services (as determined under section 1861(v)), less the amount the hospital may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services exceed 80 percent of such reasonable cost."

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to services furnished on or after October 1, 1995.

PART 2—PART B PREMIUM

SEC. 16411. EXTENSION OF PART B PREMIUM.

(a) **IN GENERAL.**—Section 1839(e)(1) (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 new subparagraph:

“(C) For purposes of subparagraph (A), the percent described in this subparagraph is the ratio (expressed as a percentage) of the monthly premium established under this section for months in 1995 to the monthly actuarial rate for enrollees age 65 and over applicable to such months (as specified in the most recent report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund published prior to the date of the enactment of the Medicare Preservation Act of 1995).”.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) apply to premiums for months beginning with January 1996.

SEC. 16412. INCOME-RELATED REDUCTION IN MEDICARE SUBSIDY.

(a) **IN GENERAL.**—Section 1839 (42 U.S.C. 1395r) is amended by adding at the end the following:

“(h)(1) Notwithstanding the previous subsections of this section, in the case of an individual whose modified adjusted gross income for a taxable year ending with or within a calendar year (as initially determined by the Secretary in accordance with paragraph (3)) exceeds the threshold amount described in paragraph (4), the Secretary shall increase the amount of the monthly premium for months in the calendar year by an amount equal to the difference between—

“(A) 200 percent of the monthly actuarial rate for enrollees age 65 and over as determined under subsection (a)(1) for that calendar year; and

“(B) the total of the monthly premiums paid by the individual under this section (determined without regard to subsection (b)) during such calendar year.

“(2) In the case of an individual described in paragraph (1) whose modified adjusted gross exceeds the threshold amount by less than \$25,000, the amount of the increase in the monthly premium applicable under paragraph (1) shall be an amount which bears the same ratio to the amount of the increase described in paragraph (1) (determined without regard to this paragraph) as such excess bears to \$25,000. In the case of a joint return filed under section 6013 of the Internal Revenue Code of 1986 by spouses both of whom are enrolled under this part, the previous sentence shall be applied by substituting “\$50,000” for “\$25,000”. The preceding provisions of this paragraph shall not apply to any individual whose threshold amount is zero.

“(3) The Secretary shall make an initial determination of the amount of an individual's adjusted gross income for a taxable year ending with or within a calendar year for purposes of this subsection as follows:

“(A) Not later than October 1 of the year preceding the year, the Secretary shall provide notice to each individual whom the Secretary finds (on the basis of the individual's actual adjusted gross income for the most recent taxable year for which such information is available or other information provided to the Secretary by the Secretary of the Treasury) will be subject to an increase under this subsection that the individual will be subject to such an increase, and shall include in such notice the Secretary's estimate of the individual's adjusted gross income for the year.

"(B) If, during the 30-day period beginning on the date notice is provided to an individual under subparagraph (A), the individual provides the Secretary with information on the individual's anticipated adjusted gross income for the year, the amount initially determined by the Secretary under this paragraph with respect to the individual shall be based on the information provided by the individual.

"(C) If an individual does not provide the Secretary with information under subparagraph (B), the amount initially determined by the Secretary under this paragraph with respect to the individual shall be the amount included in the notice provided to the individual under subparagraph (A).

"(4)(A) If the Secretary determines (on the basis of final information provided by the Secretary of the Treasury) that the amount of an individual's actual adjusted gross income for a taxable year ending with or within a calendar year is less than or greater than the amount initially determined by the Secretary under paragraph (3), the Secretary shall increase or decrease the amount of the individual's monthly premium under this section (as the case may be) for months during the following calendar year by an amount equal to $\frac{1}{12}$ of the difference between—

"(i) the total amount of all monthly premiums paid by the individual under this section during the previous calendar year; and

"(ii) the total amount of all such premiums which would have been paid by the individual during the previous calendar year if the amount of the individual's adjusted gross income initially determined under paragraph (3) were equal to the actual amount of the individual's adjusted gross income determined under this paragraph.

"(B) In the case of an individual who is not enrolled under this part for any calendar year for which the individual's monthly premium under this section for months during the year would be increased pursuant to subparagraph (A) if the individual were enrolled under this part for the year, the Secretary may take such steps as the Secretary considers appropriate to recover from the individual the total amount by which the individual's monthly premium for months during the year would have been increased under subparagraph (A) if the individual were enrolled under this part for the year.

"(5) In this subsection, the following definitions apply:

"(A) The term 'modified adjusted gross income' means, with respect to an individual for a taxable year, the individual's adjusted gross income under the Internal Revenue Code of 1986—

"(i) determined without regard to sections 135, 911, 931, and 933 of such Code, and

"(ii) increased by the amount of interest received or accrued by the individual during the taxable year which is exempt from tax under such Code.

"(B) The term 'threshold amount' means—

"(i) except as otherwise provided in this paragraph, \$75,000,

"(ii) \$125,000, in the case of a joint return, and

"(iii) zero in the case of a taxpayer who—

"(I) is married at the close of the taxable year but does not file a joint return for such year, and

"(II) does not live apart from his spouse at all times during the taxable year."

(b) CONFORMING AMENDMENT.—Section 1839(f) (42 U.S.C. 1395r(f)) is amended by striking "if an individual" and inserting the following: "if an individual (other than an individual subject to an increase in the monthly premium under this section pursuant to subsection (h))".

(c) REPORTING REQUIREMENTS FOR SECRETARY OF THE TREASURY.—Notwithstanding section 6103 of the Internal Revenue Code

of 1986, the Secretary of the Treasury shall provide, at the request of the Secretary of Health and Human Services, such information (at such times and in such form as the Secretary of Health and Human Services may require) as is necessary for the Secretary of Health and Human Services to carry out section 1839(h) of the Social Security Act (as added by subsection (a)).

(d) **EFFECTIVE DATE.**—The amendments made by subsections (a) and (b) shall apply to the monthly premium under section 1839 of the Social Security Act for months beginning with January 1997.

Subtitle H—Provisions Relating to Medicare Parts A and B

PART 1—PAYMENTS FOR HOME HEALTH SERVICES

SEC. 15701. PAYMENT FOR HOME HEALTH SERVICES.

(a) **IN GENERAL.**—Title XVIII (42 U.S.C. 1395 et seq.), as amended by section 15106, is amended by adding at the end the following new section:

“PAYMENT FOR HOME HEALTH SERVICES

“SEC. 1894. (a) **IN GENERAL.**—

“(1) **PER VISIT PAYMENTS.**—Subject to subsection (c), the Secretary shall make per visit payments beginning with fiscal year 1997 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, 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 SERVICES.**—

“(1) **IN GENERAL.**—The Secretary shall, subject to paragraph (3), establish a per visit payment rate for a home health agency in an area 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 such 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, 1995).

“(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 1997, is an amount equal to the national average amount paid per visit under this title to home health agencies for such type of service during the most recent 12-month cost reporting period ending on or before June 30, 1994, increased (in a compounded manner) by the home health market basket percentage increase for fiscal years 1995, 1996, and 1997; and

"(B) for each subsequent fiscal year, is an amount equal to the national per visit payment rate in effect for the preceding fiscal year, increased by the home health market basket percentage increase for such subsequent fiscal year minus 2 percentage points.

"(3) REBASING OF RATES.—The Secretary shall provide for an update to the national per visit payment rates under this subsection for cost reporting periods beginning not later than the first day of the fifth fiscal year which begins after fiscal year 1997, and not later than every 5 years thereafter, to reflect the most recent available data.

"(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 the fiscal year.

"(c) PER EPISODE LIMIT.—

"(1) AGGREGATE LIMIT.—

"(A) IN GENERAL.—Except as provided in paragraph (2), a home health agency may not receive aggregate per visit payments under subsection (a) for a fiscal year in excess of an amount equal to the sum of the following products determined for each case-mix category for which the agency receives payments:

"(i) The number of episodes of each case-mix category during the fiscal year, multiplied by

"(ii) the per episode limit determined for such case-mix category for such fiscal year.

"(B) ESTABLISHMENT OF PER EPISODE LIMITS.—

"(i) IN GENERAL.—The per episode limit for a fiscal year for any case-mix category for the area in which a home health agency is located is equal to—

"(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 1994, adjusted by the case-mix adjustment factor determined in clause (ii) for the fiscal year involved; multiplied by

"(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) CASE MIX ADJUSTMENT FACTOR.—For purposes of clause (i), the case-mix adjustment factor for a year is the factor determined by the Secretary to assure that aggregate payments for home health services under this section during the year will not exceed the payment for such services during the previous year as a result of changes in the number and type of home health visits within case-mix categories over the previous year.

"(iii) REBASING OF PER EPISODE AMOUNTS.—Beginning with fiscal year 1999 and every 2 years there-

after, the Secretary shall revise the mean number of home health visits determined under clause (i)(1) for each type of home health service visit described in subsection (a)(2) furnished during an episode in a case-mix category to reflect the most recently available data on the number of visits.

"(iv) DETERMINATION OF APPLICABLE AREA.—For purposes of determining per episode limits under this subparagraph, the area in which a home health agency is considered to be located shall be such area as the Secretary finds appropriate for purposes of this subparagraph.

"(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 Phase II Home Health Agency Prospective Payment Demonstration Project conducted by the Health Care Financing Administration. The Secretary may develop an alternate methodology for determining case-mix categories.

"(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 60-day period in which the individual did not receive visits for a type of home health service described in subsection (a)(2).

"(ii) TREATMENT OF EPISODES SPANNING COST REPORTING PERIODS.—The Secretary shall provide for such rules as the Secretary considers appropriate regarding the treatment of episodes under this paragraph which begin during a cost reporting period and end in a subsequent cost reporting period.

"(E) EXEMPTIONS AND EXCEPTIONS.—The Secretary may provide for exemptions and exceptions to the limits established under this paragraph for a fiscal year as the Secretary deems appropriate, to the extent such exemptions and exceptions do not result in greater payments under this section than the exemptions and exceptions provided under section 1861(v)(1)(L)(ii) in fiscal year 1994, increased by the home health market basket percentage increase for the fiscal year involved (as defined in subsection (b)(4)).

"(2) RECONCILIATION OF AMOUNTS.—

"(A) OVERPAYMENTS TO HOME HEALTH AGENCIES.—Subject to subparagraph (B), 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) EXCEPTION FOR HOME HEALTH SERVICES FURNISHED OVER A PERIOD GREATER THAN 165 DAYS.—

"(i) IN GENERAL.—For purposes of subparagraph (A), the amount of aggregate per visit payments determined under subsection (a) shall not include payments for home health visits furnished to an individual on or after a continuous period of more than 165 days after an individual begins an episode described in sub-

section (c)(1)(D) (if such period is not interrupted by the beginning of a new episode).

"(ii) REQUIREMENT OF CERTIFICATION.—Clause (i) shall not apply if the agency has not obtained a physician's certification with respect to the individual requiring such visits that includes a statement that the individual requires such continued visits, the reason for the need for such visits, and a description of such services furnished during such visits.

"(C) SHARE OF SAVINGS.—

"(i) BONUS PAYMENTS.—If a home health agency has received aggregate per visit payments under subsection (a) for a fiscal year in an amount less than the amount determined under paragraph (1) with respect to such home health agency for such fiscal year, the Secretary shall pay such home health agency a bonus payment equal to 50 percent of the difference between such amounts in the following fiscal year, except that the bonus payment may not exceed 5 percent of the aggregate per visit payments made to the agency for the year.

"(ii) INSTALLMENT BONUS PAYMENTS.—The Secretary may make installment payments during a fiscal year to a home health agency based on the estimated bonus payment that the agency would be eligible to receive with respect to such fiscal year.

"(d) MEDICAL REVIEW PROCESS.—The Secretary shall implement a medical review process (with a particular emphasis on fiscal years 1997 and 1998) 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. Such review process shall focus on low-cost cases described in subsection (e)(3) and cases described in subsection (c)(2)(B) and shall require recertification by intermediaries at 30, 60, 90, 120, and 165 days into an episode described in subsection (c)(1)(D).

"(e) ADJUSTMENT OF PAYMENTS TO AVOID CIRCUMVENTION OF LIMITS.—

"(1) IN GENERAL.—The Secretary shall provide for appropriate adjustments to payments to home health agencies under this section to ensure that agencies do not circumvent the purpose of this section by—

"(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; or

"(C) undertaking other actions considered unnecessary for effective patient care and intended to achieve maximum payments under this title.

"(2) TRACKING OF PATIENTS THAT SWITCH HOME HEALTH AGENCIES DURING EPISODE.—

"(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 during an episode described in subsection (c)(1)(D).

"(B) ADJUSTMENT OF PAYMENTS.—The Secretary shall adjust payments 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) **LOW-COST CASES.**—The Secretary shall develop a system designed to adjust payments to a home health agency for a fiscal year to eliminate any increase in growth of the percentage of low-cost episodes for which home health services are furnished by the agency over such percentage determined for the agency for the 12-month cost reporting period ending on June 30, 1994. The Secretary shall define a low-cost episode 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.

"(f) **REPORT BY MEDICARE PAYMENT REVIEW COMMISSION.**—During the first 3 years in which payments are made under this section, the Medicare 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 a capitated payment for home care patients receiving care during a continuous period exceeding 165 days is warranted.

"(4) Whether public providers of service are adequately reimbursed

"(5) The adequacy of the exemptions and exceptions to the limits provided under subsection (c)(1)(E).

"(6) The appropriateness of the methods provided under this section to adjust the per episode 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.

"(7) The geographic areas used to determine the per episode limits."

(b) **PAYMENT FOR PROSTHETICS AND ORTHOTICS UNDER PART A.**—Section 1814(k) (42 U.S.C. 1395f(k)) is amended—

(1) by inserting "and prosthetics and orthotics" after "durable medical equipment"; and

(2) by inserting "and 1834(h), respectively" after "1834(a)(1)".

(c) **CONFORMING AMENDMENTS.**—

(1) **PAYMENTS UNDER PART A.**—Section 1814(b) (42 U.S.C. 1395f(b)), as amended by section 15522(b), is amended in the matter preceding paragraph (1) by striking "1888 and 1888A" and inserting "1888, 1888A, and 1894".

(2) **TREATMENT OF ITEMS AND SERVICES PAID UNDER PART B.**—

(A) **PAYMENTS UNDER PART B.**—Section 1833(a)(2) (42 U.S.C. 1395l(a)(2)) is amended—

(i) by amending subparagraph (A) to read as follows:

"(A) with respect to home health services—

"(i) that are a type of home health service described in section 1894(a)(2), and which are furnished to an individual who (at the time the item or service is furnished) is under a plan of care of a home health agency, the amount determined under section 1894;

"(ii) that are not described in clause (i) (other than a covered osteoporosis drug) (as defined in section 1861(kk)), the lesser of—

"(I) the reasonable cost of such services, as determined under section 1861(v), or

"(II) the customary charges with respect to such services;".

(ii) by striking "and" at the end of subparagraph (E);

(iii) by adding "and" at the end of subparagraph (F); and

(iv) by adding at the end the following new subparagraph:

"(G) with respect to items and services described in section 1861(s)(10)(A), the lesser of—

"(i) the reasonable cost of such services, as determined under section 1861(v), or

"(ii) the customary charges with respect to such services,

or, if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this provision), free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2);".

(B) **REQUIRING PAYMENT FOR ALL ITEMS AND SERVICES TO BE MADE TO AGENCY.**—

(i) **IN GENERAL.**—The first sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended—

(I) by striking "and (D)" and inserting "(D)"; and

(II) by striking the period at the end and inserting the following: "; and (E) in the case of types of home health services described in section 1894(a)(2) furnished to an individual who (at the time the item or service is furnished) is under a plan of care of a home health agency, payment shall be made to the agency (without regard to whether or not the item or service was furnished by the agency, by others under arrangement with them made by the agency, or otherwise).".

(ii) **CONFORMING AMENDMENT.**—Section 1832(a)(1) (42 U.S.C. 1395k(a)(1)) is amended by striking "(2);" and inserting "(2) and section 1842(b)(6)(E);".

(C) **EXCLUSIONS FROM COVERAGE.**—Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 15525(a)(2), is amended—

(i) by striking "or" at the end of paragraph (15);

(ii) by striking the period at the end of paragraph

(16) and inserting "or"; and

(iii) by adding at the end the following new paragraph:

"(17) where such expenses are for home health services furnished to an individual who is under a plan of care of the home health agency if the claim for payment for such services is not submitted by the agency.".

(3) **SUNSET OF REASONABLE COST LIMITATIONS.**—Section 1861(v)(1)(L) (42 U.S.C. 1395x(v)(1)(L)) is amended by adding at the end the following new clause:

"(iv) This subparagraph shall apply only to services furnished by home health agencies during cost reporting periods ending on or before September 30, 1996.".

(c) **EFFECTIVE DATE.**—The amendments made by subsections (a) and (b) shall apply to cost reporting periods beginning on or after October 1, 1996.

SEC. 15702. MAINTAINING SAVINGS RESULTING FROM TEMPORARY FREEZE ON PAYMENT INCREASES FOR HOME HEALTH SERVICES.

(a) **BASING UPDATES TO PER VISIT COST LIMITS ON LIMITS FOR FISCAL YEAR 1993.**—Section 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by adding at the end the following sentence: "In establishing limits under this subparagraph, the Secretary may not take into account any changes in the costs of the provision of services furnished by home health agencies with re-

spect to cost reporting periods which began on or after July 1, 1994, and before July 1, 1996."

(b) **NO EXCEPTIONS PERMITTED BASED ON AMENDMENT.**—The Secretary of Health and Human Services shall not consider the amendment made by subsection (a) in making any exemptions and exceptions pursuant to section 1861(v)(1)(L)(ii) of the Social Security Act.

SEC. 16703. EXTENSION OF WAIVER OF PRESUMPTION OF LACK OF KNOWLEDGE OF EXCLUSION FROM COVERAGE FOR HOME HEALTH AGENCIES.

Section 9305(g)(3) of OBRA-1986, as amended by section 426(d) of the Medicare Catastrophic Coverage Act of 1988 and section 4207(b)(3) of OBRA-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 "September 30, 1996".

PART 2—MEDICARE SECONDARY PAYER IMPROVEMENTS

SEC. 16711. EXTENSION AND EXPANSION OF EXISTING REQUIREMENTS.

(a) **DATA MATCH.**—

(1) Section 1862(b)(5)(C) (42 U.S.C. 1395y(b)(5)(C)) is amended by striking clause (iii).

(2) Section 6103(l)(12) of the Internal Revenue Code of 1986 is amended by striking subparagraph (F).

(b) **APPLICATION TO DISABLED INDIVIDUALS IN LARGE GROUP HEALTH PLANS.**—

(1) **IN GENERAL.**—Section 1862(b)(1)(B) (42 U.S.C. 1395y(b)(1)(B)) is amended—

(A) in clause (i), by striking "clause (iv)" and inserting "clause (iii)",

(B) by striking clause (iii), and

(C) by redesignating clause (iv) as clause (iii).

(2) **CONFORMING AMENDMENTS.**—Paragraphs (1) through (3) of section 1837(i) (42 U.S.C. 1395p(i)) and the second sentence of section 1839(b) (42 U.S.C. 1395r(b)) are each amended by striking "1862(b)(1)(B)(iv)" each place it appears and inserting "1862(b)(1)(B)(iii)".

(c) **EXPANSION OF PERIOD OF APPLICATION TO INDIVIDUALS WITH END STAGE RENAL DISEASE.**—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended—

(1) in the first sentence, by striking "12-month" each place it appears and inserting "24-month", and

(2) by striking the second sentence.

SEC. 16712. IMPROVEMENTS IN RECOVERY OF PAYMENTS.

(a) **PERMITTING RECOVERY AGAINST THIRD PARTY ADMINISTRATORS OF PRIMARY PLANS.**—Section 1862(b)(2)(B)(ii) (42 U.S.C. 1395y(b)(2)(B)(ii)) is amended—

(1) by striking "under this subsection to pay" and inserting "(directly, as a third-party administrator, or otherwise) to make payment", and

(2) by adding at the end the following: "The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan."

(b) **EXTENSION OF CLAIMS FILING PERIOD.**—Section 1862(b)(2)(B) (42 U.S.C. 1395y(b)(2)(B)) is amended by adding at the end the following new clause:

"(vi) **CLAIMS-FILING PERIOD.**—Notwithstanding any other time limits that may exist for filing a claim under an employer group health plan, the United States may seek to recover conditional payments in accordance with this subparagraph where the request

for payment is submitted to the entity required or responsible under this subsection to pay with respect to the item or service (or any portion thereof) under a primary plan within the 3-year period beginning on the date on which the item or service was furnished."

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to items and services furnished on or after the date of the enactment of this Act.

SEC. 16713. PROHIBITING RETROACTIVE APPLICATION OF POLICY REGARDING ESRD BENEFICIARIES ENROLLED IN PRIMARY PLANS.

For purposes of carrying out section 1862(b)(1)(C) of the Social Security Act, the Secretary of Health and Human Services shall apply the policy directive issued by the Administrator of the Health Care Financing Administration on April 24, 1995, only with respect to items and services furnished on or after such date.

PART 3—FAILSAFE

SEC. 16721. FAILSAFE BUDGET MECHANISM.

(a) **IN GENERAL.**—Title XVIII, as amended by sections 15106(a) and 15701(a), is amended by adding at the end the following new section:

"FAILSAFE BUDGET MECHANISM

"SEC. 1895. (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 1998) that—

"(A) the fee-for-service expenditures (as defined in subsection (f)) for a sector of medicare services (as defined in subsection (b)) 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 (h) for that fiscal year),

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 the sector in the fiscal year so that such expenditures for the sector for the year will be reduced by 133⅓ percent of the amount of such excess.

"(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 items and services 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 (h)(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 the MedicarePlus program under part C.

In making the estimate under clause (ii), the Secretary shall take into account estimated enrollment and demographic profile of individuals electing MedicarePlus products.

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

"(i) for fiscal year 1997 is \$203.1 billion;

"(ii) for fiscal year 1998 is \$214.3 billion;

"(iii) for fiscal year 1999 is \$227.2 billion;

"(iv) for fiscal year 2000 is \$241.0 billion;

"(v) for fiscal year 2001 is \$259.1 billion;

"(vi) for fiscal year 2002 is \$280.0 billion; and

"(vi) for a subsequent fiscal year is equal to the medicare benefit budget under this subparagraph for the preceding fiscal year increased by the sum of (I) 5 percentage points, and (II) 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 1996 is equal to fee-for-service expenditures for such sector during fiscal year 1995, increased by the baseline annual growth rate for such sector of medicare services for fiscal year 1996 (as specified in 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—						
	1996	1997	1998	1999	2000	2001	2002 and thereafter
(A) Inpatient hospital services	5.7%	5.6%	6.0%	6.1%	5.7%	5.5%	5.2%
(B) Home health services	17.2%	15.1%	11.7%	9.1%	8.4%	8.1%	7.9%
(C) Extended care services	19.7%	12.3%	9.3%	8.7%	8.6%	8.4%	8.0%
(D) Hospice care	32.0%	24.0%	18.0%	15.0%	12.0%	10.0%	9.0%
(E) Physicians' services	12.4%	9.7%	8.7%	9.0%	9.3%	9.6%	10.1%
(F) Outpatient hospital services	14.7%	13.9%	14.5%	15.0%	14.1%	13.9%	14.0%
(G) Durable medical equipment and supplies	16.1%	15.5%	13.7%	12.4%	13.2%	13.9%	14.5%
(H) Diagnostic tests	13.1%	11.3%	11.0%	11.4%	11.4%	11.5%	11.9%
(I) Other items and services	11.2%	10.2%	10.9%	12.0%	11.6%	11.6%	11.8%

"(d) MANNER OF PAYMENT ADJUSTMENT.—

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

"(A) 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

"(B) provide for the full appropriate adjustment so that the fee-for-service expenditures for the sector for the fiscal year will approximate (and not exceed) the allotment for the sector for the fiscal year.

"(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 1894, to the computation of the increase in the national per visit payment rates established for the year under section 1894(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.

"(v) COVERED NON-ROUTINE SERVICES OF SKILLED NURSING FACILITIES.—To the computation of the facility per stay limits for the year under section 1888A(d) for covered non-routine services of a skilled nursing facility (as described in such section).

"(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 1997, the reduction shall be made for payment rates during calendar year 1997 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 1997.

"(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 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, for services furnished during the calendar year in which the fiscal year ends.

"(iii) UPDATE IN LAB 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 pay-

ment 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 a 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(j) 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 (other than covered non-routine services subject to section 1888A) 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 a 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 payment for items and services within a sector as may be appropriate based on (and in order to properly carry out) the adjustment on 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, 1996, 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 1999, 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 1998) 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 COMMISSION.—By not later than March 1 of each year (beginning with 1997), the Medicare Payment Review Commission shall 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 1998), 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 1999, 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 1998), 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 (h).

"(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 part C.

"(g) EXPEDITED PROCESS FOR ADJUSTMENT OF SECTOR GROWTH RATES.—

"(1) OPTIONAL INCLUSION OF LEGISLATIVE PROPOSAL.—The President may include in recommendations under subsection (e)(2)(B) submitted with respect to a fiscal year a specific legislative proposal that provides only for the substitution of percentages specified in the proposal for one or more of the baseline annual growth rates (specified in the table in subsection (c)(3)(C) or in a previous legislative proposal under this subsection) for that fiscal year or any subsequent fiscal year.

"(2) CONGRESSIONAL CONSIDERATION.—

"(A) IN GENERAL.—The percentages contained in a legislative proposal submitted under paragraph (1) shall apply under this section if a joint resolution (described in subparagraph (B)) approving such proposal is enacted, in accordance with the provisions of subparagraph (C), before the end of the 60-day period beginning on the date on which such proposal was submitted. For purposes of applying the preceding sentence and subparagraphs (B) and (C), the days on which either House of Congress is not in session because of an adjournment of more than three days to a day certain shall be excluded in the computation of a period.

"(B) JOINT RESOLUTION OF APPROVAL.—A joint resolution described in this subparagraph means only a joint resolution which is introduced within the 10-day period beginning on the date on which the President submits a proposal under paragraph (1) and—

"(i) which does not have a preamble;

"(ii) the matter after the resolving clause of which is as follows: 'That Congress approves the proposal of the President providing for substitution of percentages for certain baseline annual growth rates under section 1895 of the Social Security Act, as submitted by the President on _____', the blank space being filled in with the appropriate date; and

"(iii) the title of which is as follows: 'Joint resolution approving Presidential proposal to substitute certain specified percentages for baseline annual growth

rates under section 1895 of the Social Security Act, as submitted by the President on _____, the blank space being filled in with the appropriate date.

"(C) PROCEDURES FOR CONSIDERATION OF RESOLUTION OF APPROVAL.—Subject to subparagraph (D), the provisions of section 2908 (other than subsection (a)) of the Defense Base Closure and Realignment Act of 1990 shall apply to the consideration of a joint resolution described in subparagraph (B) in the same manner as such provisions apply to a joint resolution described in section 2908(a) of such Act.

"(D) SPECIAL RULES.—For purposes of applying subparagraph (C) with respect to such provisions—

"(i) any reference to the Committee on Armed Services of the House of Representatives shall be deemed a reference to an appropriate Committee of the House of Representatives (specified by the Speaker of the House of Representatives at the time of submission of a legislative proposal under paragraph (1)) and any reference to the Committee on Armed Services of the Senate shall be deemed a reference to the Committee on Finance of the Senate; and

"(ii) any reference to the date on which the President transmits a report shall be deemed a reference to the date on which the President submits the legislative proposal under paragraph (1).

"(h) LOOK-BACK ADJUSTMENT IN ALLOTMENTS TO REFLECT ACTUAL EXPENDITURES.—

"(1) IN GENERAL.—If the Secretary determines under subsection (e)(3)(B) with respect to a particular fiscal year (beginning with fiscal year 1999) that the fee-for-service expenditures for a sector of medicare services for the second preceding fiscal year—

"(A) exceeded the adjusted allotment for such sector for such year (as defined in paragraph (2)), then the allotment for the sector for the particular fiscal year shall be reduced by 13 1/3 percent of the amount of such excess, or

"(B) was less than the adjusted allotment for such sector for such year, then the allotment for the sector for the particular fiscal year shall be increased by the amount of such deficit.

"(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 MedicarePlus program under part C 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 previous fiscal year).

"(i) PROSPECTIVE APPLICATION OF CERTAIN NATIONAL COVERAGE DETERMINATIONS.—In the case of a national coverage determination that the Secretary projects will result in significant additional expenditures under this title (taking into account any substitution for existing procedures or technologies), such determination shall not become effective before the beginning of the fiscal year that begins after the date of such determination and shall apply to contracts under part C entered into (or renewed) after the date of such determination."

(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 new subsection:

"(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 1895 restrain the rate of growth of expenditures under this part in order to achieve such solvency.”

PART 4—ADMINISTRATIVE SIMPLIFICATION

SEC. 16731. STANDARDS FOR MEDICARE INFORMATION TRANSACTIONS AND DATA ELEMENTS.

Title XVIII, as amended by section 15031, is amended by inserting after section 1806 the following new section:

“STANDARDS FOR MEDICARE INFORMATION TRANSACTIONS AND DATA ELEMENTS

“SEC. 1807. (a) ADOPTION OF STANDARDS FOR DATA ELEMENTS.—

“(1) IN GENERAL.—Pursuant to subsection (b), the Secretary shall adopt standards for information transactions and data elements of medicare information and modifications to the standards under this section that are—

“(A) consistent with the objective of reducing the administrative costs of providing and paying for health care; and

“(B) developed or modified by a standard setting organization (as defined in subsection (h)(8)).

“(2) SPECIAL RULE RELATING TO DATA ELEMENTS.—The Secretary may adopt or modify a standard relating to data elements that is different from the standard developed by a standard setting organization, if—

“(A) the different standard or modification will substantially reduce administrative costs to health care providers and health plans compared to the alternative; and

“(B) the standard or modification is promulgated in accordance with the rulemaking procedures of subchapter III of chapter 5 of title 5, United States Code.

“(3) SECURITY STANDARDS FOR HEALTH INFORMATION NETWORK.—

“(A) IN GENERAL.—Each person, who maintains or transmits medicare information or data elements of medicare information and is subject to this section, shall maintain reasonable and appropriate administrative, technical, and physical safeguards—

“(i) to ensure the integrity and confidentiality of the information;

“(ii) to protect against any reasonably anticipated—

“(I) threats or hazards to the security or integrity of the information; and

“(II) unauthorized uses or disclosures of the information; and

“(iii) to otherwise ensure compliance with this section by the officers and employees of such person.

“(B) SECURITY STANDARDS.—The Secretary shall establish security standards and modifications to such standards with respect to medicare information network services, health plans, and health care providers that—

“(i) take into account—

“(I) the technical capabilities of record systems used to maintain medicare information;

“(II) the costs of security measures;

“(III) the need for training persons who have access to medicare information; and

“(IV) the value of audit trails in computerized record systems; and

“(ii) ensure that a medicare information network service, if it is part of a larger organization, has poli-

cies and security procedures which isolate the activities of such service with respect to processing information in a manner that prevents unauthorized access to such information by such larger organization.

The security standards established by the Secretary shall be based on the standards developed or modified by standard setting organizations. If such standards do not exist, the Secretary shall rely on the recommendations of the Health Information Advisory Committee (established under subsection (g)) and shall consult with appropriate government agencies and private organizations in accordance with paragraph (5).

"(4) IMPLEMENTATION SPECIFICATIONS.—The Secretary shall establish specifications for implementing each of the standards and the modifications to the standards adopted pursuant to paragraph (1).

"(5) ASSISTANCE TO THE SECRETARY.—In complying with the requirements of this section, the Secretary shall rely on recommendations of the Medicare Information Advisory Committee established under subsection (g) and shall consult with appropriate Federal and State agencies and private organizations. The Secretary shall publish in the Federal Register the recommendations of the Medicare Information Advisory Committee regarding the adoption of a standard under this section.

"(b) STANDARDS FOR INFORMATION TRANSACTIONS AND DATA ELEMENTS.—

"(1) IN GENERAL.—The Secretary shall adopt standards for transactions and data elements to make medicare information uniformly available to be exchanged electronically, that is—

"(A) appropriate for the following financial and administrative transactions: claims (including coordination of benefits) or equivalent encounter information, enrollment and disenrollment, eligibility, premium payments, and referral certification and authorization; and

"(B) related to other financial and administrative transactions determined appropriate by the Secretary consistent with the goals of improving the operation of the health care system and reducing administrative costs.

"(2) UNIQUE HEALTH IDENTIFIERS.—

"(A) ADOPTION OF STANDARDS.—The Secretary shall adopt standards providing for a standard unique health identifier for each individual, employer, health plan, and health care provider for use in the medicare information system. In developing unique health identifiers for each health plan and health care provider, the Secretary shall take into account multiple uses for identifiers and multiple locations and specialty classifications for health care providers.

"(B) PENALTY FOR IMPROPER DISCLOSURE.—A person who knowingly uses or causes to be used a unique health identifier under subparagraph (A) for a purpose that is not authorized by the Secretary shall—

"(i) be fined not more than \$50,000, imprisoned not more than 1 year, or both; or

"(ii) if the offense is committed under false pretenses, be fined not more than \$100,000, imprisoned not more than 5 years, or both.

"(3) CODE SETS.—

"(A) IN GENERAL.—The Secretary, in consultation with the Medicare Information Advisory Committee, experts from the private sector, and Federal and State agencies, shall—

"(i) select code sets for appropriate data elements from among the code sets that have been developed by private and public entities; or

"(ii) establish code sets for such data elements if no code sets for the data elements have been developed.

"(B) DISTRIBUTION.—The Secretary shall establish efficient and low-cost procedures for distribution (including electronic distribution) of code sets and modifications made to such code sets under subsection (c)(2).

"(4) ELECTRONIC SIGNATURE.—

"(A) IN GENERAL.—The Secretary, after consultation with the Medicare Information Advisory Committee, shall promulgate regulations specifying procedures for the electronic transmission and authentication of signatures, compliance with which will be deemed to satisfy Federal and State statutory requirements for written signatures with respect to information transactions required by this section and written signatures on enrollment and disenrollment forms.

"(B) PAYMENTS FOR SERVICES AND PREMIUMS.—Nothing in this section shall be construed to prohibit the payment of health care services or health plan premiums by debit, credit, payment card or numbers, or other electronic means.

"(5) TRANSFER OF INFORMATION BETWEEN HEALTH PLANS.—The Secretary shall develop rules and procedures—

"(A) for determining the financial liability of health plans when health care benefits are payable under two or more health plans; and

"(B) for transferring among health plans appropriate standard data elements needed for the coordination of benefits, the sequential processing of claims, and other data elements for individuals who have more than one health plan.

"(6) COORDINATION OF BENEFITS.—If, at the end of the 5-year period beginning on the date of the enactment of this section, the Secretary determines that additional transaction standards for coordinating benefits are necessary to reduce administrative costs or duplicative (or inappropriate) payment of claims, the Secretary shall establish further transaction standards for the coordination of benefits between health plans.

"(7) PROTECTION OF TRADE SECRETS.—Except as otherwise required by law, the standards adopted under this section shall not require disclosure of trade secrets or confidential commercial information by an entity operating a medicare information network.

"(c) TIMETABLES FOR ADOPTION OF STANDARDS.—

"(1) INITIAL STANDARDS.—Not later than 18 months after the date of the enactment of this section, the Secretary shall adopt standards relating to the information transactions, data elements of medicare information and security described in subsections (a) and (b).

"(2) ADDITIONS AND MODIFICATIONS TO STANDARDS.—

"(A) IN GENERAL.—The Secretary shall review the standards adopted under this section and shall adopt additional or modified standards, that have been developed or modified by a standard setting organization, as determined appropriate, but not more frequently than once every 12 months. Any addition or modification to such standards shall be completed in a manner which minimizes the disruption and cost of compliance.

"(B) ADDITIONS AND MODIFICATIONS TO CODE SETS.—

"(i) IN GENERAL.—The Secretary shall ensure that procedures exist for the routine maintenance, testing, enhancement, and expansion of code sets.

"(ii) ADDITIONAL RULES.—If a code set is modified under this paragraph, the modified code set shall include instructions on how data elements of medicare

information that were encoded prior to the modification may be converted or translated so as to preserve the informational value of the data elements that existed before the modification. Any modification to a code set under this paragraph shall be implemented in a manner that minimizes the disruption and cost of complying with such modification.

"(d) REQUIREMENTS FOR HEALTH PLANS.—

"(1) IN GENERAL.—If a person desires to conduct any of the information transactions described in subsection (b)(1) with a health plan as a standard transaction, the health plan shall conduct such standard transaction in a timely manner and the information transmitted or received in connection with such transaction shall be in the form of standard data elements of medicare information.

"(2) SATISFACTION OF REQUIREMENTS.—A health plan may satisfy the requirement imposed on such plan under paragraph (1) by directly transmitting standard data elements of medicare information or submitting nonstandard data elements to a medicare information network service for processing into standard data elements and transmission.

"(3) TIMETABLES FOR COMPLIANCE WITH REQUIREMENTS.—Not later than 24 months after the date on which standards are adopted under subsections (a) and (b) with respect to any type of information transaction or data element of medicare information or with respect to security, a health plan shall comply with the requirements of this section with respect to such transaction or data element.

"(4) COMPLIANCE WITH MODIFIED STANDARDS.—If the Secretary adopts a modified standard under subsection (a) or (b), a health plan shall be required to comply with the modified standard at such time as the Secretary determines appropriate taking into account the time needed to comply due to the nature and extent of the modification. However, the time determined appropriate under the preceding sentence shall be not earlier than the last day of the 180-day period beginning on the date such modified standard is adopted. The Secretary may extend the time for compliance for small health plans, if the Secretary determines such extension is appropriate.

"(e) GENERAL PENALTY FOR FAILURE TO COMPLY WITH REQUIREMENTS AND STANDARDS.—

"(1) GENERAL PENALTY.—

"(A) IN GENERAL.—Except as provided in paragraph (2), the Secretary shall impose on any person that violates a requirement or standard—

"(i) with respect to medicare information transactions, data elements of medicare information, or security imposed under subsection (a) or (b); or

"(ii) with respect to health plans imposed under subsection (d);

a penalty of not more than \$100 for each such violation of a specific standard or requirement, but the total amount imposed for all such violations of a specific standard or requirement during the calendar year shall not exceed \$25,000.

"(B) PROCEDURES.—The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to the imposition of a civil money penalty under this paragraph in the same manner as such provisions apply to the imposition of a penalty under such section 1128A.

"(C) DENIAL OF PAYMENT.—Except as provided in paragraph (2), the Secretary may deny payment under this title for an item or service furnished by a person if the person fails to comply with an applicable requirement or

standard for medicare information relating to that item or service.

"(2) LIMITATIONS.—

"(A) NONCOMPLIANCE NOT DISCOVERED.—A penalty may not be imposed under paragraph (1) if it is established to the satisfaction of the Secretary that the person liable for the penalty did not know, and by exercising reasonable diligence would not have known, that such person failed to comply with the requirement or standard described in paragraph (1).

"(B) FAILURES DUE TO REASONABLE CAUSE.—

"(i) IN GENERAL.—Except as provided in clause (ii), a penalty may not be imposed under paragraph (1) if—

"(I) the failure to comply was due to reasonable cause and not to willful neglect; and

"(II) the failure to comply is corrected during the 30-day period beginning on the first date the person liable for the penalty knew, or by exercising reasonable diligence would have known, that the failure to comply occurred.

"(ii) EXTENSION OF PERIOD.—

"(I) NO PENALTY.—The period referred to in clause (i)(II) may be extended as determined appropriate by the Secretary based on the nature and extent of the failure to comply.

"(II) ASSISTANCE.—If the Secretary determines that a health plan failed to comply because such plan was unable to comply, the Secretary may provide technical assistance to such plan during the period described in clause (i)(II). Such assistance shall be provided in any manner determined appropriate by the Secretary.

"(C) REDUCTION.—In the case of a failure to comply which is due to reasonable cause and not to willful neglect, any penalty under paragraph (1) that is not entirely waived under subparagraph (B) may be waived to the extent that the payment of such penalty would be excessive relative to the compliance failure involved.

"(f) EFFECT ON STATE LAW.—

"(1) GENERAL EFFECT.—

"(A) GENERAL RULE.—Except as provided in subparagraph (B), a provision, requirement, or standard under this section shall supersede any contrary provision of State law, including a provision of State law that requires medical or health plan records (including billing information) to be maintained or transmitted in written rather than electronic form.

"(B) EXCEPTIONS.—A provision, requirement, or standard under this section shall not supersede a contrary provision of State law, if the provision of State law—

"(i) provides requirements or standards that are more stringent than the requirements or standards under this section with respect to the privacy of individually identifiable medicare information; or

"(ii) is a provision the Secretary determines is necessary to prevent fraud and abuse with respect to controlled substances, or for other purposes.

"(2) PUBLIC HEALTH REPORTING.—Nothing in this section shall be construed to invalidate or limit the authority, power, or procedures established under any law providing for the reporting of disease or injury, child abuse, birth, or death, public health surveillance, or public health investigation or intervention.

"(g) MEDICARE INFORMATION ADVISORY COMMITTEE.—

"(1) **ESTABLISHMENT.**—There is established a committee to be known as the Medicare Information Advisory Committee (in this subsection referred to as the 'committee').

"(2) **DUTIES.**—The committee shall—

"(A) advise the Secretary in the development of standards under this section; and

"(B) be generally responsible for advising the Secretary and the Congress on the status and the future of the medicare information network.

"(3) **MEMBERSHIP.**—

"(A) **IN GENERAL.**—The committee shall consist of 9 members of whom—

"(i) 3 shall be appointed by the President;

"(ii) 3 shall be appointed by the Speaker of the House of Representatives after consultation with the minority leader of the House of Representatives; and

"(iii) 3 shall be appointed by the President pro tempore of the Senate after consultation with the minority leader of the Senate.

The appointments of the members shall be made not later than 60 days after the date of the enactment of this section. The President shall designate 1 member as the Chair.

"(B) **EXPERTISE.**—The membership of the committee shall consist of individuals who are of recognized standing and distinction in the areas of information systems, information networking and integration, consumer health, or health care financial management, and who possess the demonstrated capacity to discharge the duties imposed on the committee.

"(C) **TERMS.**—Each member of the committee shall be appointed for a term of 5 years, except that the members first appointed shall serve staggered terms such that the terms of not more than 3 members expire at one time.

"(D) **INITIAL MEETING.**—Not later than 30 days after the date on which a majority of the members have been appointed, the committee shall hold its first meeting.

"(4) **REPORTS.**—Not later than 1 year after the date of the enactment of this section, and annually thereafter, the committee shall submit to Congress and the Secretary a report regarding—

"(A) the extent to which entities using the medicare information network are meeting the standards adopted under this section and working together to form an integrated network that meets the needs of its users;

"(B) the extent to which such entities are meeting the security standards established pursuant to this section and the types of penalties assessed for noncompliance with such standards;

"(C) any problems that exist with respect to implementation of the medicare information network; and

"(D) the extent to which timetables under this section are being met.

Reports made under this subsection shall be made available to health care providers, health plans, and other entities that use the medicare information network to exchange medicare information.

"(h) **DEFINITIONS.**—For purposes of this section:

"(1) **CODE SET.**—The term 'code set' means any set of codes used for encoding data elements, such as tables of terms, enrollment information, and encounter data.

"(2) **COORDINATION OF BENEFITS.**—The term 'coordination of benefits' means determining and coordinating the financial obligations of health plans when health care benefits are payable under such a plan and under this title (including under a MedicarePlus product).

"(3) **MEDICARE INFORMATION.**—The term 'medicare information' means any information that relates to the enrollment of individuals under this title (including information relating to elections of MedicarePlus products under section 1805) and the provision of health benefits (including benefits provided under such products) under this title.

"(4) **MEDICARE INFORMATION NETWORK.**—The term 'medicare information network' means the medicare information system that is formed through the application of the requirements and standards established under this section.

"(5) **MEDICARE INFORMATION NETWORK SERVICE.**—The term 'medicare information network service' means a public or private entity that—

"(A) processes or facilitates the processing of non-standard data elements of medicare information into standard data elements;

"(B) provides the means by which persons may meet the requirements of this section; or

"(C) provides specific information processing services.

"(6) **HEALTH PLAN.**—The term 'health plan' means a plan which provides, or pays the cost of, health benefits. Such term includes the following, or any combination thereof:

"(A) Part A or part B of this title, and includes a MedicarePlus product.

"(B) The medicaid program under title XIX and the MediGrant program under title XXI.

"(C) A medicare supplemental policy (as defined in section 1882(g)(1)).

"(D) Worker's compensation or similar insurance.

"(E) Automobile or automobile medical-payment insurance.

"(F) A long-term care policy, other than a fixed indemnity policy.

"(G) The Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code.

"(H) An employee welfare benefit plan, as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(1)), but only to the extent the plan is established or maintained for the purpose of providing health benefits.

"(7) **INDIVIDUALLY IDENTIFIABLE MEDICARE INFORMATION.**—The term 'individually identifiable medicare information' means medicare enrollment information, including demographic information collected from an individual, that—

"(A) is created or received by a health care provider, health plan, employer, or medicare information network service, and

"(B) identifies an individual.

"(8) **STANDARD SETTING ORGANIZATION.**—The term 'standard setting organization' means a standard setting organization accredited by the American National Standards Institute.

"(9) **STANDARD TRANSACTION.**—The term 'standard transaction' means, when referring to an information transaction or to data elements of medicare information, any transaction that meets the requirements and implementation specifications adopted by the Secretary under subsections (a) and (b)."

PART 5—OTHER PROVISIONS RELATING TO PARTS A AND B

SEC. 16741. CLARIFICATION OF MEDICARE COVERAGE OF ITEMS AND SERVICES ASSOCIATED WITH CERTAIN MEDICAL DEVICES APPROVED FOR INVESTIGATIONAL USE.

(a) **COVERAGE.**—Nothing in title XVIII of the Social Security Act may be construed to prohibit coverage under part A or part B of the medicare program of items and services associated with the

use of a medical device in the furnishing of inpatient or outpatient hospital services (including outpatient diagnostic imaging services) for which payment may be made under the program solely on the grounds that the device is not an approved device, if—

- (1) the device is an investigational device; and
- (2) the device is used instead of either an approved device or a covered procedure.

(b) **CLARIFICATION OF PAYMENT AMOUNT.**—Notwithstanding any other provision of title XVIII of the Social Security Act, the amount of payment made under the medicare program for any item or service associated with the use of an investigational device in the furnishing of inpatient or outpatient hospital services (including outpatient diagnostic imaging services) for which payment may be made under the program may not exceed the amount of the payment which would have been made under the program for the item or service if the item or service were associated with the use of an approved device or a covered procedure.

(c) **DEFINITIONS.**—In this section—

(1) the term “approved device” means a medical device (or devices) which has been approved for marketing under pre-market approval under the Federal Food, Drug, and Cosmetic Act or cleared for marketing under a 510(k) notice under such Act; and

(2) the term “investigational device” means—

(A) a medical device or devices (other than a device described in paragraph (1)) approved for investigational use under section 520(g) of the Federal Food, Drug, and Cosmetic Act, or

(B) an investigational combination product under section 503(g) of the Federal Food, Drug, and Cosmetic Act which includes a device (or devices) authorized for use under section 505(i) of such Act.

SEC. 15742. ADDITIONAL EXCLUSION FROM COVERAGE.

(a) **IN GENERAL.**—Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 15525(a)(2) and section 15701(c)(2)(C), is amended—

- (1) by striking “or” at the end of paragraph (16),
- (2) by striking the period at the end of paragraph (17) and inserting “; or”, and
- (3) by inserting after paragraph (17) the following new paragraph:

“(18) where such expenses are for items or services, or to assist in the purchase, in whole or in part, of health benefit coverage that includes items or services, for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.”

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply to payment for items and services furnished on or after the date of the enactment of this Act.

Subtitle I—Clinical Laboratories

SEC. 15801. EXEMPTION OF PHYSICIAN OFFICE LABORATORIES.

Section 353(d) of the Public Health Service Act (42 U.S.C. 263a(d)) is amended—

- (1) by redesignating paragraphs (2), (3), and (4) as paragraphs (3), (4), and (5) and by adding after paragraph (1) the following:

“(4) **EXEMPTION OF PHYSICIAN OFFICE LABORATORIES.**—

“(A) **IN GENERAL.**—Except as provided in subparagraph (B), a clinical laboratory in a physician’s office (including an office of a group of physicians) which is directed by a physician and in which examinations and procedures are either performed by a physician or by individuals supervised by a physician solely as an adjunct to other serv-

ices provided by the physician's office is exempt from this section.

"(B) EXCEPTION.—A clinical laboratory described in subparagraph (A) is not exempt from this section when it performs a pap smear (Papanicolaou Smear) analysis.

"(C) DEFINITION.—For purposes of subparagraph (A), the term 'physician' has the same meaning as is prescribed for such term by section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)).";

(2) in paragraph (3) (as so redesignated) by striking "(3)" and inserting "(4)"; and

(3) in paragraphs (4) and (5) (as so redesignated) by striking "(2)" and inserting "(3)".

"ADVISORY OPINIONS

"SEC. 1130. (a) ISSUANCE OF ADVISORY OPINIONS.—The Secretary shall issue written advisory opinions as provided in this section.

"(b) MATTERS SUBJECT TO ADVISORY OPINIONS.—The Secretary shall issue advisory opinions as to the following matters:

"(1) What constitutes prohibited remuneration within the meaning of section 1128B(b).

"(2) Whether an arrangement or proposed arrangement satisfies the criteria set forth in section 1128B(b)(3) for activities which do not result in prohibited remuneration.

"(3) Whether an arrangement or proposed arrangement satisfies the criteria which the Secretary has established, or shall establish by regulation for activities which do not result in prohibited remuneration.

"(4) What constitutes an inducement to reduce or limit services to individuals entitled to benefits under title XVIII or title XIX within the meaning of section 1128B(b).

"(5) Whether any activity or proposed activity constitutes grounds for the imposition of a sanction under section 1128, 1128A, or 1128B.

"(c) MATTERS NOT SUBJECT TO ADVISORY OPINIONS.—Such advisory opinions shall not address the following matters:

"(1) Whether the fair market value shall be, or was paid or received for any goods, services or property.

"(2) Whether an individual is a bona fide employee within the requirements of section 3121(d)(2) of the Internal Revenue Code of 1986.

"(d) EFFECT OF ADVISORY OPINIONS.—

"(1) BINDING AS TO SECRETARY AND PARTIES INVOLVED.—Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion.

"(2) FAILURE TO SEEK OPINION.—The failure of a party to seek an advisory opinion may not be introduced into evidence to prove that the party intended to violate the provisions of sections 1128, 1128A, or 1128B.

"(e) REGULATIONS.—

"(1) IN GENERAL.—Not later than 180 days after the date of the enactment of this section, the Secretary shall issue regulations to carry out this section. Such regulations shall provide for—

"(A) the procedure to be followed by a party applying for an advisory opinion;

"(B) the procedure to be followed by the Secretary in responding to a request for an advisory opinion;

"(C) the interval in which the Secretary shall respond;

"(D) the reasonable fee to be charged to the party requesting an advisory opinion; and

"(E) the manner in which advisory opinions will be made available to the public.

"(2) SPECIFIC CONTENTS.—Under the regulations promulgated pursuant to paragraph (1)—

"(A) the Secretary shall be required to respond to a party requesting an advisory opinion by not later than 30 days after the request is made; and

"(B) the fee charged to the party requesting an advisory opinion shall be equal to the costs incurred by the Secretary in responding to the request."

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to requests for advisory opinions made on or after January 1, 1996.