LEGISLATIVE HISTORY
TITLES I-XX
OF THE
SOCIAL SECURITY ACT

Volume XXIV
101st Congress
1989-1990

Part 1

Legislative History of Titles I-XX of the Social Security Act

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Technical Documents Branch
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PREFACE

This legislative history has been prepared to provide a convenient reference source for studies of the development of the provisions of the Social Security Act as amended by the 101st Congress.

The legislative history began with the Social Security Act, as enacted on August 14, 1935, and pertained only to the benefit programs (titles II, XVI, and XVIII) administered by the Social Security Administration. Beginning with the legislative history of the 95th Congress, the history has been expanded to include the 20 titles of the Social Security Act.

This legislative history includes:

- Every enactment of the 101st Congress amending the Social Security Act.
- Relevant Committee Reports of the House of Representatives and the Senate relating to the Social Security Act together with the Conference Reports.

Excerpts were substituted for the full text where pertinent.

In some instances a report accompanying a public law will not reflect a particular amendment to the Social Security Act because the amendment was added to the bill on the floor of the House or Senate after issuance of the report, or the subject matter involved was not included in the report of the committee proceedings. In these cases, background material relating to the amendment may be found in the Congressional Record report of the House or Senate debate on the bill. The Congressional Record may also provide a useful supplemental reference source even in those cases in which the House or Senate report discusses the particular provision in which the researcher is interested. It is not feasible to reproduce in this legislative history the thousands of pages of the Congressional Record carrying the House and Senate debates with respect to the public laws included in this history. However, the volume number of the Congressional Record and the listing of the dates on which the public law was considered in the House and Senate appear on the last page of each public law.

Finder's Aid

P.L. 101-45 (103 Stat. 97) Approved June 30, 1989
Dire Emergency Supplemental Appropriations and Transfers,
Urgent Supplementals, and Correcting Enrollment Errors of 1989

Subject	S.S. Act Section	P.L. Section	103 Stat.
National Commission on Children	1139(f)	409	130

Public Law 101-45
101st Congress

An Act

Making supplemental appropriations for the Department of Veterans Affairs for the fiscal year ending September 30, 1989, and for other purposes.

June 30, 1989
[H.R. 2402]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the following sums are hereby appropriated, out of any money in the Treasury not otherwise appropriated, to provide supplemental appropriations for the Department of Veterans Affairs for the fiscal year ending September 30, 1989, and for other purposes, namely:

Dire Emergency Supplemental Appropriations and Transfers, Urgent Supplementals, and Correcting Enrollment Errors Act of 1989.

DEPARTMENT OF VETERANS AFFAIRS

Veterans Benefits Administration

COMPENSATION AND PENSIONS

For an additional amount for "Compensation and pensions", $701,481,000, to remain available until expended.

READJUSTMENT BENEFITS

For an additional amount for "Readjustment benefits", $22,212,000, to remain available until expended.

LOAN GUARANTY REVOLVING FUND

For an additional amount for "Loan Guaranty Revolving Fund", $120,100,000, to remain available until expended.

Veterans Health Service and Research Administration

MEDICAL CARE

For an additional amount for "Medical care", $340,125,000: *Provided,* That of the sums appropriated under this heading in fiscal year 1989, not less than $6,800,000,000 shall be available only for expenses in the personnel compensation and benefits object classifications.

HEALTH CARE FINANCING ADMINISTRATION

PROGRAM MANAGEMENT

Funds appropriated by the Department of Health and Human Services Appropriations Act, 1989, to implement section 4005(e) of the Omnibus Budget Reconciliation Act of 1987, Public Law 100-203, may not be used to provide forward or multiyear funding.

SOCIAL SECURITY ADMINISTRATION

LIMITATION ON ADMINISTRATIVE EXPENSES

The last proviso under this heading in Public Law 100-436, related to automatic data processing and telecommunications expenditures, is deleted. 102 Stat. 1695.

ASSISTANT SECRETARY FOR HUMAN DEVELOPMENT SERVICES

PAYMENTS TO STATES FOR FOSTER CARE AND ADOPTION ASSISTANCE

For an additional amount for "Payments to States for Foster Care and Adoption Assistance", $423,345,000 for title IV-E of the Social Security Act, which shall be available for prior years' claims.

DEPARTMENT OF EDUCATION

IMPACT AID

Section 5(e)(1)(D) of the Act of September 30, 1950, as amended (20 U.S.C. ch. 13), shall not apply to any local educational agency that was an agency described in section 5(c)(2)(A)(ii) of the Act in fiscal year 1987 but is an agency described in section 5(c)(2)(A)(iii) of the Act in fiscal year 1989 as a result of families being moved off-base in order to renovate base housing: *Provided*, That any school district which received a payment under section 5(b)(2) of the Act for fiscal year 1986 but which the Department of Education has determined to be ineligible for section 2 assistance due to a review of the original assessed value of the real property involved at the time of acquisition of the Federal property shall be deemed eligible for payments under section 2, for fiscal year 1989 only.

REHABILITATION SERVICES AND HANDICAPPED RESEARCH

Appropriations under the heading "Rehabilitation Services and Handicapped Research" shall be considered as funds mandated by law for purposes of applying section 517 of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 1989.

GUARANTEED STUDENT LOANS

For payment of obligations under this heading incurred during fiscal year 1989, $892,428,000.

(1) coordinating United States diplomatic efforts to obtain the agreement of all appropriate countries to a missile technology control regime encompassing chemical, biological, and nuclear capable missiles; and

(2) coordinating policies within the United States Government on strategies for restricting the export to foreign countries of components of missiles which are capable of carrying nuclear, chemical, or biological weapons.

(b) REPORT REQUESTED.—The Secretary of State shall submit within ninety days of the date of enactment of this Act to the Speaker of the House of Representatives and the President pro tempore of the Senate a report setting forth the Administration strategy for dealing with the missile proliferation issue, and specifying the steps taken to ensure that adequate resources will be allocated for that purpose.

(c) CONTENTS OF REPORT.—The report required in subsection (b) shall contain, but is not limited to—

(1) a discussion of efforts that can be made to strengthen the Missile Technology Control Regime to restrict the flow of Western missile hardware and knowhow;

(2) a discussion of ways to strengthen international arrangements, including the formation of a new international organization, to monitor missile-related exports and compliance with missile nonproliferation efforts; and

(3) a discussion of how incentives and threats of sanctions can be used to win the cooperation of more nations in controlling missile proliferation.

SEC. 408. TEMPORARY SUSPENSION OF RIGHT TO REPURCHASE STINGER MISSILES.—Notwithstanding section 573(b)(4) of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988, and section 566(b)(4) of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1989, the United States hereby suspends its obligation to repurchase STINGER antiaircraft missiles from Bahrain until October 31, 1989.

SEC. 409. EXEMPTION PROVIDED FOR NATIONAL COMMISSION ON CHILDREN FROM CERTAIN PROVISIONS OF TITLE 5.—Section 1139 of the Social Security Act (42 U.S.C. 1320b-9) is amended by striking subsection (f) and inserting in lieu thereof the following new subsection:

"(f)(1) The Commission shall appoint an Executive Director of the Commission. In addition to the Executive Director, the Commission may appoint and fix the compensation of such personnel as it deems advisable. Such appointments and compensation may be made without regard to the provisions of title 5, United States Code, that govern appointments in the competitive services, and the provisions of chapter 51 and subchapter III of chapter 53 of such title that relate to classifications and the General Schedule pay rates.

"(2) The Commission may procure such temporary and intermittent services of consultants under section 3109(b) of title 5, United States Code, as the Commission determines to be necessary to carry out the duties of the Commission.".

Aircraft and air carriers.

SEC. 410. It is the sense of the Senate that the Secretary of Transportation should conduct a review of the potential impact of highly leveraged acquisitions of control of United States air carriers. The potential impacts to be addressed in such review should include the effects of increased expenses associated with increased debt on carriers' ability to—

(i) modernize their fleets;
(ii) make necessary expenditures for maintenance;
(iii) survive economic downturns (and the effect on competition among air carriers if some do not survive);
(iv) provide small community services;
(v) compete internationally against foreign airlines; and
(vi) make and/or keep the financial commitments to airport projects necessary to expand capacity and improve safety, and meet the future needs of their employees with regard to such matters as salaries, benefits, pensions, and job security and growth.

Pursuant to the conclusions of such review, the Secretary should make a report to the Congress and include in such report an assessment with respect to any major air carrier that is the object of a highly leveraged buy-out. Reports.

SEC. 411. The Secretary of Agriculture may use his section 32 authority in appropriate instances to stabilize the apple market and to satisfy the request of recipient agencies.

This Act may be cited as the "Dire Emergency Supplemental Appropriations and Transfers, Urgent Supplementals, and Correcting Enrollment Errors Act of 1989".

Approved June 30, 1989.

LEGISLATIVE HISTORY—H.R. 2402:

CONGRESSIONAL RECORD, Vol. 135 (1989):
May 18, considered and passed House; considered and passed Senate, amended.
May 24, House disagreed to Senate amendment.
June 22, Senate receded; reconsidered and passed Senate, amended.
June 23, House concurred in Senate amendments.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 25 (1989):
June 30, Presidential statement.

Finder's Aid

P.L. 101-140 (103 Stat. 830) Approved November 8, 1989

"Public Debt Limit Increase"

Subject	S.S. Act Section	P.L. Section	103 Stat.
Definition of Wages	209(end)(2)	203(a)(2)	830
Definition of Wages	209(end)(3) Stricken	203(a)(2)	830

PUBLIC DEBT LIMIT INCREASE

Public Law 101-140
101st Congress

Joint Resolution

Nov. 8, 1989
[H.J. Res. 280]

Increasing the statutory limit on the public debt.

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That subsection (b) of section 3101 of title 31, United States Code, is amended by striking out the dollar limitation contained in such subsection, and inserting in lieu thereof "$3,122,700,000,000"

TITLE II—REPEAL OF SECTION 89 NONDISCRIMINATION RULES

SEC. 201. AMENDMENT OF 1986 CODE.

Whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

SEC. 202. REPEAL OF SECTION 89.

(a) IN GENERAL.—Section 89 (relating to benefits provided under certain discriminatory employee benefit plans) is hereby repealed.

(b) CLERICAL AMENDMENT.—The table of sections for part II of subchapter B of chapter 1 is amended by striking the item relating to section 89.

26 USC 89 note.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in section 1151 of the Tax Reform Act of 1986.

SEC. 203. REINSTATEMENT OF PRE-1986 ACT NONDISCRIMINATION RULES.

(a) IN GENERAL.—

26 USC 6652, 79, 105, 120, 127, 129, 125, 117, 132, 505.

(1) Each provision of law amended by subsection (b), (c), (d)(1), or (g) of section 1151 of the Tax Reform Act of 1986 is amended to read as if the amendments made by such subsection had not been enacted.

26 USC 3121, 3231, 3306, 3401, 4976, 505, 129, 117, 120, 127, 132; 42 USC 409.

(2) Each provision of law amended by paragraph (22), (27), or (31) of section 1011B(a) of the Technical and Miscellaneous Revenue Act of 1988 is amended to read as if the amendments made by such paragraph had not been enacted.

(3) Subparagraph (A) of section 125(g)(3) (as in effect on the day before the date of the enactment of the Tax Reform Act of 1986) is amended by striking "subparagraph (B) of section 410(b)(1)" and inserting "section 410(b)(2)(A)(i)".

(4) Section 162(l)(2) is amended by striking subparagraph (B) and redesignating subparagraph (C) as subparagraph (B).

(5) Subparagraph (C) of section 401(a)(9) is amended—

(A) by striking "(as defined in section 89(i)(4))", and

(B) by adding at the end the following: "For purposes of this subparagraph, the term 'church plan' means a plan

of public money, money otherwise required to be deposited in the Treasury, or amounts appropriated; except that such term shall not include the Civil Service Retirement and Disability Fund or the Thrift Savings Fund of the Federal Employees' Retirement System.

Approved November 8, 1989.

LEGISLATIVE HISTORY—H.J. Res. 280:

CONGRESSIONAL RECORD, Vol. 135 (1989):
May 17, considered and passed House pursuant to H. Con. Res. 106.
Nov. 7, considered and passed Senate, amended. House concurred in Senate amendment.

○

Finder's Aid

P.L. 101-166 (103 Stat. 1159) Approved November 21, 1989
Departments of Labor, Health, and Human Services,
and Education, and Related Agencies Appropriations Act, 1990

Note: There are no amendments to the Social Security Act contained in this Public Law. The provisions included here deal with appropriations for programs administered under the Social Security Act.

Public Law 101-166
101st Congress

An Act

Making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies, for the fiscal year ending September 30, 1990, and for other purposes.

Nov. 21, 1989
[H.R. 3566]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the following sums are appropriated, out of any money in the Treasury not otherwise appropriated, for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 1990, and for other purposes, namely:

Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 1990.
Department of Labor Appropriations Act, 1990.

TITLE I—DEPARTMENT OF LABOR

Employment and Training Administration

PROGRAM ADMINISTRATION

For expenses of administering employment and training programs, $64,693,000 together with not to exceed $53,817,000 which may be expended from the Employment Security Administration account in the Unemployment Trust Fund.

TRAINING AND EMPLOYMENT SERVICES

For expenses necessary to carry into effect the Job Training Partnership Act, including the purchase and hire of passenger motor vehicles, the construction, alteration, and repair of buildings and other facilities, and the purchase of real property for training centers as authorized by the Job Training Partnership Act, $3,907,746,000, plus reimbursements, to be available for obligation for the period July 1, 1990, through June 30, 1991, of which $58,996,000 shall be for carrying out section 401, $70,000,000 shall be for carrying out section 402, $9,474,000 shall be for carrying out section 441, $2,000,000 shall be for the National Commission for Employment Policy, $4,100,000 shall be for all activities conducted by and through the National Occupational Information Coordinating Committee under the Job Training Partnership Act, and $5,150,000 shall be for service delivery areas under section 101(a)(4)(A)(iii) of the Job Training Partnership Act in addition to amounts otherwise provided under sections 202 and 251(b) of the Act; and, in addition, $50,432,000 is appropriated for the Job Corps, in addition to amounts otherwise provided herein for the Job Corps, to be available for obligation for the period July 1, 1990 through June 30, 1993; and, in addition, $13,000,000, of which $1,500,000 shall be available for obligation for the period October 1, 1990 through September 30, 1991, is appropriated for activities authorized by title VII, subtitle C of the Stewart B. McKinney Homeless Assistance Act: *Provided,* That no funds from any other appropriation shall be used to provide meal services at or for Job Corps centers.

For Job Corps program operations authorized by the Job Training Partnership Act, $13,492,000, in addition to amounts otherwise provided herein for these purposes, to be available for obligation for the period July 1, 1989, through June 30, 1990.

COMMUNITY SERVICE EMPLOYMENT FOR OLDER AMERICANS

To carry out the activities for national grants or contracts with public agencies and public or private nonprofit organizations under paragraph (1)(A) of section 506(a) of title V of the Older Americans Act of 1965, as amended, $282,360,000.

To carry out the activities for grants to States under paragraph (3) of section 506(a) of title V of the Older Americans Act of 1965, as amended, $79,640,000.

FEDERAL UNEMPLOYMENT BENEFITS AND ALLOWANCES

For payments during the current fiscal year of benefits and payments as authorized by title II of Public Law 95-250, as amended, and of trade adjustment benefit payments and allowances under part I, and for training, for allowances for job search and relocation, and for related administrative expenses under part II, subchapter B, chapter 2, title II of the Trade Act of 1974, as amended, $284,000,000, together with such amounts as may be necessary to be charged to the subsequent appropriation for payments for any period subsequent to September 15 of the current year: *Provided,* That amounts received or recovered pursuant to section 208(e) of Public Law 95-250 shall be available for payments.

STATE UNEMPLOYMENT INSURANCE AND EMPLOYMENT SERVICE OPERATIONS

For activities authorized by the Act of June 6, 1933, as amended (29 U.S.C. 49-49l-1; 39 U.S.C. 3202(a)(1)(E)); title III of the Social Security Act, as amended (42 U.S.C. 502-504); necessary administrative expenses for carrying out 5 U.S.C. 8501-8523, and sections 225, 231-235 and 243-244, title II of the Trade Act of 1974, as amended; as authorized by section 7c of the Act of June 6, 1933, as amended, necessary administrative expenses under sections 101(a)(15)(H)(ii), 212(a)(14), and 216(g) (1), (2), and (3) of the Immigration and Nationality Act, as amended (8 U.S.C. 1101 et seq.); and necessary administrative expenses to carry out the Targeted Jobs Tax Credit Program under section 51 of the Internal Revenue Code of 1986, $22,000,000 together with not to exceed $2,575,200,000 (including not to exceed $3,000,000 which may be used for amortization payments to States which had independent retirement plans in their State employment service agencies prior to 1980), which may be expended from the Employment Security Administration account in the Unemployment Trust Fund, and of which the sums available in the basic allocation for activities authorized by title III of the Social Security Act, as amended (42 U.S.C. 502-504), and the sums available in the basic allocation for necessary administrative expenses for carrying out 5 U.S.C. 8501-8523, shall be available for obligation by the States through December 31, 1990, and of which $19,148,000 of the amount which may be expended from said trust fund shall be available for obligation for the period April 1, 1990, through December 31, 1990, for automation of the State activities under title III of

the Social Security Act, as amended (42 U.S.C. 502-504 and 5 U.S.C. 8501-8523), and of which $20,800,000 together with not to exceed $768,900,000 of the amount which may be expended from said trust fund shall be available for obligation for the period July 1, 1990, through June 30, 1991, to fund activities under section 6 of the Act of June 6, 1933, as amended, including the cost of penalty mail made available to States in lieu of allotments for such purpose, and of which $12,500,000 of the amount which may be expended from said trust fund shall be available for obligation for the period October 1, 1990, through June 30, 1991, for automation of the State activities under section 6 of the Act of June 6, 1933, as amended, and of which $193,468,000 shall be available only to the extent necessary to administer unemployment compensation laws to meet increased costs of administration resulting from changes in a State law or increases in the number of unemployment insurance claims filed and claims paid or increased salary costs resulting from changes in State salary compensation plans embracing employees of the State generally over those upon which the State's basic allocation was based, which cannot be provided for by normal budgetary adjustments based on State obligations as of December 31, 1990.

ADVANCES TO THE UNEMPLOYMENT TRUST FUND AND OTHER FUNDS

For repayable advances to the Unemployment Trust Fund as authorized by sections 905(d) and 1203 of the Social Security Act, as amended, and to the Black Lung Disability Trust Fund as authorized by section 9501(c)(1) of the Internal Revenue Code of 1954, as amended; and for nonrepayable advances to the Unemployment Trust Fund as authorized by section 8509 of title 5, United States Code, and to the "Federal unemployment benefits and allowances" account, to remain available until September 30, 1991, $33,000,000.

Labor-Management Services

SALARIES AND EXPENSES

For necessary expenses for Labor-Management Services, $75,207,000, of which $6,400,000 for a pension plan data base shall remain available until September 30, 1991: *Provided,* That of the amount appropriated by Public Law 100-202 for a pension plan data base, up to $1,500,000 of unobligated balances as of September 30, 1989 shall remain available for such pension plan data base until September 30, 1990.

Pension Benefit Guaranty Corporation

PENSION BENEFIT GUARANTY CORPORATION FUND

The Pension Benefit Guaranty Corporation is authorized to make such expenditures, including financial assistance authorized by section 104 of Public Law 96-364, within limits of funds and borrowing authority available to such Corporation, and in accord with law, and to make such contracts and commitments without regard to fiscal year limitations as provided by section 104 of the Government Corporation Control Act, as amended (31 U.S.C. 9104), as may be necessary in carrying out the program through September 30, 1990, for such Corporation: *Provided,* That not to exceed $42,301,000 shall be available for administrative expenses of the Corporation: *Pro-*

Department of Health and Human Services Appropriations Act, 1990.

TITLE II—DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

HEALTH RESOURCES AND SERVICES

PROGRAM OPERATIONS

For carrying out titles III, VII, VIII, X, XXIV, XVI, and XXVI of the Public Health Service Act, section 427(a) of the Federal Coal Mine Health and Safety Act, title V of the Social Security Act, and the Health Care Quality Improvement Act of 1986, as amended, $1,782,271,000, of which $11,885,000 for health care for the homeless shall be available for obligation for the quarter beginning October 1, 1990, and ending December 31, 1990, of which $889,000, to remain available until expended, shall be available for renovating the Gillis W. Long Hansen's Disease Center, 42 U.S.C. 247e, of which $494,000 shall remain available until expended for interest subsidies on loan guarantees made prior to fiscal year 1981 under part B of title VII of the Public Health Service Act and of which $4,400,000 shall be made available until expended to make grants under section 1610(b) of the Public Health Service Act for renovation or construction of non-acute care intermediate and long-term care facilities for AIDS patients: *Provided,* That notwithstanding section 838 of the Public Health Service Act, not to exceed $10,000,000 of funds returned to the Secretary pursuant to section 839(c) of the Public Health Service Act or pursuant to a loan agreement under section 740 or 835 of the Act may be used for activities under titles III, VII, and VIII of the Act: *Provided further,* That when the Department of Health and Human Services administers or operates an employee health program for any Federal department or agency, payment for the full estimated cost shall be made by way of reimbursement or in advances to this appropriation: *Provided further,* That of this amount, $30,000,000 is available until expended for grants to States for Human Immunodeficiency Virus drug reimbursement, pursuant to section 319 of the Public Health Service Act: *Provided further,* That user fees authorized by 31 U.S.C. 9701 may be credited to appropriations under this heading, notwithstanding 31 U.S.C. 3302.

MEDICAL FACILITIES GUARANTEE AND LOAN FUND

FEDERAL INTEREST SUBSIDIES FOR MEDICAL FACILITIES

For carrying out subsections (d) and (e) of section 1602 of the Public Health Service Act, $21,000,000, together with any amounts received by the Secretary in connection with loans and loan guarantees under title VI of the Public Health Service Act, to be available without fiscal year limitation for the payment of interest subsidies. During the fiscal year, no commitments for direct loans or loan guarantees shall be made.

HEALTH PROFESSIONS GRADUATE STUDENT LOAN FUND

For carrying out title VII of the Public Health Service Act, $25,000,000, to remain available until expended, for payments on defaulted loans for the Health Education Assistance Loan program.

herein, up to $14,681,000 shall be available from amounts available under section 2611 of the Public Health Service Act, to carry out the National Medical Expenditure Survey and the Hospital Studies Program.

RETIREMENT PAY AND MEDICAL BENEFITS FOR COMMISSIONED OFFICERS

For retirement pay and medical benefits of Public Health Service Commissioned Officers as authorized by law, and for payments under the Retired Serviceman's Family Protection Plan and Survivor Benefit Plan and for medical care of dependents and retired personnel under the Department's Medical Care Act (10 U.S.C. ch.55), and for payments pursuant to section 229(b) of the Social Security Act (42 U.S.C. 429(b)), such amounts as may be required during the current fiscal year.

MEDICAL TREATMENT EFFECTIVENESS

For expenses necessary for the Public Health Service to support medical effectiveness research, $27,000,000, together with not to exceed $5,000,000 to be transferred and expended as authorized by title VIII, subsection E, section 8413 of the Technical and Miscellaneous Revenue Act of 1988 from the Federal Hospital Insurance and Supplementary Medical Insurance Trust Funds referred to therein.

HEALTH CARE FINANCING ADMINISTRATION

GRANTS TO STATES FOR MEDICAID

For carrying out, except as otherwise provided, titles XI and XIX of the Social Security Act, $30,136,654,000, to remain available until expended.

For making, after May 31, 1990, payments to States under title XIX of the Social Security Act for the last quarter of fiscal year 1990 for unanticipated costs, incurred for the current fiscal year, such sums as may be necessary.

For making payments to States under title XIX of the Social Security Act for the first quarter of fiscal year 1991, $10,400,000,000, to remain available until expended.

Payment under title XIX may be made for any quarter with respect to a State plan or plan amendment in effect during such quarter, if submitted in or prior to such quarter and approved in that or any subsequent quarter.

PAYMENTS TO HEALTH CARE TRUST FUNDS

For payment to the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds, as provided under sections 217(g) and 1844 of the Social Security Act, sections 103(c) and 111(d) of the Social Security Amendments of 1965, and section 278(d) of Public Law 97-248, $36,338,500,000.

PROGRAM MANAGEMENT

For carrying out, except as otherwise provided, titles XI, XVIII, and XIX of the Social Security Act, title XIII of the Public Health Service Act, the Clinical Laboratories Improvement Act of 1988, and section 4005(e) of Public Law 100-203, $101,908,000 together with not

to exceed $1,917,172,000 to be transferred to this appropriation as authorized by section 201(g) of the Social Security Act, from the Federal Hospital Insurance, the Federal Supplementary Medical Insurance, the Federal Catastrophic Drug Insurance, and the Federal Hospital Insurance Catastrophic Coverage Reserve Trust Funds: *Provided,* That $100,000,000 of said trust funds shall be expended only to the extent necessary to meet unanticipated costs of agencies or organizations with which agreements have been made to participate in the administration of title XVIII and after maximum absorption of such costs within the remainder of the existing limitation has been achieved: *Provided further,* That all funds derived in accordance with 31 U.S.C. 9701 are to be credited to this appropriation.

HEALTH MAINTENANCE ORGANIZATION LOAN AND LOAN GUARANTEE FUND

For carrying out subsections (d) and (e) of section 1308 of the Public Health Service Act, $5,000,000, together with any amounts received by the Secretary in connection with loans and loan guarantees under title XIII of the Public Health Service Act, to be available without fiscal year limitation for the payment of prepayment premiums and interest subsidies. During the fiscal year, no commitments for direct loans or loan guarantees shall be made.

Social Security Administration

PAYMENTS TO SOCIAL SECURITY TRUST FUNDS

For payment to the Federal Old-Age and Survivors Insurance and the Federal Disability Insurance Trust Funds, as provided under sections 201(m), 228(g), and 1131(b)(2) of the Social Security Act, $191,968,000.

SPECIAL BENEFITS FOR DISABLED COAL MINERS

For carrying out title IV of the Federal Mine Safety and Health Act of 1977, including the payment of travel expenses on an actual cost or commuted basis, to an individual, for travel incident to medical examinations, and when travel of more than 75 miles is required, to parties, their representatives, and all reasonably necessary witnesses for travel within the United States, Puerto Rico, and the Virgin Islands, to reconsideration interviews and to proceedings before administrative law judges, $648,862,000, to remain available until expended: *Provided,* That monthly benefit payments shall be paid consistent with section 215(g) of the Social Security Act.

For making, after July 31 of the current fiscal year, benefit payments to individuals under title IV of the Federal Mine Safety and Health Act of 1977, for costs incurred in the current fiscal year, such amounts as may be necessary.

For making benefit payments under title IV of the Federal Mine Safety and Health Act of 1977 for the first quarter of fiscal year 1991, $215,000,000, to remain available until expended.

SUPPLEMENTAL SECURITY INCOME PROGRAM

For carrying out the Supplemental Security Income Program, title XI of the Social Security Act, section 401 of Public Law 92-603,

section 212 of Public Law 93-66, as amended, and section 405 of Public Law 95-216, including payment to the Social Security trust funds for administrative expenses incurred pursuant to section 201(g)(1) of the Social Security Act, $9,098,758,000, to remain available until expended: *Provided,* That any portion of the funds provided to a State in the current fiscal year and not obligated by the State during that year shall be returned to the Treasury.

For making, after July 31 of the current fiscal year, benefit payments to individuals under title XVI of the Social Security Act, for unanticipated costs incurred for the current fiscal year, such sums as may be necessary.

For carrying out the Supplemental Security Income Program for the first quarter of fiscal year 1991, $3,157,000,000, to remain available until expended.

LIMITATION ON ADMINISTRATIVE EXPENSES

For necessary expenses, not more than $3,837,389,000 may be expended, as authorized by section 201(g)(1) of the Social Security Act, from any one or all of the trust funds referred to therein: *Provided,* That travel expense payments under section 1631(h) of such Act for travel to hearings may be made only when travel of more than seventy-five miles is required: *Provided further,* That $97,870,000 of the foregoing amount shall be apportioned for use only to the extent necessary to process workloads or meet other costs not anticipated in the budget estimates and to meet mandatory increases in costs of agencies or organizations with which agreements have been made to participate in the administration of titles XVI and XVIII and section 221 of the Social Security Act, and after maximum absorption of such costs within the remainder of the existing limitation has been achieved: *Provided further,* That none of the funds appropriated by this Act may be used for the manufacture, printing, or procuring of social security cards, as provided in section 205(c)(2)(D) of the Social Security Act, where paper and other materials used in the manufacture of such cards are produced, manufactured, or assembled outside of the United States.

42 USC 1383 note.

Family Support Administration

FAMILY SUPPORT PAYMENTS TO STATES

For making payments to States or other non-Federal entities, except as otherwise provided, under titles I, IV-A and -D, X, XI, XIV, and XVI of the Social Security Act, section 903 of Public Law 100-628, and the Act of July 5, 1960 (24 U.S.C. ch. 9), $9,007,946,000, to remain available until expended.

For making, after May 31 of the current fiscal year, payments to States or other non-Federal entities under titles I, IV-A and -D, X, XI, XIV, and XVI of the Social Security Act, for the last three months of the current year for unanticipated costs, incurred for the current fiscal year, such sums as may be necessary.

For making payments to States or other non-Federal entities under titles I, IV-A and -D, X, XI, XIV, and XVI of the Social Security Act, and the Act of July 5, 1960 (24 U.S.C. ch. 9) for the first quarter of fiscal year 1991, $3,000,000,000, to remain available until expended.

PAYMENTS TO STATES FOR AFDC WORK PROGRAMS

For carrying out aid to families with dependent children work programs, as authorized by part F and part C (including registration of individuals for such programs, and for related child care and other supportive services as authorized by section 402(a)(19)(G)) of title IV of the Social Security Act, $349,975,000, together with such additional amounts as may be necessary for unanticipated costs incurred for the current fiscal year for carrying out those programs: *Provided,* That the total amount appropriated under this paragraph shall not exceed the limit established in section 403(k)(3) of the Act (as added by section 201(c) of the Family Support Act of 1988): *Provided further,* That a State may not receive more than one-fourth of the amount of its fiscal year 1989 allotment under part C for each quarter in fiscal year 1990 during which part C applies to that State, and a State may not receive more than one-fourth of its annual limitation determined under section 403(k)(2) for each quarter in fiscal year 1990 during which part F applies to that State: *Provided further,* That the quarterly amounts specified in this paragraph shall be the maximum amounts to which the States may become entitled for these purposes.

LOW INCOME HOME ENERGY ASSISTANCE

For making payments under title XXVI of the Omnibus Budget Reconciliation Act of 1981, $1,393,000,000, of which $60,000,000 shall become available for making payments on September 30, 1990.

REFUGEE AND ENTRANT ASSISTANCE

For making payments for refugee and entrant assistance activities authorized by title IV of the Immigration and Nationality Act and section 501 of the Refugee Education Assistance Act of 1980 (Public Law 96-422), $368,822,000, of which $210,000,000 shall be available for State cash and medical assistance.

INTERIM ASSISTANCE TO STATES FOR LEGALIZATION

8 USC 1255a note.

Section 204(a)(1) of the Immigration Reform and Control Act of 1986 is amended—

(1) by inserting "(A)" after "IN GENERAL.—"; and

(2) by adding at the end thereof the following new subparagraphs:

"(B) Funds appropriated for fiscal year 1990 under this section are reduced by $555,244,000.

"(C) For fiscal year 1992, there are appropriated to carry out this section for costs incurred on or after October 1, 1989 (including Federal, State, and local administrative costs) out of any money in the Treasury not otherwise appropriated, $1,000,000,000 (less the amount described in paragraph (2)) less the amount made available for allotments to States under subsection (b) for fiscal year 1990.".

COMMUNITY SERVICES BLOCK GRANT

For making payments under the Community Services Block Grant Act and the Stewart B. McKinney Homeless Assistance Act, $396,680,000, of which $8,041,000 for homeless activities shall be

available for obligation for the period October 1, 1990 through September 30, 1991, of which $20,254,000 shall be for carrying out section 681(a)(2)(A), $4,013,000 shall be for carrying out section 681(a)(2)(D), $2,948,000 shall be for carrying out section 681(a)(2)(E), $9,669,000 shall be for carrying out section 681(a)(2)(F), $236,000 shall be for carrying out section 681(a)(3), $3,512,000 shall be for carrying out section 408 of Public Law 99-425, and $2,418,000 shall be for carrying out section 681A with respect to the community food and nutrition program.

PROGRAM ADMINISTRATION

For necessary administrative expenses to carry out titles I, IV, X, XI, XIV, and XVI of the Social Security Act, the Act of July 5, 1960 (24 U.S.C. ch. 9), title XXVI of the Omnibus Budget Reconciliation Act of 1981, the Community Services Block Grant Act, title IV of the Immigration and Nationality Act, section 501 of the Refugee Education Assistance Act of 1980, Public Law 100-77, Public Law 100-628, and section 126 and titles IV and V of Public Law 100-485, $86,806,000.

ASSISTANT SECRETARY FOR HUMAN DEVELOPMENT SERVICES

SOCIAL SERVICES BLOCK GRANT

For carrying out the Social Services Block Grant Act, $2,700,000,000.

HUMAN DEVELOPMENT SERVICES

For carrying out, except as otherwise provided, the Runaway and Homeless Youth Act, the Older Americans Act of 1965, the Developmental Disabilities Assistance and Bill of Rights Act, the Child Abuse Prevention and Treatment Act, section 404 of Public Law 98-473, chapters 1 and 2 of subtitle B of title III of the Anti-Drug Abuse Act of 1988, the Family Violence Prevention and Services Act (title III of Public Law 98-457), the Native American Programs Act, title II of Public Law 95-266 (adoption opportunities), title II of the Children's Justice and Assistance Act of 1986, chapter 8-D of title VI of the Omnibus Budget Reconciliation Act of 1981 (pertaining to grants to States for planning and development of dependent care programs), the Head Start Act, the Comprehensive Child Development Centers Act of 1988, the Child Development Associate Scholarship Assistance Act of 1985, the Abandoned Infants Assistance Act of 1988 and part B of title IV and section 1110 of the Social Security Act, $2,784,090,000.

PAYMENTS TO STATES FOR FOSTER CARE AND ADOPTION ASSISTANCE

For carrying out part E of title IV of the Social Security Act, $1,380,048,000, of which $50,000,000 shall be for carrying out section 477 of the Social Security Act.

DEPARTMENTAL MANAGEMENT

GENERAL DEPARTMENTAL MANAGEMENT

For necessary expenses, not otherwise provided, for general departmental management, including hire of six medium sedans, $80,577,000, of which $19,281,000 shall be available for expenses

NATIONAL COUNCIL ON DISABILITY

SALARIES AND EXPENSES

For expenses necessary for the National Council on Disability as authorized by section 405 of the Rehabilitation Act of 1973, as amended, $1,557,000.

NATIONAL LABOR RELATIONS BOARD

SALARIES AND EXPENSES

For expenses necessary for the National Labor Relations Board to carry out the functions vested in it by the Labor-Management Relations Act, 1947, as amended (29 U.S.C. 141-167), and other laws, $140,111,000: *Provided,* That no part of this appropriation shall be available to organize or assist in organizing agricultural laborers or used in connection with investigations, hearings, directives, or orders concerning bargaining units composed of agricultural laborers as referred to in section 2(3) of the Act of July 5, 1935 (29 U.S.C. 152), and as amended by the Labor-Management Relations Act, 1947, as amended, and as defined in section 3(f) of the Act of June 25, 1938 (29 U.S.C. 203), and including in said definition employees engaged in the maintenance and operation of ditches, canals, reservoirs, and waterways when maintained or operated on a mutual, nonprofit basis and at least 95 per centum of the water stored or supplied thereby is used for farming purposes.

NATIONAL MEDIATION BOARD

SALARIES AND EXPENSES

For expenses necessary to carry out the provisions of the Railway Labor Act, as amended (45 U.S.C. 151-188), including emergency boards appointed by the President, $6,384,000.

OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION

SALARIES AND EXPENSES

For the expenses necessary for the Occupational Safety and Health Review Commission (29 U.S.C. 661), $5,970,000.

PHYSICIAN PAYMENT REVIEW COMMISSION

SALARIES AND EXPENSES

For expenses necessary to carry out section 1845(a) of the Social Security Act, $3,847,000, to be transferred to this appropriation from the Federal Supplementary Medical Insurance Trust Fund.

PRESCRIPTION DRUG PAYMENT REVIEW COMMISSION

SALARIES AND EXPENSES

For expenses necessary to carry out section 1847 of the Social Security Act, $1,500,000, to be transferred to this appropriation from the Federal Catastrophic Drug Insurance Trust Fund.

PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

SALARIES AND EXPENSES

For expenses necessary to carry out section 1886(e) of the Social Security Act, $3,919,000, to be transferred to this appropriation from the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds.

RAILROAD RETIREMENT BOARD

DUAL BENEFITS PAYMENTS ACCOUNT

For payment to the Dual Benefits Payments Account, authorized under section 15(d) of the Railroad Retirement Act of 1974, $340,000,000, which shall include amounts becoming available in fiscal year 1990 pursuant to section 224(c)(1)(B) of Public Law 98-76: *Provided,* That the total amount provided herein shall be credited to the account in 12 approximately equal amounts on the first day of each month in the fiscal year.

LIMITATION ON ADMINISTRATION

For necessary expenses for the Railroad Retirement Board, $63,900,000, to be derived from the railroad retirement accounts: *Provided,* That $200,000 of the foregoing amount shall be available only to the extent necessary to process workloads not anticipated in the budget estimates and after maximum absorption of the costs of such workloads within the remainder of the existing limitation has been achieved: *Provided further,* That notwithstanding any other provision of law, no portion of this limitation shall be available for payments of standard level user charges pursuant to section 210(j) of the Federal Property and Administrative Services Act of 1949, as amended (40 U.S.C. 490(j); 45 U.S.C. 228a-r).

LIMITATION ON RAILROAD UNEMPLOYMENT INSURANCE ADMINISTRATION FUND

For further expenses necessary for the Railroad Retirement Board, for administration of the Railroad Unemployment Insurance Act, not less than $14,100,000 shall be apportioned for fiscal year 1990 from moneys credited to the railroad unemployment insurance administration fund.

LIMITATION ON REVIEW ACTIVITY

For expenses necessary for the Office of Inspector General for audit, investigatory and review activities, as authorized by the Inspector General Act of 1978, as amended, not more than $3,950,000, to be derived from the railroad retirement accounts and railroad unemployment insurance account.

SOLDIERS' AND AIRMEN'S HOME

OPERATION AND MAINTENANCE

For maintenance and operation of the United States Soldiers' and Airmen's Home, to be paid from the Soldiers' and Airmen's Home permanent fund, $39,287,000: *Provided,* That this appropriation

any contract with a nongovernmental entity to administer or manage a Civilian Conservation Center of the Job Corps.

SEC. 517. Notwithstanding any other provision of this Act, funds appropriated for Labor-Management Services, Salaries and Expenses are hereby reduced by $1,000,000 and funds appropriated for Employment Standards Administration, Salaries and Expenses are hereby reduced by $2,000,000.

SEC. 518. Notwithstanding any other provision of this Act, funds appropriated for salaries and expenses of the Department of Health and Human Services are hereby reduced by $15,000,000: *Provided,* That no trust fund limitation shall be reduced.

SEC. 519. Notwithstanding any other provision of law, no funds appropriated under this Act may be expended for the purpose of implementing in whole or in part the proposed regulation published in the Federal Register on September 1, 1989 (54 FR 36485), relating to the classification of rural referral centers.

Notwithstanding any other provision of law, the amount available for transfer to Health Care Financing Administration Program Management as authorized by section 201(g) of the Social Security Act, from the Federal Hospital Insurance, the Federal Supplementary Medical Insurance, the Federal Catastrophic Drug Insurance, and the Federal Hospital Insurance Catastrophic Coverage Reserve Trust Funds are hereby reduced by $15,000,000.

Drugs and drug abuse.
AIDS.

SEC. 520. None of the funds appropriated under this Act shall be used to carry out any program of distributing sterile needles for the hypodermic injection of any illegal drug unless the President of the United States certifies that such programs are effective in stopping the spread of HIV and do not encourage the use of illegal drugs.

Communications and telecommunications.

SEC. 521. RESTORATION AND CORRECTION OF DIAL-A-PORN SANCTIONS.—(1) AMENDMENT.—Section 223 of the Communications Act of 1934 (47 U.S.C. 223) is amended by striking subsection (b) and inserting the following:

"(b)(1) Whoever knowingly—

"(A) within the United States, by means of telephone, makes (directly or by recording device) any obscene communication for commercial purposes to any person, regardless of whether the maker of such communication placed the call; or

"(B) permits any telephone facility under such person's control to be used for an activity prohibited by subparagraph (A),

shall be fined in accordance with title 18, United States Code, or imprisoned not more than two years, or both.

"(2) Whoever knowingly—

"(A) within the United States, by means of telephone, makes (directly or by recording device) any indecent communication for commercial purposes which is available to any person under 18 years of age or to any other person without that person's consent, regardless of whether the maker of such communication placed the call; or

"(B) permits any telephone facility under such person's control to be used for an activity prohibited by subparagraph (A),

shall be fined not more than $50,000 or imprisoned not more than six months, or both.

"(3) It is a defense to prosecution under paragraph (2) of this subsection that the defendant restrict access to the prohibited communication to persons 18 years of age or older in accordance with subsection (c) of this section and with such procedures as the Commission may prescribe by regulation.

47 USC 152 note.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect 120 days after the date of enactment of this Act.

This Act may be cited as the "Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 1990".

Approved November 21, 1989.

LEGISLATIVE HISTORY—H.R. 3566:

HOUSE REPORTS: No. 101-354 (Comm. on Appropriations).
CONGRESSIONAL RECORD, Vol. 135 (1989):
Nov. 15, considered and passed House.
Nov. 16, considered and passed Senate, amended.
Nov. 17, House concurred in certain Senate amendments, in another with an amendment; and disagreed to another.
Nov. 19, Senate insisted on its amendment No. 5; concurred in House amendment.
Nov. 20, House receded and concurred in Senate amendment No. 5.
WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 25 (1989):
Nov. 21, Presidential statement.

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101ST CONGRESS
1st Session
HOUSE OF REPRESENTATIVES
REPORT
101-354

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATION BILL, 1990

NOVEMBER 14, 1989.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. NATCHER, from the Committee on Appropriations, submitted the following

REPORT

[To accompany H.R. 3566]

The Committee on Appropriations, to whom was referred H.R. 3566, making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 1990, and for other purposes, report the same to the House without amendment and with the recommendation that the bill be passed.

The Committee on Appropriations submits the following report in explanation of the accompanying bill making appropriations for the Departments of Labor, Health and Human Services (except the Food and Drug Administration, Indian Health Service, and the Office of Consumer Affairs), and Education (except Indian Education), Action, the Corporation for Public Broadcasting, the Federal Mediation and Conciliation Service, the Federal Mine Safety and Health Review Commission, the National Commission on Acquired Immune Deficiency Syndrome, the National Commission on Children, the National Commission on Libraries and Information Science, the National Commission to Prevent Infant Mortality, the National Council on Disability, the National Labor Relations Board, the National Mediation Board, the Occupational Safety and Health Review Commission, the Prescription Drug Payment Review Commission, the Prospective Payment Assessment Commission, the Physician Payment Review Commission, the Railroad Retirement Board, the Soldiers' and Airmen's Home, the United States Bipartisan Commission on Comprehensive Health Care, the

employers of 10 or fewer from routine safety inspections under certain circumstances.

On page 14 of the bill is language allowing the Secretary of Labor to use any funds available to the Department to provide for the costs of mine rescue and survival operations in the event of major disasters.

On page 14 of the bill is a proviso prohibiting the carrying out of sections 104(g)(1) or 115 of the Federal Mine Safety and Health Act with respect to shell dredging, or with respect to any sand, gravel, surface limestone, surface clay, or colloidal phosphate mine.

On page 16 of the bill is a provision directing the Secretary of Labor to convey to the State of Oregon certain property related to the Job Corps.

On page 18 of the bill is a provision that, notwithstanding section 838 of the Public Health Service Act, not to exceed $10,000,000 of funds returned to the Secretary pursuant to section 839(c) of the Public Health Service Act or pursuant to a loan agreement under section 740 or 835 of the Act may be used for activities under titles III, VII, and VIII of the Act.

On page 18 is language providing that collections from user fees may be credited to the appropriation for the Health Resources, and Services Administration.

On page 19 is language providing that the Vaccine Injury Compensation Trust Fund shall be reimbursed for claims arising from liability related to the administration of vaccines before October 1, 1988 and that administrative expenses may be reimbursed from the fund.

On page 21 is language providing that collections from user fees may be credited to the Centers for Disease Control appropriation.

On page 21 is language providing that certain Centers for Disease Control employees shall be treated as non-Federal employees for reporting purposes only.

On page 25 of the bill is language providing that the Secretary of Health and Human Services shall utilize $15,000,000 from appropriations available to each of the National Institutes of Health which shall be available for extramural facilities construction grants if authorized in law and if awarded competitively including such amount as he may deem appropriate for research animal production facilities.

On page 27 of the bill is language providing that funds appropriated for Federal activities authorized by sections 6 and 9 of the Saint Elizabeths Hospital and District of Columbia Mental Health Services Act may be used for administrative and maintenance functions in implementing the Act.

On page 29 of the bill is a provision that in the administration of title XIX of the Social Security Act, payments to a State for any quarter may be made with respect to a State plan or plan amendment in effect during any such quarter, if submitted in, or prior to, such quarter and approved in that or any such subsequent quarter.

On page 30 is language allowing fees charged in accordance with 31 U.S.C. 9701 to be credited to the Health Care Financing Administration administrative account.

On page 31 is language providing that certain travel expense payments under the Federal Mine Safety and Health Act may be made only when travel of more than 75 miles is required.

On page 31 is language providing that monthly black lung benefits shall be rounded to the nearest dollar as is currently done with other benefits paid by the Social Security Administration.

On page 32 is language providing that travel expense payments under section 1631(h) of the Social Security Act may be made only when travel of more than 75 miles is required.

On page 33 is language requiring that none of the funds appropriated by this Act may be used for the manufacture, printing, or procuring of social security cards, as provided in section 205(c)(2)(D) of the Social Security Act, where paper and other materials used in the manufacture of such cards are produced, manufactured, or assembled outside of the United States.

On page 34 is language providing that a State may not receive more than one-fourth of the amount of its fiscal year 1989 allotment under part C of the Social Security Act for each quarter in fiscal year 1990 during which part C applies to that State, and a State may not receive more than one-fourth of its annual limitation determined under section 403(k)(2) of the Social Security Act for each quarter in fiscal year 1990 during which part F of the Act applies to that State, provided that the quarterly amounts specified shall be the maximum amounts to which the States may become entitled for these purposes.

On page 35 is language reducing the previously enacted appropriation for fiscal year 1990 for interim assistance to States for legalization under the Immigration Reform and Control Act of 1986 and language appropriating the same amount for fiscal year 1992 for unreimbursed costs incurred after September 30, 1989 if these costs would have been eligible for reimbursement under the original appropriation prior to the enactment of this Act.

On pages 47–48 of the bill is language setting minimum State allotments for chapter 1 concentration grants and State administration grants.

On page 48 is language providing that funds made available under sections 1437 and 1463 of the Elementary and Secondary Education Act may be expended by the Secretary of Education at any time, providing that notices of proposed rules for all currently operating programs authorized under chapter 1 of the Act have been published.

On page 48 is language providing that from the amounts appropriated for part A of chapter 1 of title I of the Elementary and Secondary Education Act, an amount not to exceed $125,000,000 may be obligated to carry out a new Merit Schools program and an amount not to exceed $50,000,000 may be obligated to carry out a new Magnet Schools of Excellence program only if such programs are specifically authorized in law prior to March 1, 1990.

On page 51 of the bill is language providing that $900,000 appropriated for the National Technical Institute for the Deaf shall be retained by the Secretary of Education for the purpose of supporting a consortium of institutions to provide education and vocational rehabilitation services for low functioning adults who are deaf.

H.R. 3566 - FY 1990 DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1989 Comparable	FY 1990 Budget Request	H.R. 2990 (Vetoed) House Bill	H.R. 2990 (Vetoed) Senate Bill	H.R. 3566 Committee Bill
HEALTH CARE FINANCING ADMINISTRATION					
GRANTS TO STATES FOR MEDICAID					
Medicaid current law benefits	32,782,986,000	37,297,341,000	36,777,184,000	37,297,341,000	37,297,341,000
State and local administration	1,529,000,000	1,839,313,000	1,839,313,000	1,839,313,000	1,839,313,000
Subtotal, medicaid program level, FY 1990	34,291,986,000	39,136,654,000	38,616,497,000	39,136,654,000	39,136,654,000
Less funds advanced in prior year	-8,000,000,000	-9,000,000,000	-9,000,000,000	-9,000,000,000	-9,000,000,000
Total, current request, FY 1990	26,291,986,000	30,136,654,000	29,616,497,000	30,136,654,000	30,136,654,000
New advance, 1st quarter, FY 1991	9,000,000,000	10,400,000,000	10,400,000,000	10,400,000,000	10,400,000,000

H.R. 3566 - FY 1990 DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1989 Comparable	FY 1990 Budget Request	H.R. 2990 (Vetoed) House Bill	H.R. 2990 (Vetoed) Senate Bill	H.R. 3566 Committee Bill
PAYMENTS TO HEALTH CARE TRUST FUNDS					
Supplemental medical insurance	30,712,000,000	35,925,500,000	35,925,500,000	35,925,500,000	35,925,500,000
Hospital insurance for uninsured	493,000,000	378,000,000	378,000,000	378,000,000	378,000,000
Federal uninsured payment	22,000,000	35,000,000	35,000,000	35,000,000	35,000,000
Total, Payment to Trust Funds 1/	31,227,000,000	36,338,500,000	36,338,500,000	36,338,500,000	36,338,500,000
PROGRAM MANAGEMENT					
Research, demonstration, and evaluation:					
Regular program:					
Federal funds	9,880,000	14,000,000	13,000,000	14,000,000	13,000,000
Trust funds	(19,760,000)	(23,000,000)	(21,000,000)	(23,000,000)	(21,000,000)
Mandated studies related to catastrophic HI, trust funds	(12,000,000)	---	---	---	---
Rural hospital transition demonstrations, trust funds	(8,892,000)	---	(12,000,000)	(20,000,000)	(19,000,000)
Subtotal, research, demonstration, & evaluation.	50,532,000	37,000,000	46,000,000	57,000,000	52,000,000
Medicare Contractors (Trust Funds):					
Operating funds, current	(1,361,588,000)	(1,439,013,000)	(1,520,000,000)	(1,439,013,000)	(1,439,013,000)
Contingency reserve fund	(98,800,000)	(100,000,000)	(100,000,000)	(100,000,000)	(100,000,000)
Subtotal, Contractors	(1,460,388,000)	(1,539,013,000)	(1,620,000,000)	(1,539,013,000)	(1,539,013,000)

1/ Excludes legislative savings of $850 million proposed for later transmittal.

H.R. 3566 - FY 1990 DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1989 Comparable	FY 1990 Budget Request	H.R. 2990 (Vetoed) House Bill	H.R. 2990 (Vetoed) Senate Bill	H.R. 3566 Committee Bill
State Certification:					
Medicare certification, trust funds	(63,168,000)	(92,442,000)	(92,442,000)	(92,442,000)	(92,442,000)
General program support, federal funds	4,173,000	6,558,000	6,558,000	6,558,000	6,558,000
Subtotal, State certification	(67,341,000)	(99,000,000)	(99,000,000)	(99,000,000)	(99,000,000)
Federal Administration:					
Federal funds	80,759,000	82,633,000	82,633,000	82,633,000	82,633,000
Less user fees	-1,538,000	-283,000	-283,000	-283,000	-283,000
Trust funds	(235,496,000)	(246,717,000)	(246,717,000)	(246,717,000)	(246,717,000)
Subtotal, Federal Administration	314,727,000	329,067,000	329,067,000	329,067,000	329,067,000
Total, Program management	1,892,986,000	2,004,080,000	2,094,067,000	2,024,080,000	2,019,080,000
Federal funds	93,284,000	102,908,000	101,908,000	102,908,000	101,908,000
Trust funds	(1,799,704,000)	(1,901,172,000)	(1,992,159,000)	(1,921,172,000)	(1,917,172,000)
HMO LOAN AND LOAN GUARANTEE FUND	---	5,000,000	5,000,000	5,000,000	5,000,000
Total, Health Care Financing Administration:					
Federal funds	68,612,270,000	76,983,062,000	76,461,905,000	76,983,062,000	76,982,062,000
Current year, FY 1990	(57,612,270,000)	(66,583,062,000)	(66,061,905,000)	(66,583,062,000)	(66,582,062,000)
New advance, 1st quarter, FY 1991	(9,000,000,000)	(10,400,000,000)	(10,400,000,000)	(10,400,000,000)	(10,400,000,000)
Trust funds	(1,799,704,000)	(1,901,172,000)	(1,992,159,000)	(1,921,172,000)	(1,917,172,000)

	FY 1989 Comparable	FY 1990 Budget Request	H.R. 2990 (Vetoed) House Bill	H.R. 2990 (Vetoed) Senate Bill	H.R. 3566 Committee Bill
SOCIAL SECURITY ADMINISTRATION					
PAYMENTS TO SOCIAL SECURITY TRUST FUNDS	93,631,000	181,968,000	191,968,000	191,968,000	191,968,000
SPECIAL BENEFITS FOR DISABLED COAL MINERS					
Benefit payments	878,656,000	853,000,000	853,000,000	853,000,000	853,000,000
Administration	6,680,000	6,862,000	6,862,000	6,862,000	6,862,000
Subtotal, Black Lung, FY 1990 program level	885,336,000	859,862,000	859,862,000	859,862,000	859,862,000
Less funds advanced in prior year	-250,000,000	-211,000,000	-211,000,000	-211,000,000	-211,000,000
Total, Black Lung, current request, FY 1990	635,336,000	648,862,000	648,862,000	648,862,000	648,862,000
New advance, 1st quarter, FY 1991	211,000,000	215,000,000	215,000,000	215,000,000	215,000,000
SUPPLEMENTAL SECURITY INCOME					
Federal benefit payments	11,358,000,000	10,925,613,000	10,925,613,000	10,925,613,000	10,925,613,000
Beneficiary services	13,547,000	13,739,000	13,739,000	13,739,000	13,739,000
Research demonstration	2,275,000	2,275,000	5,275,000	2,275,000	5,275,000
Administration	1,090,131,000	1,110,815,000	1,090,131,000	1,090,131,000	1,090,131,000
Subtotal, SSI FY 1990 program level	12,473,953,000	12,052,442,000	12,034,758,000	12,031,758,000	12,034,758,000
Less funds advanced in prior year	-3,000,000,000	-2,936,000,000	-2,936,000,000	-2,936,000,000	-2,936,000,000
Total, SSI, current request, FY 1990	9,473,953,000	9,116,442,000	9,098,758,000	9,095,758,000	9,098,758,000
New advance, 1st quarter, FY 1991	2,936,000,000	3,157,000,000	3,157,000,000	3,157,000,000	3,157,000,000
LIMITATION ON ADMINISTRATIVE EXPENSES (Trust Funds)	(3,731,398,000)	(3,833,389,000)	(3,833,389,000)	(3,847,389,000)	(3,837,389,000)
(Contingency reserve, non-add)	(97,870,000)	(47,870,000)	(97,870,000)	(97,870,000)	(97,870,000)
Total, Social Security Administration:					
Federal funds	13,349,920,000	13,329,272,000	13,311,588,000	13,308,588,000	13,311,588,000
Current year FY 1990	(10,202,920,000)	(9,957,272,000)	(9,939,588,000)	(9,936,588,000)	(9,939,588,000)
New advances, 1st quarter FY 1991	(3,147,000,000)	(3,372,000,000)	(3,372,000,000)	(3,372,000,000)	(3,372,000,000)
Trust funds	(3,731,398,000)	(3,833,389,000)	(3,833,389,000)	(3,847,389,000)	(3,837,389,000)

H.R. 3566 - FY 1990 DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1989 Comparable	FY 1990 Budget Request	H.R. 2990 (Vetoed) House Bill	Senate Bill	H.R. 3566 Committee Bill
FAMILY SUPPORT ADMINISTRATION					
FAMILY SUPPORT PAYMENTS TO STATES 1/					
Aid to Families with Dependant Children (AFDC).....	8,897,874,000	9,345,000,000	9,345,000,000	9,345,000,000	9,345,000,000
Quality control disallowances.....	-63,000,000	-516,000,000	---	---	---
Payments to territories.....	16,346,000	16,346,000	16,346,000	16,346,000	16,346,000
Emergency assistance, incl. welfare hotel demos 2/....	131,200,000	157,200,000	157,200,000	157,200,000	157,200,000
Repatriation.....	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000
State and local welfare administration.....	1,474,600,000	1,599,400,000	1,599,400,000	1,599,400,000	1,599,400,000
Work activities / child care.....	12,000,000	163,000,000	163,000,000	163,000,000	163,000,000
Regulatory savings, essential persons.....	-25,000,000	-55,000,000	-55,000,000	-55,000,000	-55,000,000
Subtotal, Welfare payments.....	10,445,020,000	10,710,946,000	11,226,946,000	11,226,946,000	11,226,946,000
Child Support Enforcement:					
State and local administration.....	941,000,000	1,033,000,000	1,033,000,000	1,033,000,000	1,033,000,000
Federal incentive payments.....	260,000,000	294,000,000	294,000,000	294,000,000	294,000,000
Less federal share collections.....	-754,000,000	-846,000,000	-846,000,000	-846,000,000	-846,000,000
Subtotal, Child support.....	447,000,000	481,000,000	481,000,000	481,000,000	481,000,000
Total, Payments, FY 1990 program level.....	10,892,020,000	11,191,946,000	11,707,946,000	11,707,946,000	11,707,946,000
Less funds advanced in previous years.....	-2,500,000,000	-2,700,000,000	-2,700,000,000	-2,700,000,000	-2,700,000,000
Total, Payments, current request, FY 1990.....	8,392,020,000	8,491,946,000	9,007,946,000	9,007,946,000	9,007,946,000
New advance, 1st quarter, FY 1991.....	2,700,000,000	3,000,000,000	3,000,000,000	3,000,000,000	3,000,000,000

1/ Excludes legislative savings of $350 million proposed for later transmittal.

2/ Administration proposed to fund demos under the Office of Human Development Services.

	FY 1989 Comparable	FY 1990 Budget Request	H.R. 2990 (Vetoed) House Bill	H.R. 2990 (Vetoed) Senate Bill	H.R. 3566 Committee Bill
PAYMENTS TO STATES FOR AFDC WORK PROGRAMS					
New Jobs Activities program	---	264,000,000	318,535,000	329,975,000	329,975,000
WIN Phaseout	91,440,000	85,975,000	31,440,000	20,000,000	20,000,000
Total, AFDC work programs	91,440,000	349,975,000	349,975,000	349,975,000	349,975,000
LOW INCOME HOME ENERGY ASSISTANCE					
Energy Assistance Block Grant: FY 1990	1,383,200,000	1,100,000,000	1,400,000,000	1,278,654,000	1,333,000,000
Forward funding	---	---	---	---	60,000,000
Total, Energy Assistance	1,383,200,000	1,100,000,000	1,400,000,000	1,278,654,000	1,393,000,000
REFUGEE AND ENTRANT ASSISTANCE					
Cash and medical assistance 1/	261,820,000	201,658,000	DEFER	261,820,000	210,000,000
Social services	64,908,000	30,000,000	DEFER	69,908,000	75,000,000
Voluntary agency program	15,808,000	7,859,000	DEFER	45,808,000	40,000,000
Preventive health	5,770,000	3,000,000	DEFER	5,770,000	5,770,000
Targeted assistance	34,052,000	---	DEFER	34,052,000	38,052,000
Total, Refugee Resettlement	382,356,000	242,316,000	DEFER	417,356,000	368,822,000
STATE LEGALIZATION IMPACT ASSISTANCE GRANTS					
FY 1990	---	-400,000,000	---	-555,244,000	-555,244,000
FY 1991	---	-400,000,000	---	555,244,000	---
FY 1992	---	---	---	---	555,244,000

1/ Includes State admin. costs.

	FY 1989 Comparable	FY 1990 Budget Request	H.R. 2990 (Vetoed) House Bill	H.R. 2990 (Vetoed) Senate Bill	H.R. 3566 Committee Bill
COMMUNITY SERVICES BLOCK GRANT					
Grants to States for Community Services	318,630,000	---	297,000,000	329,255,000	323,630,000
Homeless services grants 1/	18,918,000	42,000,000	35,000,000	18,918,000	21,959,000
Advance funding for FY 1991	---	---	---	---	8,041,000
Discretionary funds:					
Community economic development	20,254,000	---	20,254,000	20,254,000	20,254,000
Rural housing	4,013,000	---	4,013,000	4,013,000	4,013,000
Farmworker assistance	2,948,000	---	2,948,000	2,948,000	2,948,000
National youth sports, regular activities	6,669,000	---	9,669,000	9,669,000	9,669,000
National youth sports, substance abuse	3,000,000	---	---	---	---
Technical assistance	236,000	---	236,000	236,000	236,000
Subtotal, discretionary funds	37,120,000	---	37,120,000	37,120,000	37,120,000
Community Partnerships	3,512,000	---	DEFER	3,512,000	3,512,000
Community Food and Nutrition	2,418,000	---	2,418,000	2,418,000	2,418,000
Total, Community services	380,598,000	42,000,000	371,538,000	391,223,000	396,680,000
Current year, FY 1990	(380,598,000)	(42,000,000)	(371,538,000)	(391,223,000)	(388,639,000)
Advance funding for FY 1991	---	---	---	---	(8,041,000)

1/ Administration requested under the Office of Human Development Services.

H.R. 3568 - FY 1990 DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1989 Comparable	FY 1990 Budget Request	H.R. 2990 (Vetoed) House Bill	H.R. 2990 (Vetoed) Senate Bill	H.R. 3566 Committee Bill
PROGRAM ADMINISTRATION					
Federal Administration 1/	77,882,000	73,881,000	78,431,000	76,431,000	78,431,000
Research & evaluation	2,750,000	2,750,000	6,000,000	14,750,000	10,375,000
Total, program administration	80,632,000	76,631,000	82,431,000	91,181,000	86,806,000
Total, Family Support Administration, authorized	13,410,246,000	12,502,870,000	14,211,890,000	14,536,335,000	14,603,229,000
Current year FY 1990	(10,710,246,000)	(9,902,870,000)	(11,211,890,000)	(10,981,091,000)	(11,039,944,000)
FY 1991	(2,700,000,000)	(2,600,000,000)	(3,000,000,000)	(3,555,244,000)	(3,008,041,000)
FY 1992	---	---	---	---	(555,244,000)

1/ FY90 request assumes an additional $1,550,000 from user fees.

H.R. 3566 - FY 1990 DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1989 Comparable	FY 1990 Budget Request	H.R. 2990 (Vetoed) House Bill	H.R. 2990 (Vetoed) Senate Bill	H.R. 3566 Committee Bill
ASSISTANT SECRETARY FOR HUMAN DEVELOPMENT SERVICES					
SOCIAL SERVICES BLOCK GRANT (TITLE XX).....	2,700,000,000	2,700,000,000	2,700,000,000	2,700,000,000	2,700,000,000
HUMAN DEVELOPMENT SERVICES 2/					
Programs for Children, Youth, and Families:					
Head start, current law.....	1,235,000,000	1,405,000,000	1,400,000,000	1,405,000,000	1,405,000,000
Proposed expansion, unauthorized.....	---	80,000,000	DEFER	80,000,000	---
Child development associate scholarships.....	1,450,000	1,450,000	1,450,000	1,450,000	1,450,000
Family crisis program:					
Child abuse state grants.....	11,648,000	---	11,648,000	11,824,000	11,736,000
Child abuse challenge grants.....	4,834,000	---	DEFER	5,000,000	5,000,000
Runaway and homeless youth.....	26,923,000	---	26,923,000	28,923,000	27,923,000
Family violence.....	8,219,000	---	8,219,000	8,548,000	8,384,000
Consolidated request.....	---	46,790,000	---	---	---
Abandoned infants assistance 2/.....	---	---	---	4,000,000	4,000,000
Subtotal, family crisis.....	51,624,000	46,790,000	46,790,000	58,295,000	57,043,000
Dependent Care Planning and Development.....	11,856,000	---	11,856,000	14,856,000	13,356,000
Child welfare assistance 1/.....	246,679,000	256,053,000	256,053,000	256,053,000	256,053,000
Subtotal.....	1,546,609,000	1,789,293,000	1,716,149,000	1,815,654,000	1,732,902,000

1/ Excludes $20 million for welfare hotel demos. considered under Family Support.

2/ Funded at $4,000,000 in House bill under Assistant Secretary for Health.

H.R. 3566 - FY 1990 DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1989 Comparable	FY 1990 Budget Request	H.R. 2990 (Vetoed) House Bill	Senate Bill	H.R. 3566 Committee Bill
Programs for the Aging:					
Grants to States:					
Supportive Services and Centers	274,352,000	275,652,000	278,652,000	275,652,000	276,652,000
Ombudsman activities	988,000	986,000	988,000	988,000	988,000
Nutrition:					
Congregate meals	356,668,000	358,668,000	356,668,000	356,668,000	356,668,000
Home-delivered meals	78,546,000	78,546,000	78,546,000	81,546,000	80,046,000
Aging outreach	---	---	---	5,000,000	---
Federal Council on Aging	188,000	188,000	188,000	186,000	188,000
Grants to Indians	10,710,000	7,410,000	12,710,000	12,710,000	12,710,000
Frail elderly in-home services	4,834,000	4,834,000	4,834,000	6,834,000	8,834,000
Subtotal, Aging programs	726,288,000	724,286,000	729,588,000	739,586,000	732,086,000
Developmental disabilities program:					
State grants	59,774,000	59,774,000	59,774,000	62,774,000	62,774,000
Protection and advocacy	19,760,000	19,760,000	19,760,000	20,760,000	20,760,000
Subtotal, Developmental disabilities	79,534,000	79,534,000	79,534,000	83,534,000	83,534,000
Native American Programs	29,975,000	29,975,000	29,975,000	34,300,000	32,138,000

	FY 1989 Comparable	FY 1990 Budget Request	H.R. 2990 (Vetoed) House Bill	H.R. 2990 (Vetoed) Senate Bill	H.R. 3566 Committee Bill
Human services research, training & demonstration: New consolidated request	---	128,679,000	---	---	---
Comprehensive child development centers	19,760,000	---	24,760,000	25,000,000	25,000,000
Child abuse discretionary activities	13,647,000	---	13,647,000	13,647,000	13,647,000
Runaway youth - transitional living	---	---	5,000,000	5,000,000	5,000,000
Runaway youth activities - drugs	15,000,000	---	10,000,000	10,000,000	10,000,000
Youth gang substance abuse	15,000,000	---	12,000,000	12,000,000	11,500,000
Temporary childcare/crisis nurseries	4,940,000	---	4,940,000	5,940,000	5,440,000
Child welfare training	3,696,000	---	3,696,000	3,696,000	3,696,000
Child welfare research	9,315,000	---	11,315,000	10,965,000	11,140,000
Adoption opportunities	6,027,000	---	6,827,000	6,527,000	6,627,000
Aging research, training and special projects	22,173,000	---	26,173,000	25,173,000	25,673,000
Developmental disabilities special projects	2,901,000	---	2,901,000	2,901,000	2,901,000
Developmental disabilities university affiliated programs	12,570,000	---	12,570,000	13,370,000	13,370,000
Total, Human Services Res, Trng & demonstration	125,029,000	128,679,000	133,829,000	134,219,000	134,194,000
Program direction	66,140,000	68,886,000	68,886,000	69,586,000	69,236,000
Total, Human Development Services	2,573,573,000	2,820,653,000	2,757,959,000	2,676,679,000	2,764,090,000
CHILD CARE INITIATIVE (unauthorized)	---	---	DEFER	1,200,000,000	---

H.R. 3566 - FY 1990 DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1989 Comparable	FY 1990 Budget Request	H.R. 2990 (Vetoed) House Bill	H.R. 2990 (Vetoed) Senate Bill	H.R. 3566 Committee Bill
PAYMENTS TO STATES FOR FOSTER CARE AND ADOPTION ASSISTANCE					
Foster care	854,233,000	1,161,181,000	1,204,782,000	1,161,181,000	1,204,782,000
Adoption assistance	111,744,000	125,266,000	125,266,000	125,266,000	125,266,000
Independent living	45,000,000	---	DEFER	50,000,000	50,000,000
Prior year claims	532,275,000	---	226,318,000	---	---
Total, Payments to States	1,543,252,000	1,286,447,000	1,556,364,000	1,336,447,000	1,380,048,000
Total, Asst. Sec. for Human Development	6,818,625,000	6,807,100,000	7,014,323,000	6,113,326,000	6,864,136,000

Finder's Aid
P.L. 101-234 (103 Stat. 1979) Approved December 13, 1989
Medicare Catastrophic Coverage Repeal Act of 1989

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.C. Rep. 101-378
Trust Funds - Transfers	201(g)(1)	202(a)	1981	4,16-19
Trust Funds - Transfers	201(i)(1)	202(a)	1981	4,16-19
General Provisions - Civil Monetary Penalties (technical amendment)	1128A(a)(1)	201(a)(1)	1981	3-4, 16-17, 19
General Provisions - Civil Monetary Penalties	1128A(a)(2)(C)	201(a)(1)	1981	3-4, 16-17, 19
General Provisions - Civil Monetary Penalties (technical amendment)	1128A(a)(2)	201(a)(1)	1981	3-4, 16-17, 19
General Provisions - Civil Monetary Penalties (technical amendment)	1128A(a)(3)	201(a)(1)	1981	3-4, 16-17, 19
General Provisions - Civil Monetary Penalties	1128A(a)(4)	201(a)(1)	1981	3-4, 16-17, 19
General Provisions - Functions of Peer Review Organizations	1154(a)(16)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Hospital Insurance Benefits	1811	101(a)(1)	1979	1-2, 11-12, 14
Medicare - Scope of Benefits	1812(a)(1)	101(a)(1)	1979	1-2, 11-12, 14
Medicare - Scope of Benefits	1812(a)(2)	101(a)(1)	1979	1-2, 11-12, 14
Medicare - Scope of Benefits	1812(a)(3)	101(a)(1)	1979	1-2, 11-12, 14

P.L. 101-234

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.C. Rep. 101-378
Medicare - Scope of Benefits	1812(a)(4)	101(a)(1)	1979	1-2, 11-12, 14
Medicare - Scope of Benefits	1812(b)	101(a)(1)	1979	1-2, 11-12, 14
Medicare - Scope of Benefits	1812(c)	101(a)(1)	1979	1-2, 11-12, 14
Medicare - Scope of Benefits	1812(d)(1)	101(a)(1)	1979	1-2, 11-12, 14
Medicare - Scope of Benefits	1812(d)(2)(B)	101(a)(1)	1979	1-2, 11-12, 14
Medicare - Scope of Benefits	1812(e)	101(a)(1)	1979	1-2, 11-12, 14
Medicare - Scope of Benefits	1812(f)	101(a)(1)	1979	1-2, 11-12, 14
Medicare - Scope of Benefits	1812(g)	101(a)(1)	1979	1-2, 11-12, 14
Medicare - Deductibles and Coinsurance	1813(a)(1)	101(a)(1)	1979	1-2, 12,14
Medicare - Deductibles and Coinsurance	1813(a)(2)	101(a)(2)	1979	1-2, 12,14
Medicare - Deductibles and Coinsurance	1813(a)(3)	101(a)(1)	1979	1-2, 12,14
Medicare - Deductibles and Coinsurance	1814(b)(3)	101(a)(1)	1979	1-2, 12,14

P.L. 101-234

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.C. Rep. 101-378
Medicare - Conditions of and Limitations on Payments for Services	1814(a)(2)(B)	101(a)(1)	1979	1-2, 12,14
Medicare - Conditions of and Limitations on Payments for Services	1814(a)(2)(B)	101(a)(1)	1979	1-2, 12,14
Medicare - Conditions of and Limitations on Payments for Services	1814(a)(6)	101(a)(1)	1979	1-2, 12,14
Medicare - Conditions of and Limitations on Payments for Services (technical amendment)	1814(a)(7)(A)(i)	101(a)(1)	1979	1-2, 12,14
Medicare - Conditions of and Limitations on Payments for Services	1814(a)(7)(A)(ii)	101(a)(1)	1979	1-2, 12,14
Medicare - Conditions of and Limitations on Payments for Services	1814(a)(7)(A)(iii)	101(a)(1)	1979	1-2, 12,14
Medicare - Conditions of and Limitations on Payments for Services	1814(d)(3)	101(a)(1)	1979	1-2, 12,14
Medicare - Conditions of and Limitations on Payments for Services	1814(d)(3)	101(a)(1)	1979	1-2, 12,14
Medicare - Use of Public Agencies or Private Organizations-Payments to Providers	1816(k)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Trust Fund - Transfers	1817(b)	202(a)	1981	4, 16-19
Medicare - Federal Hospital Insurance Catastrophic Coverage Reserve Fund	1817A	102(a)	1980	3, 12-13

P.L. 101-234

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.C. Rep. 101-378
Medicare - Requirements for Skilled Nursing Facilities	1832(a)(2)(A)(i)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - In-Home Care for Certain Chronically Dependent Individuals (technical amendment)	1832(a)(2)(A)(i) Redesignated as 1832(a)(2)(A)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - In-Home Care for Certain Chronically Dependent Individuals	1832(a)(2)(A)(i)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - In-Home Care for Certain Chronically Dependent Individuals	1832(a)(2)(A)(ii) Repealed	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Supplementary Medical Insurance Benefits	1832(a)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Supplementary Medical Insurance Benefits	1832(b)	201(a)(1)	1979	1-2, 12,14
Medicare - Supplementary Medical Insurance Benefits	1832(b)	201(a)(1)	1979	1-2, 12,14
Medicare - Fund Transfers	1833(a)	202(a)	1981	4, 16-17, 19
Medicare - Coverage of Catastrophic Expenses (technical amendment)	1833(a)(1)(K)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Coverage of Catastrophic Expenses (technical amendment)	1833(a)(1)(L)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Coverage of Catastrophic Expenses	1833(a)(1)(M)	201(a)(1)	1981	3-4, 16-17, 19

P.L. 101-234

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.C. Rep. 101-378
Medicare - Coverage of Catastrophic Expenses	1833(a)(2)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - In-Home Care for Certain Chronically Dependent Individuals	1833(a)(2)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Coverage of Catastrophic Expenses	1833(a)(2)(B)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Coverage of Catastrophic Expenses	1833(a)(2)(D)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Coverage of Catastrophic Expenses	1833(a)(2)(E)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Coverage of Screening Mammography	1833(a)(2)(E)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Coverage of Home Intravenous Drug Therapy Services	1833(a)(2)(F)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - In-Home Care for Certain Chronically Dependent Individuals	1833(a)(3)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - In-Home Care for Certain Dependent Individuals	1833(a)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Coverage of Home Intravenous Drug Therapy Services	1833(b)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Coverage of Catastrophic Expenses	1833(b)(1)	201(a)(1)	1981	3-4, 16-17, 19

P.L. 101-234

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.C. Rep. 101-378
Medicare - Coverage of Catastrophic Expenses	1833(b)(2)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Limitation on Cost-Sharing	1833(c)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Limitation on Cost-Sharing	1833(c)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Limitation on Cost-Sharing	1833(d)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Limitation on Cost-Sharing	1833(d)(1)(A) Redesignated as 1833(c)(1)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Limitation on Cost-Sharing	1833(d)(1)(B) Redesignated as 1833(c)(2)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Limitation on Cost-Sharing	1833(d)(2) Redesignated as 1833(d)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Limitation on Cost-Sharing	1833(g)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Coverage of Screening Mammography	1834(b)(1)(B)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Fee Schedules for Radiologist Services	1834(b)(4)(A)	301(b)(1)	1985	8
Medicare - Fee Schedules for Radiologist Services	1834(b)(4)(A)	301(b)(1) (Duplicates 301(b)(1))	1985	8

P.L. 101-234

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.C. Rep. 101-378
Medicare - Payment for Covered Outpatient Drugs	1834(c) Repealed	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Home Intravenous Drug Therapy	1834(d) Repealed	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Payments and Standards for Screening Mammography	1834(e) Repealed	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Payment of Claims of Providers of Services (technical amendment)	1835(a)(2)(E)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Payment of Claims of Providers of Services (technical amendment)	1835(a)(2)(F)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Payment of Claims of Providers of Services (technical amendment)	1835(a)(2)(F)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Payment of Claims of Providers of Services	1835(a)(2)(G)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Payment of Claims of Providers of Services (technical amendment)	1835(a)(2)(G)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Payment of Claims of Providers of Services	1835(a)(2)(H) Repealed	201(a)(1)	1981	3-4 16-17, 19
Medicare - Amounts of Premiums	1839(a)(1)	202(a)	1981	4, 16-19
Medicare - Amounts of Premiums	1839(a)(1)	202(a)	1981	4, 16-19

P.L. 101-234

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.C. Rep. 101-378
Medicare - Amounts of Premiums	1839(a)(2)	202(a)	1981	4, 16-19
Medicare - Amounts of Premiums	1839(a)(3)	202(a)	1981	4, 16-19
Medicare - Amounts of Premiums	1839(a)(4)	202(a)	1981	4, 16-19
Medicare - Amounts of Premiums	1839(a)(4)	202(a)	1981	4, 16-19
Medicare - Amounts of Premiums	1839(b)	202(a)	1981	4, 16-19
Medicare - Amounts of Premiums	1839(e)(1)	202(a)	1981	4, 16-19
Medicare - Amounts of Premiums	1839(f)	202(a)	1981	4, 16-19
Medicare - Amounts of Premiums	1839(g) Repealed	202(a)	1981	4, 16-19
Medicare - Amounts of Premiums	1840(i) Repealed	202(a)	1981	4, 16-19
Medicare - Federal Supplementary Medical Insurance Trust Fund	1841(a)	202(a)	1981	4, 16-19
Medicare - Federal Supplementary Medical Insurance Trust Fund	1841(b)	202(a)	1981	4, 16-19
Medicare - Federal Catastrophic Drug Insurance Trust Fund	1841A Repealed	202(a)	1981	4, 16-19
Medicare - Catastrophic Coverage Account	1841B Repealed	202(a)	1981	4, 16-19
Medicare - Use of Carriers for Administration of Benefits	1842(b)(2)(A)	201(a)(1)	1981	3-4, 16-17, 19

P.L. 101-234

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.C. Rep. 101-378
Medicare - Use of Carriers for Administration of Benefits (technical amendment)	1842(b)(3)(G)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Use of Carriers for Administration of Benefits (technical amendment)	1842(b)(3)(H)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Use of Carriers for Administration of Benefits (technical amendment)	1842(b)(3)(H)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Use of Carriers for Administration of Benefits	1842(b)(3)(I) Repealed	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Use of Carriers for Administration of Benefits	1842(b)(3)(J) Repealed	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Use of Carriers for Administration of Benefits	1842(b)(3)(K) Repealed	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Use of Carriers for Administration of Benefits (technical amendment)	1842(c)(1)(A)(i) Redesignated as 1842(c)(1)(A)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Use of Carriers for Administration of Benefits	1842(c)(1)(A)(i)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Use of Carriers for Administration of Benefits	1842(c)(1)(A)(ii) Repealed	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Use of Carriers for Administration of Benefits	1842(c)(2)(A)	201(a)(1)	1981	3-4, 16-17, 19

P.L. 101-234

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.C. Rep. 101-378
Medicare - Use of Carriers for Administration of Benefits	1842(c)(3)(A)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Use of Carriers for Administration of Benefits	1842(c)(4) Repealed	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Use of Carriers for Administration of Benefits (technical amendment)	1842(f)(1)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Use of Carriers for Administration of Benefits (technical amendment)	1842(f)(2)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Use of Carriers for Administration of Benefits	1842(f)(3) Repealed	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Use of Carriers for Administration of Benefits	1842(h)(1)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Use of Carriers for Administration of Benefits	1842(h)(2)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Use of Carriers for Administration of Benefits	1842(h)(4)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Use of Carriers for Administration of Benefits	1842(j)(1)(C)(vii)	301(b)(2)	1985	8
Medicare - Use of Carriers for Administration of Benefits	1842(j)(1)(C)(vii)	301(c)(2) Duplicates 301(b)(2)	1985	8
Medicare - Use of Carriers for Administration of Benefits	1842(j)(2)(B)*	301(b)(6)	1985	8

* Should be 1842(j)(2)(A)

P.L. 101-234

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.C. Rep. 101-378
Medicare - Use of Carriers for Administration of Benefits	1842(j)(2)(B)	301(d)(B) Duplicates 301(b)(6)	1985	9
Medicare - Use of Carriers for Administration of Benefits	1842(o) Repealed	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Appropriations to Cover Government Contributions and Contingency Reserve	1844(a)	202(a)	1981	4, 16-19
Medicare - Intermediate Sanctions for Certain Providers	1846 Heading	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Intermediate Sanctions for Certain Providers	1846(a)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Intermediate Sanctions for Certain Providers	1846(b)(2)(A)(iv)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Prescription Drug Payment Review Commission	1847 Repealed	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Definitions - Spell of Illness	1861(a)	101(a)(1)	1979	1-2, 12,14
Medicare - Definitions - Hospital	1861(e)	101(a)(1)	1979	1-2, 12,14
Medicare - Definitions - Hospital	1861(e)	101(a)(1)	1979	1-2, 12,14
Medicare - Definitions - Hospital	1861(e)	101(a)(1)	1979	1-2, 12,14
Medicare - Definitions - Hospital	1861(e)	101(a)(1)	1979	1-2, 12,14

P.L. 101-234

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.C. Rep. 101-378
Medicare - Definitions - Post-Hospital Extended Care Services	1861(i)	101(a)(1)	1979	1-2, 12,14
Medicare - Definitions - Home Health Services	1861(m)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Definitions - Medical and Other Health Services	1861(s)(2)(J)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Definitions - Medical and Other Health Services (technical amendment)	1861(s)(11)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Definitions - Medical and Other Health Services (technical amendment)	1861(s)(12)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Definitions - Medical and Other Health Services	1861(s)(13) Repealed	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Definitions - Medical and Other Health Services	1861(s)(14) Redesignated as 1861(s)(13)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Definitions - Medical and Other Health Services	1861(s)(15) Redesignated as 1861(s)(14)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Definitions - Drugs and Biologicals	1861(t)(1) Redesignated as 1861(t)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Definitions - Drugs and Biologicals	1861(t)(1)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Definitions - Drugs and Biologicals	1861(t)(2)	201(a)(1)	1981	3-4, 16-17, 19

P.L. 101-234

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.C. Rep. 101-378
Medicare - Definitions - Drugs and Biologicals	1861(t)(3) Repealed	201(a)(1)	1981	3-4, 16-17,
Medicare - Definitions - Drugs and Biologicals	1861(t)(4) Repealed	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Definitions - Providers of Service	1861(u)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Definitions - Reasonable Cost	1861(v)(1)(G)(i)	101(a)(1)	1979	1-2, 12,14
Medicare - Definitions - Reasonable Cost	1861(v)(2)(A)	101(a)(1)	1979	1-2, 12,14
Medicare - Definitions - Reasonable Cost	1861(v)(3)	101(a)(1)	1979	1-2, 12,14
Medicare - Definitions - Extended Care in Christian Science Skilled Nursing Facilities	1861(y) Heading	101(a)(1)	1979	1-2, 11-12, 14
Medicare - Definitions - Extended Care in Christian Science Skilled Nursing Facilities	1861(y)(1)	101(a)(1)	1979	1-2, 11-12, 14
Medicare - Definitions - Extended Care in Christian Science Skilled Nursing Facilities	1861(y)(2)	101(a)(1)	1979	1-2, 11-12, 14
Medicare - Definitions - Extended Care in Christian Science Skilled Nursing Facilities	1861(y)(2)(A)(i)	101(a)(1)	1979	1-2, 11-12, 14

P.L. 101-234

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.C. Rep. 101-378
Medicare - Definitions - Extended Care in Christian Science Skilled Nursing Facilities	1861(y)(3)	101(a)(1)	1979	1-2, 11-12, 14
Medicare - Definitions - Extended Care in Christian Science Skilled Nursing Facilities	1861(y)(3)	101(a)(1)	1979	1-2, 11-12, 14
Medicare - Definitions - Extended Care in Christian Science Skilled Nursing Facilities	1861(y)(4)	101(a)(1)	1979	1-2, 11-12, 14
Medicare - Definitions - Home Intravenous Drug Therapy Provider	1861(jj) Repealed	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Definitions - Screening Mammography	1861(kk) Repealed	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Definitions - In-Home Care; Chronically Dependent Individual	1861(ll) Repealed	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Exclusions from Coverage	1862(a)(1)(A)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Exclusions from Coverage (technical amendment)	1862(a)(1)(D)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Exclusions from Coverage (technical amendment)	1862(a)(1)(E)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Exclusions from Coverage (technical amendment)	1862(a)(1)(E)	201(a)(1)	1981	3-4, 16-17, 19

P.L. 101-234

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.C. Rep. 101-378
Medicare - Exclusions from Coverage	1862(a)(1)(F) Repealed	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Exclusions from Coverage (technical amendment)	1862(a)(1)(F)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Exclusions from Coverage	1862(a)(1)(G) Repealed	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Exclusions from Coverage	1862(a)(6)	201(a)(1)	1981	3-4, 16-17,
Medicare - Exclusions from Coverage	1862(a)(7)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Exclusions from Coverage (technical amendment)	1862(c)(1) Redesignated as 1862(c)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Exclusions from Coverage (technical amendment)	1862(c)(1)(A) Redesignated as 1862(c)(1)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Exclusions from Coverage (technical amendment)	1862(c)(1)(A)(i) Redesignated as 1862(c)(1)(A)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Exclusions from Coverage (technical amendment)	1862(c)(1)(A)(ii) Redesignated as 1862(c)(1)(B)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Exclusions from Coverage (technical amendment)	1862(c)(1)(A) (iii) Redesignated as 1862(c)(1)(C)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Exclusions from Coverage (technical amendment)	1862(c)(1)(A)(iv) Redesignated as 1862(c)(1)(D)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Exclusions from Coverage (technical amendment)	1862(c)(1)(B) Redesignated as 1862(c)(2)	201(a)(1)	1981	3-4, 16-17, 19

P.L. 101-234

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.C. Rep. 101-378
Medicare - Exclusions from Coverage (technical amendment)	1862(c)(1)(B)(i) Redesignated as 1862(c)(2)(A)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Exclusions from Coverage (technical amendment)	1862(c)(1)(B)(ii) Redesignated as 1862(c)(2)(B)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Exclusions from Coverage	1862(c)(2) Repealed	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Determination of Conditions of Participation for Providers of Services	1863	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Determination of Conditions of Participation for Providers of Services	1863	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Compliance by Providers of Services with Conditions of Participation	1864(a)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Compliance by Providers of Services with Conditions of Participation	1864(a)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Compliance by Providers of Services with Conditions of Participation	1864(a)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Compliance by Providers of Services with Conditions of Participation	1864(a)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Effect of Accreditation	1865(a)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Effect of Accreditation	1865(a)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Agreements with Providers of Services	1866(a)(1)(F)(i)(III)	301(b)(4)	1985	8

P.L. 101-234

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.C. Rep. 101-378
Medicare - Agreements with Providers of Services	1866(a)(1)(F)(i)(III)	301(d)(1) Duplicates 301(b)(4)	1986	8
Medicare - Agreements with Providers of Services	1866(a)(2)(A)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Agreements with Providers of Services	1866(a)(2)(A)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Agreements with Providers of Services	1866(a)(2)(A)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Agreements with Providers of Services	1866(a)(2)(A)	201(a)(1)	1981	3-4, 16-17,
Medicare - Agreements with Providers of Services	1866(d)	101(a)(1)	1979	1-2, 12,14
Medicare - Studies and Recommendations	1875(c)(7)	301(b)(5)	1985	8
Medicare - Studies and Recommendations	1875(c)(7)	301(d)(2) Duplicates 301(b)(5)	1986	9
Medicare - Payments to Health Maintenance Organizations	1876(a)(5)	202(a)	1981	4, 16-19
Medicare - Payments to Health Maintenance Organizations	1876(e)(1)	202(a)	1981	3-4, 16-17, 19
Medicare - Payments to Health Maintenance Organizations	1876(g)(3)(A)	201(a)(1)	1981	3-4, 16-17, 19
Medicare - Certification of Supplemental Health Insurance Policies	1882(a)	203(a)(1)(A)	1982	4, 19-22
Medicare - Certification of Supplemental Health Insurance Policies	1882(b)(1)	203(a)(1)(A)	1982	4, 19-22

P.L. 101-234

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.C. Rep. 101-378
Medicare - Certification of Supplemental Health Insurance Policies	1882(k)(1)(A)	203(a)(1)(B)	1982	4, 19-22
Medicare - Certification of Supplemental Health Insurance Policies	1882(k)(3)	203(a)(1)(B)(iii)	1982	4, 19-22
Medicare - Certification of Supplemental Health Insurance Policies	1882(m) New	203(a)(1)(C)	1982	4-5 19-22
Medicare - Certification of Supplemental Health Insurance Policies	1882(n) New	203(a)(1)(C)	1982	4-7 19-22
Medicare - Hospital Providers of Extended Care Services	1883(d)(1)	101(a)(1)	1979	1-2, 12,14
Medicare - Hospital Providers of Extended Care Services	1883(f)	101(a)(1)	1979	1-2, 12,14
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(g)(3)(A)(iv)	301(b)(3)	1985	8
Medicare - Payment to Hospitals for Inpatient Hospital Services	1886(g)(3)(A)(iv)	301(c)(3) Duplicates 301(b)(3)	1985	8
Medicaid - State Plans for Medical Assistance	1902(a)(9)(C)	201(a)(1)	1981	3-4, 16-17, 19
Medicaid - Payment to States	1903(i)(5)	201(a)(1)	1981	3-4, 16-17, 19
Medicaid - Definitions - Qualified Medicare Beneficiary	1905(p)(3)(C)	201(b)(1)(A)	1981	4, 16-17, 19
Medicaid - Definitions - Qualified Medicare Beneficiary	1905(p)(3)(C)	201(b)(1)(B)	1981	4, 16-17, 19

P.L. 101-234

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.C. Rep. 101-378
Medicaid - Definitions - Qualified Medicare Beneficiary	1905(p)(4) Stricken	201(b)(2)	1981	4, 16-17, 19
Medicaid - Definitions - Qualified Medicare Beneficiary	1905(p)(5) Redesignated as 1905(p)(4)	201(b)(2)	1987	4, 16-17, 19
Medicaid - Inapplicability and Waiver of Certain Requirements	1915(a)(1)(B)(ii)(I)	201(a)(1)	1987	3-4, 16-17, 19

Public Law 101-234
101st Congress

An Act

To repeal medicare provisions in the Medicare Catastrophic Coverage Act of 1988.

Dec. 13, 1989
[H.R. 3607]

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

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicare Catastrophic Coverage Repeal Act of 1989".

Medicare Catastrophic Coverage Repeal Act of 1989. 42 USC 1305 note.

TITLE I—PROVISIONS RELATING TO PART A OF MEDICARE PROGRAM AND SUPPLEMENTAL MEDICARE PREMIUM

SEC. 101. REPEAL OF EXPANSION OF MEDICARE PART A BENEFITS.

(a) IN GENERAL.—

42 USC 1395e note.

(1) GENERAL RULE.—Except as provided in paragraph (2), sections 101, 102, and 104(d) (other than paragraph (7)) of the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360) (in this Act referred to as "MCCA") are repealed, and the provisions of law amended or repealed by such sections are restored or revived as if such section had not been enacted.

42 USC 1395c-1395f, 1395k, 1395x, 1395cc, 1395tt.

(2) EXCEPTION FOR BLOOD DEDUCTION.—The repeal of section 102(1) of MCCA (relating to deductibles and coinsurance under part A) shall not apply, but only insofar as such section amended paragraph (2) of section 1813(a) of the Social Security Act (relating to a deduction for blood).

(b) TRANSITION PROVISIONS FOR MEDICARE BENEFICIARIES.—

42 USC 1395e note.

(1) INPATIENT HOSPITAL SERVICES AND POST-HOSPITAL EXTENDED CARE SERVICES.—In applying sections 1812 and 1813 of the Social Security Act, as restored by subsection (a)(1), with respect to inpatient hospital services and extended care services provided on or after January 1, 1990—

(A) no day before January 1, 1990, shall be counted in determining the beginning (or period) of a spell of illness;

(B) with respect to the limitation on such services provided in a spell of illness, days of such services before January 1, 1990, shall not be counted, except that days of inpatient hospital services before January 1, 1989, which were applied with respect to an individual after receiving 90 days of services in a spell of illness (commonly known as "lifetime reserve days") shall be counted;

(C) the limitation of coverage of extended care services to post-hospital extended care services shall not apply to an individual receiving such services from a skilled nursing facility during a continuous period beginning before (and including) January 1, 1990, until the end of the period of 30

consecutive days in which the individual is not provided inpatient hospital services or extended care services; and

(D) the inpatient hospital deductible under section 1813(a)(1) of such Act shall not apply—

(i) in the case of an individual who is receiving inpatient hospital services during a continuous period beginning before (and including) January 1, 1990, with respect to the spell of illness beginning on such date, if such a deductible was imposed on the individual for a period of hospitalization during 1989;

(ii) for a spell of illness beginning during January 1990, if such a deductible was imposed on the individual for a period of hospitalization that began in December 1989; and

(iii) in the case of a spell of illness of an individual that began before January 1, 1990.

(2) HOSPICE CARE.—The restoration of section 1812(a)(4) of the Social Security Act, effected by subsection (a)(1), shall not apply to hospice care provided during the subsequent period (described in such section as in effect on December 31, 1989) with respect to which an election has been made before January 1, 1990.

42 USC 1395e note.

(3) TERMINATION OF HOLD HARMLESS PROVISIONS.—Section 104(b) of MCCA is amended by striking "or 1990" each place it appears.

(c) TERMINATION OF TRANSITIONAL ADJUSTMENTS IN PAYMENTS FOR INPATIENT HOSPITAL SERVICES.—

42 USC 1395ww note.

(1) PPS HOSPITALS.—Section 104(c)(1) of MCCA is amended by inserting "and before January 1, 1990," after "October 1, 1988,".

(2) PPS-EXEMPT HOSPITALS.—

(A) IN GENERAL.—Section 104(c)(2) of MCCA is amended—

(i) by inserting "and before January 1, 1990," after "January 1, 1989,"; and

(ii) by striking the period at the end and inserting the following: ", without regard to whether any of such beneficiaries exhausted medicare inpatient hospital insurance benefits before January 1, 1989.".

42 USC 1395ww note.

(B) TRANSITION.—The Secretary of Health and Human Services shall make an appropriate adjustment to the target amount established under section 1886(b)(3)(A) of the Social Security Act in the case of inpatient hospital services provided to an inpatient whose stay began before January 1, 1990, in order to take into account the target amount that would have applied but for the amendments made by this title.

42 USC 1395c note.

(d) EFFECTIVE DATE.—The provisions of this section shall take effect January 1, 1990, except that the amendments made by subsection (c) shall be effective as if included in the enactment of MCCA.

SEC. 102. REPEAL OF SUPPLEMENTAL MEDICARE PREMIUM AND FEDERAL HOSPITAL INSURANCE CATASTROPHIC COVERAGE RESERVE FUND.

26 USC 59B and notes, 6050F and note; 42 USC 1395i-1a and note.

(a) IN GENERAL.—Sections 111 and 112 of MCCA are repealed and the provisions of law amended by such sections are restored or revived as if such sections had not been enacted.

(b) DELAY IN STUDY DEADLINE.—Section 113(c) of MCCA is amended by striking "November 30, 1988" and inserting "May 31, 1990".

(c) DISPOSAL OF FUNDS IN FEDERAL HOSPITAL INSURANCE CATASTROPHIC COVERAGE RESERVE FUND.—Any balance in the Federal Hospital Insurance Catastrophic Coverage Reserve Fund (created under section 1817A(a) of the Social Security Act, as inserted by section 112(a) of MCCA) as of January 1, 1990, shall be transferred into the Federal Supplementary Medical Insurance Trust Fund and any amounts payable due to overpayments into such Trust Fund shall be payable from the Federal Supplementary Medical Insurance Trust Fund. 42 USC 1395t note.

(d) EFFECTIVE DATES.— 26 USC 59B note.

(1) IN GENERAL.—Except as provided in this subsection, the provisions of this section shall take effect January 1, 1990.

(2) REPEAL OF SUPPLEMENTAL MEDICARE PREMIUM.—The repeal of section 111 of MCCA shall apply to taxable years beginning after December 31, 1988.

TITLE II—PROVISIONS RELATING TO PART B OF THE MEDICARE PROGRAM

SEC. 201. REPEAL OF EXPANSION OF MEDICARE PART B BENEFITS.

(a) IN GENERAL.— 42 USC 1320a-7a note.

(1) GENERAL RULE.—Except as provided in paragraph (2), sections 201 through 208 of MCCA are repealed and the provisions of law amended or repealed by such sections are restored or revived as if such sections had not been enacted.

(2) EXCEPTION.—Paragraph (1) shall not apply to subsections (g) and (m)(4) of section 202 of MCCA.

(b) CONFORMING AMENDMENTS.—Section 1905(p) of the Social Security Act (42 U.S.C. 1396d(p)) is amended— 42 USC 1320a-7a and note, 1320c-3 and note, 1395b-1 note, 1395h, 1395k and notes, 1395*l*, 1395m and notes, 1395n, 1395u and notes, 1395w-2, 1395w-3, 1395x and notes, 1395y, 1395z, 1395aa-1395bb, 1395cc, 1395mm, 1395*ll* note, 1395ww note, 1396a, 1396b, 1396n.

(1) in paragraph (3)(C)—

(A) by striking "Subject to paragraph (4), deductibles" and inserting "Deductibles", and

(B) by striking "1813, section 1833(b)" and all that follows and inserting "1813 and section 1833(b))."; and

(2) by striking paragraph (4) and redesignating paragraph (5) as paragraph (4).

(c) EFFECTIVE DATE.—The provisions of this section shall take effect January 1, 1990.

SEC. 202. REPEAL OF CHANGES IN MEDICARE PART B MONTHLY PREMIUM AND FINANCING.

(a) IN GENERAL.—Sections 211 through 213 (other than sections 211(b) and 211(c)(3)(B)) of MCCA are repealed and the provisions of law amended or repealed by such sections are restored or revised as if such sections had not been enacted. 42 USC 1320a-7a note. 42 USC 401 note. 42 USC 401, 1395i, 1395*l*, 1395r and note, 1395s, 1395t, 1395t-1, 1395t-2, 1395w, 1395mm.

(b) EFFECTIVE DATE.—The provisions of subsection (a) shall take effect January 1, 1990, and the repeal of section 211 of MCCA shall apply to premiums for months beginning after December 31, 1989.

SEC. 203. AMENDMENT OF CERTAIN MISCELLANEOUS PROVISIONS.

(a) REVISION OF MEDIGAP REGULATIONS.—

(1) IN GENERAL.—Section 1882 of the Social Security Act (42 U.S.C. 1395ss), as amended by section 221(d) of MCCA, is amended—

(A) in the third sentence of subsection (a) and in subsection (b)(1), by striking "subsection (k)(3)" and inserting "subsections (k)(3), (k)(4), (m), and (n)";

(B) in subsection (k)—

(i) in paragraph (1)(A), by inserting "except as provided in subsection (m)," before "subsection (g)(2)(A)", and

(ii) in paragraph (3), by striking "subsection (l)" and inserting "subsections (l), (m), and (n)"; and

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

State and local governments.

"(m)(1)(A) If, within the 90-day period beginning on the date of the enactment of this subsection, the National Association of Insurance Commissioners (in this subsection and subsection (n) referred to as the 'Association') revises the amended NAIC Model Regulation (referred to in subsection (k)(1)(A) and adopted on September 20, 1988) to improve such regulation and otherwise to reflect the changes in law made by the Medicare Catastrophic Coverage Repeal Act of 1989, subsection (g)(2)(A) shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the amended NAIC Model Regulation (referred to in subsection (k)(1)(A)) as revised by the Association in accordance with this paragraph (in this subsection and subsection (n) referred to as the 'revised NAIC Model Regulation').

"(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the revised NAIC Model Regulation or 1 year after the date the Association first adopts such revised Regulation.

"(2)(A) If the Association does not revise the amended NAIC Model Regulation, within the 90-day period specified in paragraph (1)(A), the Secretary shall promulgate, not later than 60 days after the end of such period, revised Federal model standards (in this subsection and subsection (n) referred to as 'revised Federal model standards') for medicare supplemental policies to improve such standards and otherwise to reflect the changes in law made by the Medicare Catastrophic Coverage Repeal Act of 1989, subsection (g)(2)(A) shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the revised Federal model standards.

"(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the revised Federal model standards or 1 year after the date the Secretary first promulgates such standards.

"(3) Notwithstanding any other provision of this section (except as provided in subsection (n))—

"(A) no medicare supplemental policy may be certified by the Secretary pursuant to subsection (a),

"(B) no certification made pursuant to subsection (a) shall remain in effect, and

"(C) no State regulatory program shall be found to meet (or to continue to meet) the requirements of subsection (b)(1)(A),

unless such policy meets (or such program provides for the application of standards equal to or more stringent than) the standards set

forth in the revised NAIC Model Regulation or the revised Federal model standards (as the case may be) by the date specified in paragraph (1)(B) or (2)(B) (as the case may be).

"(n)(1) Until the date specified in paragraph (4), in the case of a qualifying medicare supplemental policy described in paragraph (3) issued in a State—

"(A) before the transition deadline, the policy is deemed to remain in compliance with the standards described in subsection (b)(1)(A) only if the insurer issuing the policy complies with the transition provision described in paragraph (2), or

"(B) on or after the transition deadline, the policy is deemed to be in compliance with the standards described in subsection (b)(1)(A) only if the insurer issuing the policy complies with the revised NAIC Model Regulation or the revised Federal model standards (as the case may be) before the date of the sale of the policy.

In this paragraph, the term 'transition deadline' means 1 year after the date the Association adopts the revised NAIC Model Regulation or 1 year after the date the Secretary promulgates revised Federal model standards (as the case may be).

"(2) The transition provision described in this paragraph is—

"(A) such transition provision as the Association provides, by not later than December 15, 1989, so as to provide for an appropriate transition (i) to restore benefit provisions which are no longer duplicative as a result of the changes in benefits under this title made by the Medicare Catastrophic Coverage Repeal Act of 1989 and (ii) to eliminate the requirement of payment for the first 8 days of coinsurance for extended care services, or

"(B) if the Association does not provide for a transition provision by the date described in subparagraph (A), such transition provision as the Secretary shall provide, by January 1, 1990, so as to provide for an appropriate transition described in subparagraph (A).

"(3) In paragraph (1), the term 'qualifying medicare supplemental policy' means a medicare supplemental policy which has been issued in compliance with this section as in effect on the date before the date of the enactment of this subsection.

"(4)(A) The date specified in this paragraph for a policy issued in a State is—

"(i) the first date a State adopts, after the date of the enactment of this subsection, standards equal to or more stringent than the revised NAIC Model Regulation (or revised Federal model standards), as the case may be, or

"(ii) the date specified in subparagraph (B),

whichever is earlier.

"(B) In the case of a State which the Secretary identifies, in consultation with the Association, as—

"(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet standards described in subparagraph (A)(i), but

"(ii) having a legislature which is not scheduled to meet in 1990 in a legislative session in which such legislation may be considered,

the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1,

1990. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

"(5) In the case of a medicare supplemental policy in effect on January 1, 1990, the policy shall not be deemed to meet the standards in subsection (c) unless each individual who is entitled to benefits under this title and is a policyholder or certificate holder under such policy on such date is sent a notice in an appropriate form by not later than January 31, 1990, that explains—

"(A) the changes in benefits under this title effected by the Medicare Catastrophic Coverage Repeal Act of 1989, and

"(B) how these changes may affect the benefits contained in such policy and the premium for the policy.

"(6)(A) Except as provided in subparagraph (B), in the case of an individual who had in effect, as of December 31, 1988, a medicare supplemental policy with an insurer (as a policyholder or, in the case of a group policy, as a certificate holder) and the individual terminated coverage under such policy before the date of the enactment of this subsection, no medicare supplemental policy of the insurer shall be deemed to meet the standards in subsection (c) unless the insurer—

"(i) provides written notice, no earlier than December 15, 1989, and no later than January 30, 1990, to the policyholder or certificate holder (at the most recent available address) of the offer described in clause (ii), and

"(ii) offers the individual, during a period of at least 60 days beginning not later than February 1, 1990, reinstitution of coverage (with coverage effective as of January 1, 1990), under the terms which (I) do not provide for any waiting period with respect to treatment of pre-existing conditions, (II) provides for coverage which is substantially equivalent to coverage in effect before the date of such termination, and (III) provides for classification of premiums on which terms are at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage never terminated.

"(B) An insurer is not required to make the offer under subparagraph (A)(ii) in the case of an individual who is a policyholder or certificate holder in another medicare supplemental policy as of the date of the enactment of this subsection, if (as of January 1, 1990) the individual is not subject to a waiting period with respect to treatment of a pre-existing condition under such other policy.".

42 USC 1395mm note.

(b) ADJUSTMENT OF CONTRACTS WITH PREPAID HEALTH PLANS.—Notwithstanding any other provision of this Act, the amendments made by this Act (other than the repeal of sections 1833(c)(5) and 1834(c)(6) of the Social Security Act) shall not apply to risk-sharing contracts, for contract year 1990—

(1) with eligible organizations under section 1876 of the Social Security Act, or

(2) with health maintenance organizations under section 1876(i)(2)(A) of such Act (as in effect before February 1, 1985), under section 402(a) of the Social Security Amendments of 1967, or under section 222(a) of the Social Security Amendments of 1972.

42 USC 1395b-2 note.

(c) NOTICE OF CHANGES.—The Secretary of Health and Human Services shall provide, in the notice of medicare benefits provided under section 1804 of the Social Security Act for 1990, for a descrip-

tion of the changes in benefits under title XVIII of such Act made by the amendments made by this Act.

(d) MISCELLANEOUS TECHNICAL CORRECTION.—Section 221(g)(3) of MCCA is amended by striking "subsection (f)" and inserting "subsection (e)". 42 USC 1395ss note.

(e) EFFECTIVE DATE.—The provisions of this section shall take effect January 1, 1990, except that the amendment made by subsection (d) shall be effective as if included in the enactment of MCCA. 42 USC 1395ss note.

TITLE III—MISCELLANEOUS AMENDMENTS

SEC. 301. MISCELLANEOUS MCCA AMENDMENTS.

(a) IN GENERAL.—Sections 421 through 425 and 427 of MCCA are repealed and any provision of law amended or repealed by such sections is restored or revived as if such sections had not been enacted. 5 USC 902 note; 42 USC 1395b note, 1395b-1 note, 1395b-2 note, 1395h note.

(b) MISCELLANEOUS TECHNICAL CORRECTIONS.—

(1) Effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, section 1834(b)(4)(A) of the Social Security Act, as added by section 4049(a)(2) of the Omnibus Budget Reconciliation Act of 1987, is amended by striking "insurance and deductibles under section 1835(a)(1)(I)" and inserting "coinsurance and deductibles under sections 1833(a)(1)(J)". 42 USC 1395m.

(2) Section 1842(j)(1)(C)(vii) of the Social Security Act, as added by section 4085(i)(7)(C) of the Omnibus Budget Reconciliation Act of 1987, is amended by striking "accordingly" and inserting "according". 42 USC 1395u.

(3) Section 1886(g)(3)(A)(iv) of the Social Security Act, as added by section 4006(a)(2) of the Omnibus Budget Reconciliation Act of 1987, is amended by striking "may) be" and inserting "may be)" 42 USC 1395ww.

(4) Section 1866(a)(1)(F)(i)(III) of the Social Security Act is amended by striking "fiscal year))" and inserting "fiscal year)". 42 USC 1395cc.

(5) Section 1875(c)(7) of the Social Security Act, as added by section 9316(a) of the Omnibus Budget Reconciliation Act of 1986, is amended by striking "date of the enactment of this Act" and inserting "date of the enactment of this section". 42 USC 1395*ll*.

(6) Section 1842(j)(2)(B) of the Social Security Act, as amended by section 8(c)(2)(A) of the Medicare and Medicaid Fraud and Abuse Patient Protection Act of 1987, is amended by striking "paragraphs" and inserting "subsections".

(c) MISCELLANEOUS CORRECTIONS RELATING TO THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987.—

(1) Effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, section 1834(b)(4)(A) of the Social Security Act (42 U.S.C. 1395m(b)(4)(A)), as added by section 4049(a)(2) of the Omnibus Budget Reconciliation Act of 1987, is amended by striking "insurance and deductibles under section 1835(a)(1)(I)" and inserting "coinsurance and deductibles under sections 1833(a)(1)(J)".

(2) Section 1842(j)(1)(C)(vii) of the Social Security Act (42 U.S.C. 1395u(j)(1)(C)(viii)), as added by section 4085(i)(7)(C) of the

Omnibus Budget Reconciliation Act of 1987, is amended by striking "accordingly" and inserting "according".

(3) Section 1886(g)(3)(A)(iv) of the Social Security Act (42 U.S.C. 1395ww(g)(3)(A)(iv)), as added by section 4006(a)(2) of the Omnibus Budget Reconciliation Act of 1987, is amended by striking "may) be" and inserting "may be)".

(d) OTHER CORRECTIONS.—

(1) Section 1866(a)(1)(F)(i)(III) of the Social Security Act (42 U.S.C. 1395cc(a)(1)(F)(i)(III)) is amended by striking "fiscal year))" and inserting "fiscal year)".

(2) Section 1875(c)(7) of the Social Security Act (42 U.S.C. 1395ll(c)(7)), as added by section 9316(a) of the Omnibus Budget Reconciliation Act of 1986, is amended by striking "date of the enactment of this Act" and inserting "date of the enactment of this section".

(3) Section 1842(j)(2)(B) of the Social Security Act (42 U.S.C. 1395u(j)(2)(B)), as amended by section 8(c)(2)(A) of the Medicare and Medicaid Fraud and Abuse Patient Protection Act of 1987, is amended by striking "paragraphs" and inserting "subsections".

42 USC 1395u note.

(e) EFFECTIVE DATE.—The provisions of this section (other than subsections (c) and (d)) shall take effect January 1, 1990, except that—

(1) the repeal of section 421 of MCCA shall not apply to duplicative part A benefits for periods before January 1, 1990, and

(2) the amendments made by subsection (b) shall take effect on the date of the enactment of this Act.

Approved December 13, 1989.

LEGISLATIVE HISTORY—H.R. 3607:

HOUSE REPORTS: No. 101-378 (Comm. of Conference).
CONGRESSIONAL RECORD, Vol. 135 (1989):
Nov. 8, considered and passed House; considered and passed Senate, amended.
Nov. 19, House agreed to conference report. Senate rejected conference report.
Nov. 21, Senate receded from its amendment.

○

101st Congress
1st Session
HOUSE OF REPRESENTATIVES
Report
101-378

MEDICARE CATASTROPHIC COVERAGE REPEAL ACT OF 1989

November 19, 1989.—Ordered to be printed

Mr. Rostenkowski, from the committee of conference, submitted the following

CONFERENCE REPORT

[To accompany H.R. 3607]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 3607) to repeal medicare provisions in the Medicare Catastrophic Coverage Act of 1988, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate and agree to the same with the amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicare Catastrophic Coverage Repeal Act of 1989".

TITLE I—PROVISIONS RELATING TO PART A OF MEDICARE PROGRAM AND SUPPLEMENTAL MEDICARE PREMIUM

SEC. 101. REPEAL OF EXPANSION OF MEDICARE PART A BENEFITS.

(a) In General.—

(1) General rule.—Except as provided in paragraph (2), sections 101, 102, and 104(d) (other than paragraph (7)) of the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360) (in this Act referred to as "MCCA") are repealed, and the provi-

sions of law amended or repealed by such sections are restored or revived as if such section had not been enacted.

(2) EXCEPTION FOR BLOOD DEDUCTION.—The repeal of section 102(1) of MCCA (relating to deductibles and coinsurance under part A) shall not apply, but only insofar as such section amended paragraph (2) of section 1813(a) of the Social Security Act (relating to a deduction for blood).

(b) TRANSITION PROVISIONS FOR MEDICARE BENEFICIARIES.—

(1) INPATIENT HOSPITAL SERVICES AND POST-HOSPITAL EXTENDED CARE SERVICES.—In applying sections 1812 and 1813 of the Social Security Act, as restored by subsection (a)(1), with respect to inpatient hospital services and extended care services provided on or after January 1, 1990—

(A) no day before January 1, 1990, shall be counted in determining the beginning (or period) of a spell of illness;

(B) with respect to the limitation on such services provided in a spell of illness, days of such services before January 1, 1990, shall not be counted, except that days of inpatient hospital services before January 1, 1989, which were applied with respect to an individual after receiving 90 days of services in a spell of illness (commonly known as "lifetime reserve days") shall be counted;

(C) the limitation of coverage of extended care services to post-hospital extended care services shall not apply to an individual receiving such services from a skilled nursing facility during a continuous period beginning before (and including) January 1, 1990, until the end of the period of 30 consecutive days in which the individual is not provided inpatient hospital services or extended care services; and

(D) the inpatient hospital deductible under section 1813(a)(1) of such Act shall not apply—

(i) in the case of an individual who is receiving inpatient hospital services during a continuous period beginning before (and including) January 1, 1990, with respect to the spell of illness beginning on such date, if such a deductible was imposed on the individual for a period of hospitalization during 1989;

(ii) for a spell of illness beginning during January 1990, if such a deductible was imposed on the individual for a period of hospitalization that began in December 1989; and

(iii) in the case of a spell of illness of an individual that began before January 1, 1990.

(2) HOSPICE CARE.—The restoration of section 1812(a)(4) of the Social Security Act, effected by subsection (a)(1), shall not apply to hospice care provided during the subsequent period (described in such section as in effect on December 31, 1989) with respect to which an election has been made before January 1, 1990.

(3) TERMINATION OF HOLD HARMLESS PROVISIONS.—Section 104(b) of MCCA is amended by striking "or 1990" each place it appears.

(c) TERMINATION OF TRANSITIONAL ADJUSTMENTS IN PAYMENTS FOR INPATIENT HOSPITAL SERVICES.—

(1) PPS HOSPITALS.—Section 104(c)(1) of MCCA is amended by inserting "and before January 1, 1990," after "October 1, 1988,".

(2) PPS-EXEMPT HOSPITALS.—

(A) IN GENERAL.—Section 104(c)(2) of MCCA is amended—

(i) by inserting "and before January 1, 1990," after "January 1, 1989,"; and

(ii) by striking the period at the end and inserting the following: ", without regard to whether any of such beneficiaries exhausted medicare inpatient hospital insurance benefits before January 1, 1989.".

(B) TRANSITION.—The Secretary of Health and Human Services shall make an appropriate adjustment to the target amount established under section 1886(b)(3)(A) of the Social Security Act in the case of inpatient hospital services provided to an inpatient whose stay began before January 1, 1990, in order to take into account the target amount that would have applied but for the amendments made by this title.

(d) EFFECTIVE DATE.—The provisions of this section shall take effect January 1, 1990, except that the amendments made by subsection (c) shall be effective as if included in the enactment of MCCA.

SEC. 102. REPEAL OF SUPPLEMENTAL MEDICARE PREMIUM AND FEDERAL HOSPTIAL INSURANCE CATASTROPHIC COVERAGE RESERVE FUND.

(a) IN GENERAL.—Sections 111 and 112 of MCCA are repealed and the provisions of law amended by such sections are restored or revived as if such sections had not been enacted.

(b) DELAY IN STUDY DEADLINE.—Section 113(c) of MCCA is amended by striking "November 30, 1988" and inserting "May 31, 1990".

(c) DISPOSAL OF FUNDS IN FEDERAL HOSPITAL INSURANCE CATASTROPHIC COVERAGE RESERVE FUND.—Any balance in the Federal Hospital Insurance Catastrophic Coverage Reserve Fund (created under section 1817A(a) of the Social Security Act, as inserted by section 112(a) of MCCA) as of January 1, 1990, shall be transferred into the Federal Supplementary Medical Insurance Trust Fund and any amounts payable due to overpayments into such Trust Fund shall be payable from the Federal Supplementary Medical Insurance Trust Fund.

(d) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in this subsection, the provisions of this section shall take effect January 1, 1990.

(2) REPEAL OF SUPPLEMENTAL MEDICARE PREMIUM.—The repeal of section 111 of MCCA shall apply to taxable years beginning after December 31, 1988.

TITLE II—PROVISIONS RELATING TO PART B OF THE MEDICARE PROGRAM

SEC. 201. REPEAL OF EXPANSION OF MEDICARE PART B BENEFITS.

(a) IN GENERAL.—

(1) GENERAL RULE.—Except as provided in paragraph (2), sections 201 through 208 of MCCA are repealed and the provisions of law amended or repealed by such sections are restored or revived as if such sections had not been enacted.

(2) EXCEPTION.—Paragraph (1) shall not apply to subsections (g) and (m)(4) of section 202 of MCCA.

(b) CONFORMING AMENDMENTS.—Section 1905(p) of the Social Security Act (42 U.S.C. 1396d(p)) is amended—

(1) in paragraph (3)(C)—

(A) by striking "Subject to paragraph (4), deductibles" and inserting "Deductibles", and

(B) by striking "1813, section 1833(b)" and all that follows and inserting "1813 and section 1833(b)."; and

(2) by striking paragraph (4) and redesignating paragraph (5) as paragraph (4).

(c) EFFECTIVE DATE.—The provisions of this section shall take effect January 1, 1990.

SEC. 202. REPEAL OF CHANGES IN MEDICARE PART B MONTHLY PREMIUM AND FINANCING

(a) IN GENERAL.—Sections 211 through 213 (other than sections 211(b) and 211(c)(3)(B)) of MCCA are repealed and the provisions of law amended or repealed by such sections are restored or revised as if such sections had not been enacted.

(b) EFFECTIVE DATE.—The provisions of subsection (a) shall take effect January 1, 1990, and the repeal of section 211 of MCCA shall apply to premiums for months beginning after December 31, 1989.

SEC. 203. AMENDMENT OF CERTAIN MISCELLANEOUS PROVISIONS.

(a) REVISION OF MEDIGAP REGULATIONS.—

(1) IN GENERAL.—Section 1882 of the Social Security Act (42 U.S.C. 1395ss), as amended by section 221(d) of MCCA, is amended—

(A) in the third sentence of subsection (a) and in subsection (b)(1), by striking "subsection (k)(3)" and inserting "subsections (k)(3), (k)(4), (m), and (n)";

(B) in subsection (k)—

(i) in paragraph (1)(A), by inserting "except as provided in subsection (m)," before "subsection (g)(2)(A)", and

(ii) in paragraph (3), by striking "subsection (1)" and inserting "subsections (l), (m), and (n)"; and

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

"(m)(1)(A) If, within the 90-day period beginning on the date of the enactment of this subsection, the National Association of Insurance Commissioners (in this subsection and subsection (n) referred to as the 'Association') revises the amended NAIC Model Regulation (referred to in subsection (k)(1)(A) and adopted on September 20, 1988) to improve such regulation and otherwise to reflect the changes in law made by the Medicare Catastrophic Coverage Repeal Act of 1989, subsection (g)(2)(A) shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the amended NAIC Model Regulation (referred to in subsection (k)(1)(A)) as revised by the Association in accordance with this

paragraph (in this subsection and subsection (n) referred to as the 'revised NAIC Model Regulation').

"(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the revised NAIC Model Regulation or 1 year after the date the Association first adopts such revised Regulation.

"(2)(A) If the Association does not revise the amended NAIC Model Regulation, within the 90-day period specified in paragraph (1)(A), the Secretary shall promulgate, not later than 60 days after the end of such period, revised Federal model standards (in this subsection and subsection (n) referred to as 'revised Federal model standards') for medicare supplemental policies to improve such standards and otherwise to reflect the changes in law made by the Medicare Catastrophic Coverage Repeal Act of 1989, subsection (g)(2)(A) shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the revised Federal model standards.

"(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the revised Federal model standards or 1 year after the date the Secretary first promulgates such standards.

"(3) Notwithstanding any other provision of this section (except as provided in subsection (n))—

"(A) no medicare supplemental policy may be certified by the Secretary pursuant to subsection (a),

"(B) no certification made pursuant to subsection (a) shall remain in effect, and

"(C) no State regulatory program shall be found to meet (or to continue to meet) the requirements of subsection (b)(1)(A),

unless such policy meets (or such program provides for the application of standards equal to or more stringent than) the standards set forth in the revised NAIC Model Regulation or the revised Federal model standards (as the case may be) by the date specified in paragraph (1)(B) or (2)(B) (as the case may be).

"(n)(1) Until the date specified in paragraph (4), in the case of a qualifying medicare supplemental policy described in paragraph (3) issued in a State—

"(A) before the transition deadline, the policy is deemed to remain in compliance with the standards described in subsection (b)(1)(A) only if the insurer issuing the policy complies with the transition provision described in paragraph (2), or

"(B) on or after the transition deadline, the policy is deemed to be in compliance with the standards described in subsection (b)(1)(A) only if the insurer issuing the policy complies with the revised NAIC Model Regulation or the revised Federal model standards (as the case may be) before the date of the sale of the policy.

In this paragraph, the term 'transition deadline' means 1 year after the date the Association adopts the revised NAIC Model Regulation or 1 year after the date the Secretary promulgates revised Federal model standards (as the case may be).

"(2) The transition provision described in this paragraph is—

"(A) such transition provision as the Association provides, by not later than December 15, 1989, so as to provide for an appropriate transition (i) to restore benefit provisions which are no longer duplicative as a result of the changes in benefits under this title made by the Medicare Catastrophic Coverage Repeal Act of 1989 and (ii) to eliminate the requirement of payment for the first 8 days of coinsurance for extended care services, or

"(B) if the Association does not provide for a transition provision by the date described in subparagraph (A), such transition provision as the Secretary shall provide, by January 1, 1990, so as to provide for an appropriate transition described in subparagraph (A).

"(3) In paragraph (1), the term 'qualifying medicare supplemental policy' means a medicare supplemental policy which has been issued in compliance with this section as in effect on the date before the date of the enactment of this subsection.

"(4)(A) The date specified in this paragraph for a policy issued in a State is—

"(i) the first date a State adopts, after the date of the enactment of this subsection, standards equal to or more stringent than the revised NAIC Model Regulation (or revised Federal model standards), as the case may be, or

"(ii) the date specified in subparagraph (B),

whichever is earlier.

"(B) In the case of a State which the Secretary identifies, in consultation with the Association, as—

"(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet standards described in subparagraph (A)(i), but

"(ii) having a legislature which is not scheduled to meet in 1990 in a legislative session in which such legislation may be considered,

the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1990. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

"(5) In the case of a medicare supplemental policy in effect on January 1, 1990, the policy shall not be deemed to meet the standards in subsection (c) unless each individual who is entitled to benefits under this title and is a policyholder or certificate holder under such policy on such date is sent a notice in an appropriate form by not later than January 31, 1990, that explains—

"(A) the changes in benefits under this title effected by the Medicare Catastrophic Coverage Repeal Act of 1989, and

"(B) how these changes may affect the benefits contained in such policy and the premium for the policy.

"(6)(A) Except as provided in subparagraph (B), in the case of an individual who had in effect, as of December 31, 1988, a medicare supplemental policy with an insurer (as a policyholder or, in the case of a group policy, as a certificate holder) and the individual terminated coverage under such policy before the date of the enact-

ment of this subsection, no medicare supplemental policy of the insurer shall be deemed to meet the standards in subsection (c) unless the insurer—

"(i) provides written notice, no earlier than December 15, 1989, and no later than January 30, 1990, to the policyholder or certificate holder (at the most recent available address) of the offer described in clause (ii), and

"(ii) offers the individual, during a period of at least 60 days beginning not later than February 1, 1990, reinstitution of coverage (with coverage effective as of January 1, 1990), under the terms which (I) do not provide for any waiting period with respect to treatment of pre-existing conditions, (II) provides for coverage which is substantially equivalent to coverage in effect before the date of such termination, and (III) provides for classification of premiums on which terms are at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage never terminated.

"(B) An insurer is not required to make the offer under subparagraph (A)(ii) in the case of an individual who is a policyholder or certificate holder in another medicare supplemental policy as of the date of the enactment of this subsection, if (as of January 1, 1990) the individual is not subject to a waiting period with respect to treatment of a pre-existing condition under such other policy.".

(b) ADJUSTMENT OF CONTRACTS WITH PREPAID HEALTH PLANS.—Notwithstanding any other provision of this Act, the amendments made by this Act (other than the repeal of sections 1833(c)(5) and 1834(c)(6) of the Social Security Act) shall not apply to risk-sharing contracts, for contract year 1990—

(1) with eligible organizations under section 1876 of the Social Security Act, or

(2) with health maintenance organizations under section 1876(i)(2)(A) of such Act (as in effect before February 1, 1985), under section 402(a) of the Social Security Amendments of 1967, or under section 222(a) of the Social Security Amendments of 1972.

(c) NOTICE OF CHANGES.—The Secretary of Health and Human Services shall provide, in the notice of medicare benefits provided under section 1804 of the Social Security Act for 1990, for a description of the changes in benefits under title XVIII of such Act made by the amendments made by this Act.

(d) MISCELLANEOUS TECHNICAL CORRECTION.—Section 221(g)(3) of MCCA is amended by striking "subsection (f)" and inserting "subsection (e)".

(e) EFFECTIVE DATE.—The provisions of this section shall take effect January 1, 1990, except that the amendment made by subsection (d) shall be effective as if included in the enactment of MCCA.

TITLE III—MISCELLANEOUS AMENDMENTS

SEC. 301. MISCELLANEOUS MCCA AMENDMENTS.

(a) IN GENERAL.—Sections 421 through 425 and 427 of MCCA are repealed and any provision of law amended or repealed by such sections is restored or revived as if such sections had not been enacted.

(b) MISCELLANEOUS TECHNICAL CORRECTIONS.—

(1) Effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, section 1834(b)(4)(A) of the Social Security Act, as added by section 4049(a)(2) of the Omnibus Budget Reconciliation Act of 1987, is amended by striking "insurance and deductibles under section 1835(a)(1)(I)" and inserting "coinsurance and deductibles under sections 1833(a)(1)(J)".

(2) Section 1842(j)(1)(C)(vii) of the Social Security Act, as added by section 4085(i)(7)(C) of the Omnibus Budget Reconciliation Act of 1987, is amended by striking "accordingly" and inserting "according".

(3) Section 1886(g)(3)(A)(iv) of the Social Security Act, as added by section 4006(a)(2) of the Omnibus Budget Reconciliation Act of 1987, is amended by striking "may) be" and inserting "may be)"

(4) Section 1866(a)(1)(F)(i)(III) of the Social Security Act is amended by striking "fiscal year))" and inserting "fiscal year)".

(5) Section 1875(c)(7) of the Social Security Act, as added by section 9316(a) of the Omnibus Budget Reconciliation Act of 1986, is amended by striking "date of the enactment of this Act" and inserting "date of the enactment of this section".

(6) Section 1842(j)(2)(B) of the Social Security Act, as amended by section 8(c)(2)(A) of the Medicare and Medicaid Fraud and Abuse Patient Protection Act of 1987, is amended by striking "paragraphs" and inserting "subsections".

(c) MISCELLANEOUS CORRECTIONS RELATING TO THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987.—

(1) Effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, section 1834(b)(4)(A) of the Social Security Act (42 U.S.C. 1395m(b)(4)(A)), as added by section 4049(a)(2) of the Omnibus Budget Reconciliation Act of 1987, is amended by striking "insurance and deductibles under section 1835(a)(1)(I)" and inserting "coinsurance and deductibles under sections 1833(a)(1)(J)".

(2) Section 1842(j)(1)(C)(vii) of the Social Security Act (42 U.S.C. 1395u(j)(1)(C)(viii)), as added by section 4085(i)(7)(C) of the Omnibus Budget Reconciliation Act of 1987, is amended by striking "accordingly" and inserting "according".

(3) Section 1886(g)(3)(A)(iv) of the Social Security Act (42 U.S.C. 1395ww(g)(3)(A)(iv)), as added by section 4006(a)(2) of the Omnibus Budget Reconciliation Act of 1987, is amended by striking "may) be" and inserting "may be)".

(d) OTHER CORRECTIONS.—

(1) Section 1866(a)(1)(F)(i)(III) of the Social Security Act (42 U.S.C. 1395cc(a)(1)(F)(i)(III)) is amended by striking "fiscal year))" and inserting "fiscal year)".

(2) Section 1875(c)(7) of the Social Security Act (42 U.S.C. 1395ll(c)(7)), as added by section 9316(a) of the Omnibus Budget Reconciliation Act of 1986, is amended by striking "date of the enactment of this Act" and inserting "date of the enactment of this section".

(3) Section 1842(j)(2)(B) of the Social Security Act (42 U.S.C. 1395u(j)(2)(B)), as amended by section 8(c)(2)(A) of the Medicare and Medicaid Fraud and Abuse Patient Protection Act of 1987, is amended by striking "paragraphs" and inserting "subsections".

(e) EFFECTIVE DATE.—The provisions of this section (other than subsections (c) and (d)) shall take effect January 1, 1990, except that—

(1) the repeal of section 421 of MCCA shall not apply to duplicative part A benefits for periods before January 1, 1990, and

(2) the amendments made by subsection (b) shall take effect on the date of the enactment of this Act.

And the Senate agree to the same.

From the Committee on Ways and Means, for consideration of the House bill, and the Senate amendment, and modifications committed to conference:

BRIAN DONNELLY,
BEN CARDIN,
MARTY RUSSO,
BILL ARCHER,
GUY VANDER JAGT,
PHILIP M. CRANE,
BILL FRENZEL,
R.T. SCHULZE,

From the Committee on Energy and Commerce, for consideration of the House bill, and the Senate amendment, and modifications committed to conference:

JOHN D. DINGELL,
HENRY A. WAXMAN,
DOUG WALGREN,
RON WYDEN,
TERRY L. BRUCE,
J. ROY ROWLAND,
CARDISS COLLINS,
RALPH M. HALL,
NORMAN F. LENT,
EDWARD R. MADIGAN,
BILL DANNEMEYER,
MIKE BILIRAKIS,

Managers on the Part of the House.

LLOYD BENTSEN,
SPARK M. MATSUNAGA,
DANIEL PATRICK MOYNIHAN,
MAX BAUCUS,
GEORGE J. MITCHELL,
BOB PACKWOOD,
W.V. ROTH, Jr.,
JOHN C. DANFORTH,

Managers on the Part of the Senate.

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 3607) to repeal medicare provisions in the Medicare Catastrophic Coverage Act of 1988, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report:

The Senate amendment struck out all of the House bill after the enacting clause and inserted a substitute text.

The House recedes from its disagreement to the amendment of the Senate with an amendment which is a substitute for the House bill and the Senate amendment. The differences between the House bill, the Senate amendment, and the substitute agreed to in conference are noted below, except for clerical corrections, conforming changes made necessary by agreements reached by the conferees, and minor drafting and clarifying changes.

Catastrophic Health Insurance

1. PROVISIONS RELATING TO PART A OF MEDICARE PROGRAM AND SUPPLEMENTAL PREMIUM

Present law

(a) Part A benefits

(1) *Hospital Benefits.*—The Medicare Catastrophic Coverage Act of 1988 (MCCA) provided coverage for an unlimited number of hospital days subject to one annual deductible.

Previously, coverage was linked to a spell of illness. A spell of illness began when a beneficiary entered a hospital and ended when he or she had not been an inpatient for a hospital or skilled nursing facility (SNF) for 60 days. For each spell of illness, one deductible was imposed for the first 60 days of care. Days in excess of 60 were subject to coinsurance charges; a beneficiary could potentially have exhausted all inpatient hospital benefits.

(2) *Skilled Nursing Facility Benefits.*—The SNF benefit as modified by MCCA authorizes coverage for up to 150 days of care per calendar year; no prior hospitalization is required. Daily coinsurance charges are imposed for the first 8 days per year equal to 20 percent of the national average Medicare reasonable cost for SNF care (estimated at $25.50/day in 1989).

Prior to MCCA, Medicare covered 100 days of post-hospital SNF care per spell of illness. (See definition under (1)). Beneficiaries were subject to daily cost-sharing charges (equal to one-eighth of the inpatient hospital deductible on days 21–100).

(3) *Home Health Benefits.*—Home health benefits are covered under Medicare if the beneficiary is homebound and requires skilled nursing care on an intermittent basis or physical or speech therapy. Program guidelines have defined intermittent as permitting daily care for 5 days a week for up to 2 or 3 weeks. MCCA, effective January 1, 1990 expands the intermittent definition so that daily care is defined as up to 7 days a week for 38 days.

(4) *Hospice Benefits.*—MCCA provided for an extension beyond the 210-day limit if the beneficiary is rectified as terminally ill.

(5) *Transition Provisions.*—No provision.

(6) *Hold Harmless.*—MCCA applied a special provision in the case of a beneficiary whose spell of illness (for which a deductible was imposed) began before Jan. 1, 1989 and had not ended on that date. No deductible could be applied for that spell of illness in 1989 or 1990.

(7) *PPS Payments.*—MCCA provided for transitional adjustments in PPS payments to take into account the new law.

In the case of a hospital exempt from PPS, MCCA provided for an adjustment in the target amount (the annual limit on total Medicare payment to such a hospital) to take into account the additional days of care that Medicare would be covering. In computing this adjustment, the Secretary has excluded days of care that will be provided to beneficiaries who had exhausted their Medicare inpatient benefit before January 1, 1989.

(b) *Supplemental Medicare Premium and Federal Hospital Insurance Catastrophic Coverage Reserve Fund.*—All persons entitled to Medicare Part A who have a Federal tax liability of $150 or more are required to pay the supplemental premium. The supplemental premium is collected in conjunction with income tax payments. An estimated 41 percent of enrollees will pay the supplemental premium in 1989.

The Internal Revenue Code specifies the following supplemental premium rates per $150 of tax liability for 1989 through 1993: 1989, $22.50; 1990, $37.50; 1991, $39.00; 1992, $40.50; 1993, $42.00. The maximum supplemental premium amount is $800 in 1989, $850 in 1990, $900 in 1991, $950 in 1992, and $1,050 in 1993.

MCCA created a Federal Hospital Insurance Catastrophic Coverage Reserve Fund on the books of the Treasury, to which is appropriated amounts received from the supplemental catastrophic coverage premiums equal to 100 percent of Part A catastrophic benefit outlays.

(c) *Study.*—MCCA required the Secretary of the Treasury to study and report to Congress by November 30, 1988, on Federal tax policies to promote the private financing of long-term care.

House bill

(a) Part A benefits

(1) *Hospital Benefits.*—Repeals expanded benefits and restores pre-MCCA provisions.

(2) *Skilled Nursing Facility Benefits.*—Repeals expanded benefits and restores pre-MCCA provisions.

(3) *Home Health Benefits.*—Repeals the MCCA expansion.

(4) *Hospice Benefits.*—Repeals the MCCA extension.

(5) *Transition Provisions.*—Provides transition provisions for beneficiaries using inpatient hospital and extended care services after January 1, 1990:

(A) No period before January 1, 1990 is to be counted in determining the beginning or period of a spell of illness.

(B) With respect to the spell of illness day limitation, days of services provided before January 1, 1990, are not to be counted except that any lifetime reserve days used before January 1, 1989 are to be counted.

(C) The limitation on coverage of extended care services to post-hospital extended care services shall not apply to an individual receiving such services from a SNF during a continuous period beginning before (and including) January 1, 1990, until the end of the 30 consecutive day period in which the individual is not provided inpatient hospital or extended care services.

(D) The inpatient deductible does not apply:

(i) in the case of an individual who is receiving inpatient hospital services during a continuous period beginning before (and including) January 1, 1990 with respect to the spell of illness beginning on that date, if a deductible was imposed during 1989.

(ii) for a spell of illness beginning during January 1, 1990, if such a deductible was imposed on the individual for a period of hospitalization that began in Dec. 1989.

(iii) in the case of a spell of illness of an individual that began before January 1, 1989 and has not ended as of January 1, 1990.

Specifies that the pre-MCCA hospice provisions shall not apply to hospice care provided during the subsequent extension period (beyond 210 days) for which an election was made prior to January 1, 1990.

(6) *Holds Harmless.*—Deletes application of the provision in 1990.

(7) *PPS Payments.*—Terminates the transitional adjustments for payments to PPS and PPS-exempt hospitals January 1, 1990.

Requires the Secretary to include, in computing adjustments to the target amounts for PPS-exempt hospitals, days of care for persons who had exhausted their inpatient benefit before 1989.

(b) *Supplemental Medicare Premium and Federal Hospital Insurance Catastrophic Coverage Reserve Fund.*—Repeals the supplemental Medicare premium and the Federal Hospice Insurance Catastrophic Coverage Reserve Fund. Provides that any balance in the Reserve Fund as of January 1, 1990 must be transferred to the HI Trust Fund, and any amounts payable due to overpayments into such Trust Fund must be payable from the HI Trust Fund.

(c) *Study.*—Delays reporting date to May 31, 1990.

Effective date.—(a) Effective January 1, 1990, except termination of transitional PPS adjustments effective as if included in the enactment of MCCA. (b) Effective January 1, 1990, except premium repeal applies to taxable years beginning after December 31, 1988. (c) Effective January 1, 1990.

Senate amendment

(a) Part A benefits

(1) *Hospital Benefits.*—No provision.

(2) *Skilled Nursing Facility Benefits.*—Provides post-hospital extended care services coverage for up to 100 days during any spell of SNF care. Restores post-hospital requirements in effect prior to MCCA and makes conforming changes.

Defines the term "spell of SNF care". It is a period of consecutive days. It begins with the first day (not included in a previous spell of SNF care) on which the individual is furnished extended care services and which occurs in a month the individual is entitled to Part A. It ends with the close of the first 60 consecutive days thereafter on which he is not an inpatient of a SNF.

Restores pre-MCCA coinsurance requirements. The daily coinsurance, equal to one eigth of the inpatient hospital deductible, is imposed on days 21–100.

Requires the GAO to study the reasons for the unexpected increase in cost estimates of the Medicare extended care benefit. GAO is to report to Congress by February 1, 1990 on the results of the study.

Provides that the Secretary may provide coverage for extended care services that are not post-hospital. Such coverage is available at such time and for so long as the Secretary determines that inclusion of such services will not (A) result in any increase in the total SNF payments, and (B) will not alter the acute nature of the SNF benefit. The Secretary is required to provide to the extent necessary: (A) for limitations on the scope and extent of such services and on the categories of individuals who may be eligible for such services; and (B) notwithstanding relevant payment provisions, such restrictions and alternatives on the amount and method of payment that may be necessary.

(3) *Home Health Benefits.*—No provision.

(4) *Hospice Benefits.*—No provision.

(5) *Transition Provisions.*—Provides a transition provision for an individual who is in a current spell of SNF care. The number of days of coverage of extended care services (furnished during such spell and on or after December 1, 1989) to which the individual is entitled under Part A cannot exceed 150 less the number of days for which such benefits were payable for such individual in 1989 before December 1. Further, in applying the copayment provisions (as in effect before enactment of this Act) extended care services furnished during such spell during 1990 shall be considered to have been furnished during 1989. For purposes of this provision, the term "current spell of SNF care" means a spell of SNF care which began before December 1, 1989, which includes such date, and for which benefits for extended care services were payable before such date.

Provides that in no case shall the establishment of the definition of the spell of SNF care result in an individual being entitled to benefits for extended care services for more than 150 days during 1989. Provides that if an individual would otherwise be entitled to benefits in excess of 150 days in 1989, such unpaid days in 1989 do not count in determining the number of days of benefits for such

services in 1990 during a spell of SNF care. Further they do not count in the determination of coinsurance.

Specifies that for purposes of the transition provisions, the term "spell of SNF care" has the same meaning as defined under (2) above. Days before December 1, 1989 are included in the determination of spells of SNF care.

(6) *Hold Harmless.*—No provision.

(7) *PPS Payments.*—Includes identical provisions with respect to clarification of transition for PPS-exempt hospitals.

(b) *Supplemental Medicare Premium and the Federal Hospital Insurance Catastrophic Coverage Reserve Fund.*—Similar provision except disposal of funds applies to balance as of the date of enactment.

(c) *Study.*—No provision.

Effective date.—(a) applies to extended care services furnished in a spell of SNF care beginning on or after December 1, 1989 except as provided in transition provision. PPS-exempt payment adjustment effective as if included in the enactment of MCCA. (b) enactment, except premium repeal applies to taxable years beginning after December 31, 1988.

Conference agreement

(a) *Part A Benefits.*—(1) Hospital Benefits. The conference agreement includes the House provision.

(ii) *Skilled Nursing facility Benefits.*—The Conference agreement includes the House provision.

(iii) *Home Health Benefits.*—The Conference agreement includes the House provision.

(iv) *Hospice.*—The Conference agreement includes the House provision.

(v) *Transition Provisions.*—The Conference agreement includes the House provision.

(vi) *Hold Harmless.*—The Conference agreement includes the House provision.

(vii) *PPS Payments.*—The Conference agreement includes the Senate amendment, with an amendment to terminate the transitional adjustments for payments to PPS and PPS-exempt hospitals January 1, 1990. The Secretary of Health and Human Services is required to make appropriate adjustments to the inpatient hospital services provided to an inpatient whose stay began before January 1, 1990. This adjustment shall take into account the target amount that would have been applied prior to the enactment of this Act.

(b) *Supplemental Medicare Premium and Federal Hospital Insurance Catastrophic Coverage Reserve Fund.*—The Conference agreement includes the House provision with an amendment to transfer the balance in the Reserve Fund to the Supplementary Medical Insurance Trust Fund, and any amounts payable due to overpayments must be payable from the Supplementary Medical Insurance Trust Fund.

(c) *Study.*—The Conference agreement includes the House provision.

2. PROVISIONS RELATING TO PART B OF THE MEDICARE PROGRAM

Present law

(a) Part B benefits.—MCCA provided coverage for the following new Part B benefits effective January 1, 1990: a limit on beneficiary Part B deductible and coinsurance charges ($1,370 in 1990); biennial screening mammograms, subject to a payment limit and Part B coinsurance charges; 80 hours of respite care per year if the beneficiary reaches either the catastrophic or prescription drug deductibles; and coverage for home intravenous drug therapy services.

(b) Outpatient Prescription Drug Benefits.—MCCA authorized catastrophic coverage for outpatient prescription drugs. Effective January 1, 1990, a limited prescription drug benefit is established for home IV drugs and immunosuppressive drugs furnished after the first year following a transplant (they were already covered in the first year). The deductible is $550 in 1990; the coinsurance is 20 percent for home IV drugs and 50 percent for immunosuppressives. The deductible does not apply in the case of home IV drugs dispensed in connection with home IV therapy services initiated during a hospital stay.

Coverage for all outpatient prescription drugs begins in 1991, subject to specified deductable and coinsurance anounts.

Payments for single-source drugs is the lowest of the pharmacy's actual charge, the 90th percentile of pharmacy charges (beginning in 1992) or the average wholesale price plus an administrative allowance.

(c) Part B Premium.—MCCA provided a fixed dollar increase in the monthly Part B premium for all Part B enrollees to finance a portion of the catastrophic benefits added by MCCA. The add-on to the Part B premium was $4.00 for 1989; $4.90 for 1990; $7.40 for 1991; $9.20 for 1992; and $10.20 for 1993. Amounts for future years were based on actual program experience during prior time periods. MCCA extended indefinitely a hold harmless provision, which provides that beneficiaries who have their Part B premiums deducted from their social security or railroad retirement checks cannot have the amount of the social security benefits drop because of a Part B premium increase.

MCCA established a Federal Catastrophic Drug Insurance Trust Fund, to which is transferred amounts from the supplemental premium and the new prescription drug monthly premium (a component of the additional Part B monthly premium amount) to pay for the prescription drug benefit. MCCA also established a Medicare Catastrophic Coverage Account which is credited with receipts and debited for outlays for all new catastrophic benefits except prescription drugs.

House bill

(a) Part B Benefits.—Repeals the following new Part B benefits provided in MCCA: the limit on beneficiary Part B liability, mammograms, respite care coverage, and home intraveneous (IV) drug therapy services. Also repealed are the provisions requiring research on long-term care services and that requiring the study of adult day care services.

(b) Outpatient Prescription Drug Benefits.—Deletes MCCA coverage for outpatient prescription drugs. Retains the MCCA requirement that physicians include the appropriate diagnosis code when requesting Medicare payment, effective March 31, 1989.

(c) Part B Premium.—Repeals the MCCA increase to the Medicare Part B premium for catastrophic benefits, the Federal Catastrophic Drug Insurance Trust Fund, and the Medicare Catastrophic Coverage Account. Retains the hold harmless provision.

Provides for a one-time transfer, as of January 1, 1990, from the Supplementary Medical Insurance (SMI) Trust Fund to the Hospital Insurance (HI) Trust Fund an amount equal to (1) the amount of the add-on to the Part B premiums collected for catastrophic coverage, minus (2) Part B administrative expenses incurred for implementation of MCCA, plus (3) interest accrued to the SMI Trust Fund attributable to the balance of (1) minus (2).

Effective date.—(a) and (b) effective January 1, 1990. (c) applies January 1, 1990, except that the repeal of the provision adjusting Part B premiums applies to premiums for months beginning after December 31, 1989.

Senate Amendment

(a) Part B Benefits.—Repeals the Part B cap. Delays implementation of the mammogram and home IV drug therapy services provisions until 1991 (and delays other reference dates in those provisions by one year).

Delays implementation of the respite provision until 1991. The payment threshold provision is modified to provide that the 12-month coverage period begins on the date that the Secretary determines that a chronically dependent individual has incurred out-of-pocket Part B cost-sharing equal to the Part B catastrophic limit. The catastrophic limit is $1,780 in 1991. This threshold is increased each year by an amount estimated by the Secretary to reflect the amount of such charges which will be incurred by only 5.5 percent of beneficiaries (other than HMO enrollees) in the following year. The Secretary is required to promulgate a new limit each year. The Secretary is required to submit a report to Congress by June 1, 1990 on alternative eligibility standards for respite benefits.

(b) Outpatient Prescription Drug Benefits.—Limits coverage for outpatient prescription drugs to immunosuppressives and home IV drugs provided in 1991 and thereafter. The deductible is $550 in 1991, increased in future years by the percentage increase in the MEI applicable to physicians services. Specifies that the coinsurance is 20 percent.

Provides that payment for single-source drugs on the basis of the 90th percentile of pharmacy charges is delayed until 1993. Specifies that the administrative dispensing allowance is $4.50.

Deletes provisions relating to prepaid organizations, physician guide, definition of outlays, participating pharmacies, administrative provisions, modification of HMO/CMP contracts, requirement for reestimation of costs, requirement for a series of additional studies, and development of a standard claims form. Modifies requirement for report on outlays and receipts. An annual report is required each May, beginning in 1990.

Deletes provision requiring establishing the Prescription Drug Payment Review Commission; however, the Commission is authorized to continue its activities for 30 days after enactment.

(c) *Part B Premium.*—Combines current catastrophic coverage monthly premium and prescription drug monthly premium into a single catastrophic coverage monthly premium. Specifies that this premium is the same as the total of the two premiums under current law for 1989–1993. Requires the Secretary to determine during September 1990, 1991, and 1992, the monthly actuarial rate for months in the succeeding year which if substituted for the specified amounts would assure (taking into account potential contingencies) a positive balance in the Medicare Catastrophic Coverage Account at the end of the succeeding year. If this rate is lower, it is to be substituted for the amount otherwise specified for that year.

Deletes current requirements for calculation of the premium after 1993. Specifies that each September (beginning in 1993), the Secretary is required to determine the monthly acturial rate for months in the succeeding year which would assure a balance in the Account at the end of the year equal to 20 percent of the total debits to the Account in the year. This rate is the catastrophic monthly premium for the year.

Specifies premiums applicable for residents of Puerto Rico and the territories. For Puerto Rico, it is $1.30 per month for 1989 and $1.40 per month for 1990. For other commonwealths and territories, it is $2.10 in 1989 and $2.30 in 1990. In subsequent years, a rate is determined for Puerto Rico and another rate is determined for other commonwealths and territories, each of which is a fraction of the rate determined for the States and DC. The fraction is to reflect the relative per capita outlays which are accounted for under the Account for residents in such respective areas compared to those for residents of the States and DC.

Specifies that, for Part B only individuals, the Part B premium (otherwise determined without regard to the catastrophic calculation) is to be increased (beginning January 1991) by a fraction of the increase otherwise determined. The Secretary is required from time to time to establish a fraction that reflects the relative per capita outlays accounted for under the Account by Part B only individuals compared to individuals entitled to benefits under both Parts A and B.

Includes a one-time transfer of funds provision similar to the House bill.

Provides for appropriation from the SMI trust fund to the HI trust fund from such amounts as are attributable to catastrophic coverage monthly premiums imposed after December 1989. The appropriation equals the amount by which HI outlays attributable to catastrophic expenses exceeds the amounts transferred under the one-time transfer of funds provision. The amounts shall be transferred from time to time (not less frequently than monthly) based on estimates made by the Secretary. Periodic adjustments are to be made.

Repeals the Federal Catastrophic Drug Insurance Trust Fund and makes conforming changes to provisions relating to the Medicare Catastrophic Coverage Account.

Effective date.—(a) enactment except the repeal of the Part B cap effective as if included in MCCA; (b) enactment; (c) enactment.

Conference agreement

(a) *Part B Benefits.*—The Conference agreement includes the House provision.

(b) *Outpatient Prescription Drug Benefits.*—The Conference agreement includes the House provision.

(c) *Part B Premium.*—The Conference agreement includes the House provision, with an amendment to strike the provisions pertaining to the transfer of funds from the Federal Supplementary Medical Insurance Trust Fund to the Hospital Insurance Trust Fund.

3. OTHER MISCELLANEOUS AMENDMENTS

Present law

(a) *Revision of Medigap Regulations.*—Individually purchased private health insurance policies which are designed to supplement Medicare's coverage are known as medigap plans. Law, prior to passage of MCCA established a voluntary certification program for such policies. To be certified under the program, the plan must meet or exceed standards set forth in a model regulation approved by the National Association of Insurance Commissioners (NAIC). The voluntary program applies only in States which fail to establish equivalent or more stringent programs; almost all States have established their own programs.

MCCA amended procedures for Federal certification of medigap policies. New NAIC model standards, designed to eliminate duplication between medigap policies and Medicare's new catastrophic coverage, were adopted Sept. 20, 1989 and replaced prior law standards for new medigap policies. Policies sold before enactment of MCCA and in effect on January 1, 1989 were deemed not to duplicate Medicare's new benefits if they complied with NAIC model transition rules. These rules required insurers to notify beneficiaries of policy and premium changes and to make appropriate premium adjustments in their policies.

(b) *Contracts with Prepaid Health Plans.*—MCCA required the Secretary to modify contracts with prepaid health plans, for portions of contract years occurring after December 31, 1988, to take into account the MCCA provisions. The plans are required to make appropriate adjustments in the terms of their agreements with beneficiaries, including adjustments in benefits and premiums.

The Secretary announced the average per capita rate payment for prepaid health plans on September 7, 1989.

(c) *Notice of Changes.*—MCCA provided that the Secretary must provide to new beneficiaries and annually distribute to current beneficiaries notices containing an explanation of Medicare's benefits, Medicare's limits on payments, and the limited benefits for long-term care services available under Medicare and under State Medicaid plans.

(d) *Other Miscellaneous Amendments.*—MCCA provided for a "maintenance of effort" provision requiring certain employers to provide additional benefits or refunds to beneficiaries equal to the

value of the benefits in their plans which duplicated Medicare's new catastrophic coverage. Federal Employees Health Benefits (FEHB) plans are required to provide a rebate equal to the duplicative benefits. MCCA required the Office of Personnel Management (OPM) to conduct a study of changes to the FEHB program that may be required to incorporate plans designed specifically for Medicare-eligible individuals; OPM issued the study in April 1989.

MCCA required the Secretary to establish a 3-year demonstration project to train volunteers to provide benefits counseling and assistance concerning the Medicare and Medicaid programs to elderly persons.

MCCA required the Secretary to establish by July 1, 1989, four demonstration projects to provide case management services to Medicare beneficiaries with selected high cost illnesses.

MCCA required the HCFA Administrator to appoint, within 90 days of enactment, an Advisory Committee on Medicare Home Health Claims to study the reasons for the increase in the denial rate for home health claims, the ramifications of such denials, and the need for reform. The Committee is to report its findings within 1 year of enactment.

House bill

(a) *Revision of Medigap Regulations.*—Provides a period of 90 days, beginning with enactment, for the NAIC to amend their model medigap regulation to reflect the Medicare benefit changes made by this provision. Provides that the amended regulation would apply in a State effective on the date the State adopts medigap standards equal to or more stringent than the revised regulation, or 1 year after the date the NAIC first adopts such revised regulation. Provides that if the NAIC does not amend the model regulation within 90 days, the Secretary must promulgate revised Federal model standards within the subsequent 60 day period. These standards would become effective on the earlier of the date the State adopts the standards, equal or more stringent than the revised standards, or one year after the date the Secretary promulgates the standards. After either of these dates, no medigap policy may be certified by the Secretary and no Secretarial certification may remain in effect unless the policy meets the revised NAIC model standards (or the revised Federal model standards.)

Provides that medigap policies issued after July 1, 1990 must comply with the revised NAIC model regulation or Federal model standards to be in compliance. Provides that medigap policies issued before July 1, 1990 are deemed to be in compliance with the new standards if they comply with a transition provision to be issued by the NAIC no later than December 15, 1989 (or failing that, by the Secretary by Jan. 1, 1990). The transition regulation ceases to apply on the earlier (sic) of the date the State adopts the NAIC model regulation or Federal model standard or the date established for States requiring legislative action.

Provides that medigap policies in effect on January 1, 1990 would not meet the standards unless each policy holder who is eligible for Medicare is sent a notice by Jan. 31, 1990 explaining the change in Medicare's benefits resulting from this provision, and how these changes affect the policy's benefits and premium.

Provides that if an insurer had a medigap policy in effect as of December 31, 1988 which was terminated by the policyholder as of January 1, 1989 (or at the earliest renewal date thereafter), then the insurer must offer the policyholder (through written notice by January 15, 1990) continuation of coverage from January 1, 1990 to March 1, 1990. Provides that such continuation coverage be under the terms respecting treatment of preexisting conditions and group ratings of premiums which are at least as favorable to the individual as such terms which existed with respect to the policy as of December 31, 1988.

Expresses the sense of Congress that States should respond at the earliest practicable date after the enactment to requests by insurers for review and approval of riders and premium adjustments for Medigap policies in order to comply with the changed requirements.

(b) *Contracts with Prepaid Health Plans.*—Provides that the requirement for contract adjustments ends January 1, 1990.

(c) *Notice of Changes.*—Provides that the Secretary must provide in the 1990 beneficiary notices a description of the changes in Medicare benefits made by this provision.

(d) *Other Miscellaneous Amendments.*—Repeals MCCA provisions related to maintenance of effort, FEHBP rebates, the OPM study of plans for Medicare-eligible individuals, benefits counseling and assistance demonstration project for certain Medicare and Medicaid beneficiaries, case management demonstration projects, and the Advisory Committee on Medicare Home Health Claims.

Makes other miscellaneous technical corrections.

Effective date.—(a), (b), and effective January 1, 1990, except the repeal of the maintenance of effort provision would not apply to duplicative Part A benefits for periods before January 1, 1990. (d) effective on enactment.

Senate amendment

(a) *Revision of Medigap Regulations.*—Similar provision relating to NAIC or Federal actions except refers to revised (rather than amended) NAIC Model Regulation.

Similar provision relating to policies issued after a particular date except that the date is the transition deadline (rather than July 1, 1990). The transition deadline is defined as one year after NAIC adopts the revised Model Regulation or one year after the Secretary promulgates revised Federal model standards, as the case may be. Further, the NAIC transition provision is to provide (1) for the restoration of benefits which are no longer duplicative, and (2) elimination of coinsurance for the first 8 days of SNF care.

Similar notice provision except applies to policyholder or certificate holder.

Provides that if an individual had a Medigap supplemental policy in effect as of December 31, 1988 with an insurer (as a policyholder, or in the case of a group policy, a certificate holder) and the individual terminated the policy before enactment of this Act, the insurer must offer the policyholder or certificate holder (through written notice between December 15, 1989 and January 30, 1990) reinstitution coverage. The individual must be offered during a period of at least 60 days (beginning not later than February 1,

1990) reinstitution coverage (with coverage effective as of January 1, 1990). The offering must be under the terms which: (1) do not provide for any waiting period with respect to treatment of pre-existing conditions; (2) provides for coverage which is substantially equivalent to coverage in effect before the date of such termination, and (3) provides for classification of premiums on which terms are at least as favorable to the policyholder or certificate holder as the premium classification that would have applied to that person had the coverage never been terminated. An insurer is not required to make this offer in the case of a policyholder or certificate holder in another Medigap policy as of the date of enactment of this Act if (as of January 1, 1990) the policy under which the individual was provided coverage provides for no waiting period with respect to a pre-existing condition.

Modifies sense of Congress provision to include the sense that premium adjustments be effective January 1, 1990.

(b) *Contracts with Prepaid Health Plans.*—Requires, for calendar year 1990 only, prepaid health plans with risk-sharing contracts to provide the additional Part B benefits otherwise repealed and retains the adjustment in 1990 premium rates to cover the costs of these benefits.

(c) *Notice of Changes.*—Identical provision.

(d) *Other Miscellaneous Amendments.*—Specifies that any refund under the maintenance of effort provision is not to be considered as wages or compensation (as appropriate) and is therefore not subject to taxation for purposes of social security, railroad retirement, or Federal unemployment programs.

Includes miscellaneous corrections included in House bill as well as additional technical corrections to portions of MCCA which are retained.

Effective date.—Enactment, except that provision relating to treatment of refunds under the maintenance of effort provision applies with respect to refunds provided on or after January 1, 1989.

Conference agreement

(a) *Revision of Medigap Regulations.*—The Conference agreement includes the Senate amendment, with an amendment to strike the sense of the Congress provisions. The Conferees intend that States should respond, at the earliest practicable date after the date of enactment of this Act, to requests by insurers for review of riders and premium adjustments for medicare supplemental policies in order to comply with the amendments pertaining to the revision of Medigap regulations, and that all such premium adjustments be effective January 1, 1990.

(b) *Contracts with Prepaid Health Plans.*—The Conference agreement includes the Senate amendment with an amendment to repeal sections 1833(c)(5) and 1834(c)(6).

(c) *Notice of changes.*—The Conference agreement includes the House provision.

(d) *Other Miscellaneous Amendments*—The Conference agreement includes the House provision.

From the Committee on Ways and Means, for consideration of the House bill, and the Senate amendment, and modifications committed to conference:

BRIAN DONNELLY,
BEN CARDIN,
MARTY RUSSO,
BILL ARCHER,
GUY VANDER JAGT,
PHILIP M. CRANE,
BILL FRENZEL,
R.T. SCHULZE,

From the Committee on Energy and Commerce, for consideration of the House bill, and the Senate amendment, and modifications committed to conference:

JOHN D. DINGELL,
HENRY A. WAXMAN,
DOUG WALGREN,
RON WYDEN,
TERRY L. BRUCE,
J. ROY ROWLAND,
CARDISS COLLINS,
RALPH M. HALL,
NORMAN F. LENT,
EDWARD R. MADIGAN,
BILL DANNEMEYER,
MIKE BILIRAKIS,

Managers on the Part of the House.

LLOYD BENTSEN,
SPARK M. MATSUNAGA,
DANIEL PATRICK MOYNIHAN,
MAX BAUCUS,
GEORGE J. MITCHELL,
BOB PACKWOOD,
W.V. ROTH, Jr.,
JOHN C. DANFORTH,

Managers on the Part of the Senate.

○

Finder's Aid
P.L. 101-239 (103 Stat. 2106) Approved December 19, 1989
Omnibus Budget Reconciliation Act of 1989

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Old-Age and Survivor's Insurance - Child's Benefits (technical amendment)	202(d)(8)(D)(i)	10301(a)(1)	2481	712, 969	396, 687-688
Old-Age and Survivor's Insurance - Child's Benefits (technical amendment)	202(d)(8)(D)(ii)	10301(a)(2)	2481	912, 969	396, 687-688
Old-Age and Survivor's Insurance - Child's Benefits	202(d)(8)(D)(ii) Stricken	10301(a)(2)	2481	912, 969	396-397, 687-688
Old-Age and Survivor's Insurance - Child's Benefits (conforming amendment)	202(d)(8)	10301(b)	2481	912, 969	397, 687-688
Old-Age and Survivor's Insurance - Application for Monthly Benefits	202(j)(5) New	10302(a)(1)	2481	911, 960, 963-964	397, 707, 710-711
Old-Age and Survivor's Insurance - Reduction of Benefit Amounts	202(q)(3)(E) Stricken	10203(a)(1)	2473	913, 973-974	388, 692-693
Old-Age and Survivor's Insurance - Reduction of Benefit Amounts	202(q)(3)(F) Stricken	10203(a)(1)	2473	913, 973-974	388, 692-693
Old-Age Survivor's Insurance - Reduction of Benefits	202(q)(3)(G) Stricken	10203(a)(1)	2473	913, 973-974	388, 692-693
Old-Age Survivor's Insurance - Reduction of Benefits (technical amendment)	202(q)(3)(H) Redesignated as 202(q)(3)(E)	10203(a)(2)	2473	913, 973-974	388, 692-693
Reduction of Benefits - Months to Which Earnings are Charged (conforming amendment)	203(f)(5)(C)	10208(d)(2)(A)(ii)	2480	983-984	396, 702

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Reduction of Benefits - Months to Which Earnings are Charged (conforming amendment)	203(f)(5)(C)(ii)	10208(d)(2)(A)(vi)	2481	983-984	396, 702
Reduction of Benefits - Months to Which Earnings are Charged (conforming amendment)	203(f)(8)(B)(ii)(I)	10208(b)(1)(A)	2477	914, 983-984	396 702
Reduction of Benefits - Months to Which Earnings are Charged (conforming amendment)	203(f)(8)(B)(ii)(I)	10208(b)(1)(A)(i)	2480	983-984	396, 702
Reduction of Benefits - Months to Which Earnings are Charged (conforming amendment)	203(f)(8)(B)(ii)(II)	10208(b)(1)(B)	2477	914, 983-984	393, 702
Reduction of Insurance Benefits - Good Cause of Failure to Make Reports Required	203(l)	10305(a)	2483	911, 958 961-963	398, 708
Overpayments and Underpayments	204(b)	10305(b)	2483	911, 958, 961-963	398-399, 708
Evidence, Procedure, and Certification for Payment	205(c)(5)(H)	10304	2483	911, 957, 961, 963	398, 711
Evidence, Procedure, and Certification for Payment - Same day Personal Interviews	205(t) New	10303(a)	2482	911, 960-963	397-398, 711
Representation of Claimants	206(a)	10307(a)(1)	2485	911, 959, 962-964	400, 709-710
Representation of Claimants	206(c)	10307(b)(1)	2485	911, 959, 962-964	400-401, 709-710

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Definition of Wages (technical amendment)	209 Redesignated as 209(a)	10208(d)(1)(K)	2480	983-984	395, 702
Definition of Wages	209	10208(d)(1)(L)	2480	983-984	395, 702
Definition of Wages (technical amendment)	209(a) Redesignated as 209(a)(1)	10208(d)(1)(J)	2480	983-984	395, 702
Definition of Wages (technical amendment)	209(a)(1) Redesignated as 209(a)(1)(A)	10208(d)(1)(A)	2479	983-984	395, 702
Definition of Wages (technical amendment)	209(a)(2) Redesignated as 209(a)(1)(B)	10208(d)(1)(A)	2479	983-984	395, 702
Definition of Wages (technical amendment)	209(a)(3) Redesignated as 209(a)(1)(C)	10208(d)(1)(A)	2479	983-984	395, 702
Definition of Wages (technical amendment)	209(a)(4) Redesignated as 209(a)(1)(D)	10208(d)(1)(A)	2479	983-984	395, 702
Definition of Wages (technical amendment)	209(a)(5) Redesignated as 209(a)(1)(E)	10208(d)(1)(A)	2479	983-984	395, 702
Definition of Wages (technical amendment)	209(a)(6) Redesignated as 209(a)(1)(F)	10208(d)(1)(A)	2479	983-984	395, 702
Definition of Wages (technical amendment)	209(a)(7) Redesignated as 209(a)(1)(G)	10208(d)(1)(A)	2479	983-984	395, 702
Definition of Wages (technical amendment)	209(a)(8) Redesignated as 209(a)(1)(H)	10208(d)(1)(A)	2479	983-984	395, 702
Definition of Wages (technical amendment)	209(a)(9) Redesignated as 209(a)(1)(I)	10208(d)(1)(A)	2479	983-984	395, 702

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Definition of Wages (technical amendment)	209(b) Redesignated as 209(a)(2)	10208(d)(1)(J)	2480	983-984	395, 702
Definition of Wages (technical amendment)	209(b)(1) Redesignated as 209(a)(2)(A)	10208(d)(1)(B)	2479	983-984	395, 702
Definition of Wages (technical amendment)	209(b)(2) Redesignated as 209(a)(2)(B)	10208(d)(1)(B)	2479	983-984	395, 702
Definition of Wages (technical amendment)	209(b)(3) Redesignated as 209(a)(2)(C)	10208(d)(1)(B)	2479	983-984	395, 702
Definition of Wages (technical amendment)	209(d) Redesignated as 209(a)(3)	10208(d)(1)(J)	2480	983-984	395, 702
Definition of Wages (technical amendment)	209(e) Redesignated as 209(a)(4)	10208(d)(1)(J)	2480	983-984	395, 702
Definition of Wages (technical amendment)	209(e)(1) Redesignated as 209(a)(4)(A)	10208(d)(1)(C)	2479	983-984	395, 702
Definition of Wages (technical amendment)	209(e)(2) Redesignated as 209(a)(4((B)	10208(d)(1)(C)	2479	983-984	395, 702
Definition of Wages (technical amendment)	209(e)(3) Redesignated as 209(a)(4)(C)	10208(d)(1)(C)	2479	983-984	395, 702
Definition of Wages (technical amendment)	209(e)(4) Redesignated as 209(a)(4)(D)	10208(d)(1)(C)	2479	983-984	395, 702
Definition of Wages (technical amendment)	209(e)(5) Redesignated as 209(a)(4)(E)	10208(d)(1)(C)	2479	983-984	395, 702
Definition of Wages (technical amendment)	209(e)(6) Redesignated as 209(a)(4)(F)	10208(d)(1)(C)	2479	983-984	395, 702

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Definition of Wages (technical amendment)	209(e)(7) Redesignated as 209(a)(4)(G)	10208(d)(1)(C)	2479	983-984	395, 702
Definition of Wages (technical amendment)	209(e)(8) Redesignated as 209(a)(4)(H)	10208(d)(1)(C)	2479	983-984	395, 702
Definition of Wages (technical amendment)	209(e)(9) Redesignated as 209(a)(4)(I)	10208(d)(1)(C)	2479	983-984	395, 702
Definition of Wages (technical amendment)	209(f) Redesignated as 209(a)(5)	10208(d)(1)(J)	2480	983-984	395, 702
Definition of Wages (technical amendment)	209(f)(1) Redesignated as 209(a)(5)(A)	10208(d)(1)(D)	2479	983-984	395, 702
Definition of Wages (technical amendment)	209(f)(2) Redesignated as 209(a)(5)(B)	10208(d)(1)(D)	2479	983-984	395, 702
Definition of Wages (technical amendment)	209(g) Redesignated as 209(a)(6)	10208(d)(1)(J)	2480	983-984	395, 702
Definition of Wages (technical amendment)	209(g)(1) Redesignated as 209(a)(6)(A)	10208(d)(1)(E)	2479	983-984	395, 702
Definition of Wages (technical amendment)	209(g)(2) Redesignated as 209(a)(6)(B)	10208(d)(1)(E)	2479	983-984	395, 702
Definition of Wages (technical amendment)	209(g)(3) Redesignated as 209(a)(6)(C)	10208(d)(1)(E)	2479	983-984	395, 702
Definition of Wages (technical amendment)	209(h) Redesignated as 209(a)(7)	10208(d)(1)(J)	2480	983-984	395, 702
Definition of Wages (technical amendment)	209(h)(1) Redesignated as 209(a)(7)(A)	10208(d)(1)(F)	2479	983-984	395, 702

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Definition of Wages (technical amendment)	209(h)(i) Redesignated as 209(a)(7)(I)	10208(d)(1)(F)	2479	983-984	395, 702
Definition of Wages (technical amendment)	209(h)(ii) Redesignated as 209(a)(7)(II)	10208(d)(1)(F)	2479	983-984	395, 702
Definition of Wages (technical amendment)	209(h)(iii) Redesignated as 209(a)(7)(III)	10208(d)(1)(F)	2479	983-984	395, 702
Definition of Wages (technical amendment)	209(h)(2) Redesignated as 209(a)(7)(B)	10208(d)(1)(F)	2479	983-984	395, 702
Definition of Wages (technical amendment)	209(h)(2)(A) Redesignated as 209(a)(7)(B)(i)	10208(d)(1)(F)	2479	983-984	395, 702
Definition of Wages (technical amendment)	209(h)(2)(B) Redesignated as 209(a)(7)(B)(ii)	10208(d)(1)(F)	2479	983-984	395, 702
Definition of Wages (technical amendment)	209(j) Redesignated as 209(a)(8)	10208(d)(1)(J)	2480	983-984	395, 702
Definition of Wages	209(k) New	10208(a)	2476	914, 983-984	392, 702
Definition of Wages (technical amendment)	209(k) Redesignated as 209(a)(9)	10208(d)(1)(J)	2480	983-984	395, 702
Definition of Wages (technical amendment)	209(l) Redesignated as 209(a)(10)	10208(d)(1)(J)	2480	983-984	395, 702
Definition of Wages (technical amendment)	209(l)(1) Redesignated as 209(a)(10)(A)	10208(d)(1)(G)	2480	983-984	395, 702
Definition of Wages (technical amendment)	209(l)(2) Redesignated as 209(a)(10)(B)	10208(d)(1)(G)	2480	983-984	395, 702

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Definition of Wages (technical amendment)	209(m) Redesignated as 209(a)(11)	10208(d)(1)(J)	2480	983-984	395, 702
Definition of Wages (technical amendment)	209(m)(1) Redesignated as 209(a)(11)(A)	10208(d)(1)(H)	2480	983-984	395, 702
Definition of Wages (technical amendment)	209(n)(2) Redesignated as 209(a)(11)(B)	10208(d)(1)(H)	2480	983-984	395, 702
Definition of Wages (technical amendment)	209(n) Redesignated as 209(a)(12)	10208(d)(1)(J)	2480	983-984	395, 702
Definition of Wages (technical amendment)	209(o) Redesignated as 209(a)(13)	10208(d)(1)(J)	2480	983-984	395, 702
Definition of Wages (technical amendment)	209(p) Redesignated as 209(a)(14)	10208(d)(1)(J)	2480	983-984	395, 702
Definition of Wages (technical amendment)	209(p)(1) Redesignated as 209(a)(14)(A)	10208(d)(1)(I)	2480	983-984	395, 702
Definition of Wages (technical amendment)	209(p)(2) Redesignated as 209(a)(14)(B)	10208(d)(1)	2480	983-984	395, 702
Definition of Wages (technical amendment)	209(q) Redesignated as 209(a)(15)	10208(d)(1)(J)	2480	983-984	395, 702
Definition of Wages (technical amendment)	209(r) Redesignated as 209(a)(16)	10208(d)(1)(J)	2480	983-984	395, 702
Definition of Wages (technical amendment)	209(s) Redesignated as 209(a)(17)	10208(d)(1)(J)	2480	983-984	395, 702
Definition of Wages (technical amendment)	209(t) Redesignated as 209(a)(18)	10208(d)(1)(J)	2480	983-984	395, 702
Definition of Wages	209	10208(d)(1)(M)	2480	983-984	395, 702

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Definition of Wages	209	10208(d)(1)(N)	2480	983-984	395, 702
Definition of Wages	209	10208(d)(1)(O)	2480	983-984	395, 702
Definition of Wages	209	10208(d)(1)(P)	2480	983-984	395, 702
Definition of Wages	209	10208(d)(1)(Q)	2480	983-984	396, 702
Definition of Wages	209	10208(d)(1)(R)	2480	983-984	396, 702
Definition of Wages	209	10208(d)(1)(S)	2480	983-984	396, 702
Definition of Wages	209	10208(d)(1)(T)	2480	983-984	396, 702
Definition of Employment	210(a)	10201(b)(1)	2472	912, 970	387, 689
Quarter of Coverage	213(d)(2)(B)	10208(b)(2)(A)	2477	914, 983-984	393, 702
Quarter of Coverage	213(d)(2)(B)	10208(b)(2)(B)	2478	914, 983-984	393, 702
Quarter of Coverage (conforming amendment)	213(d)(2)(B)	10208(d)(2)(A)(i)	2480	983-984	396, 702
Computation of Primary Insurance Amount	215(a)(1)(B)(ii)(I)	10208(b)(2)(A)	2477	914, 983-984	393, 702
Computation of Primary Insurance Amount (conforming amendment)	215(a)(1)(B)(ii)(I)	10208(d)(2)(A)(i)	2480	983-984	396, 702
Computation of Primary Insurance Amount	215(a)(1)(B)(ii)(II)	10208(b)(2)(B)	2478	914, 983-984	393, 702
Computation of Primary Insurance Amount	215(a)(1)(C)(ii)	10208(b)(4)	2478	914, 983 984	393, 702

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Computation of Primary Insurance Amount	215(b)(3)(A)(ii)(I)	10208(b)(1)(A)	2477	914, 983-984	392, 702
Computation of Primary Insurance Amount	215(b)(3)(A)(ii)(I)	10208(b)(1)(C)	2477	914, 983-984	392, 702
Computation of Primary Insurance Amount	215(b)(3)(A)(ii)(I)	10208(d)(2)(A)(i)	2480	983-984	396, 702
Computation of Primary Insurance Amount	215(b)(3)(A)(ii)(II)	10208(b)(1)(B)	2477	914, 983-984	392, 702
Computation of Primary Insurance Amount	215(i)(1)(G)	10208(b)(3)	2478	914, 983-984	393, 702
Benefits in Case of Veterans	217(b)(1)	10208(d)(2)(A)(iv)	2481	983-984	396, 702
Voluntary Agreements for Coverage of State and Local Employees-Services Covered	218(c)(5)	10208(d)(2)(A)(v)	2481	983-984	396, 702
Disability Determinations	221(l)	10306(a)(1)	2484	911, 958	399-400, 709
Standard of Review for Termination of Disability Benefits	223(f)(4)	10305(c)	2483	911, 958	399, 708
Continued Payment of Disability Benefits During Appeal	223(g)(1)(iii)	10101(1)	2471	912, 973	386, 691-692
Continued Payment of Disability Benefits During Appeal	223(g)(2)(B)	10305(d)	2483	911, 958	399, 708
Continued Payment of Disability Benefits During Appeal	223(g)(3)(B)	10101(2)	2471	912, 973	386, 691-692
Reduction of Benefits Based on Disability	224(a)(B)	10208(d)(2)(A)(iii)	2481	983-984	396, 702

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Reduction of Benefits Based on Disability	224(a)(C)	10208(d)(2)(A)(iii)	2481	983-984	396, 702
Reduction of Benefits Based on Disability	224(f)(2)(B)(i)	10208(b)(2)(A)	2477	914, 983-984	393, 702
Reduction of Benefits Based on Disability (conforming amendment)	224(f)(2)(B)(i)	10208(d)(2)(A)(i)	2480	983-984	396, 702
Reduction of Benefits Based on Disability (technical amendment)	224(f)(2)(B)(ii) Redesignated as 224(f)(2)(B)(ii)(II)	10208(b)(2)(C)	2478	914, 983-984	393, 702
Reduction of Benefits Based on Disability	224(f)(2)(B)(ii)(I)	10208(b)(2)(C)	2478	914, 983-984	393, 702
Reduction of Benefits Based on Disability	224(f)(2)(B)(ii)(II) New	10208(b)(2)(C)	2478	914, 983-984	393, 702
Adjustment of the Contribution and Benefit Base	230(b)(2)(A)	10208(b)(1)(A)	2477	914, 983-984	392, 702
Adjustment of the Contribution and Benefit Base (conforming amendment)	230(b)(2)(A)	10208(d)(2)(A)(i)	2480	983-984	396, 702
Adjustment of the Contribution and Benefit Base	230(b)(2)(A)*	10208(b)(1)(B)	2477	914, 983-984	393, 702
Adjustment of the Contribution and Benefit Base	230(d)	10208(b)(5)	2478	914, 983-984	393, 702
AFDC-State Plans for Aid and Services to Needy Families with Children (technical amendment)	402(a)(30)	10403(a)(1)(B)(i)	2487	---	403
AFDC-State Plans for Aid and Services to Needy Families with Children	402(g)(1)(A)(iv)	10403(a)(1)(C)(i)(I)	2487	---	403

*Should be 230(b)(2)(B).

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
AFDC-State Plans for Aid and Services to Needy Families with Children	402(g)(1)(A)(v)	10403(a)(1)(C)(i)(II)	2487	---	403
AFDC-Payment to States	403(i) Repealed	8004(b)	2460	1092-1093	374, 929-933
AFDC-Payment to States	403(j) Repealed	8004(b)	2460	1092-1093	374, 929-933
AFDC-Dependent Children of Unemployed Parents	407(b)(1)(B)(iii)(I)	10403(a)(1)(A)(i)	2487	---	403
AFDC-Dependent Children of Unemployment Parents	407(d)(1)	10403(a)(2)	2488	---	403
AFDC-Quality Control System	408 New	8004(a)	2454	1092-1093	368-374, 929-933
Child Welfare Services-Appropriation	420(a)	10401(a)	2487	932, 1067	402, 902-903
Child Welfare Services-State Plans	422(b)(1)(A)	10403(b)(1)	2488	---	403
Child Welfare Services-Foster Care Protection Required for Additional Federal Payment	427(b)	10401(a)	2487	932, 1067	402, 902-903
Child Support and Establishment of Paternity-Duties of the Secretary (technical amendment)	452(d)(2)(B)	10403(a)(1)(B)(i)	2487	---	403
Foster Care and Adoption Assistance-Payments to States (technical amendment)	474(a)(3)(A)	8006(a)(1)	2461	932-933, 1069-1070	376, 904-905
Foster Care and Adoption Assistance-Payments to States (technical amendment)	474(a)(3)(B) Redesignated as 474(a)(3)(C)	8006(a)(2)	2461	932-933, 1069-1070	376, 904-905

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Foster Care and Adoption Assistance-Payments to States	474(a)(3)(B) New	8006(a)(3)	2461	932-933, 1069-1070	376, 904-905
Foster Care and Adoption Assistance-Payments to States	474(a)(4)	8002(c)	2453	1071	367, 906-907
Foster Care and Adoption Assistance-Payments to States	474(b)(1)	8001(a)	2452	1067-1068	366, 903
Foster Care and Adoption Assistance-Payments to States (technical amendment)	474(b)(2)(A) (ii)	10402(a)(1)	2487	932, 1067-1068	402, 903
Foster Care and Adoption Assistance-Payments to States (technical amendment)	474(b)(2)(A) (iii)	10402(a)(2)	2487	932, 1067-1068	402, 903
Foster Care and Adoption Assistance-Payments to States	474(b)(2)(A) (iv) New	10402(a)(3)	2487	932, 1067-1068	402, 903
Foster Care and Adoption Assistance -Payments to States	474(b)(2)(B)	8001(a)	2452	1067-1068	366, 903
Foster Care and Adoption Assistance-Payment to States	474(b)(4)(B)	8001(a)	2452	1067-1068	366, 903
Foster Care and Adoption Assistance-Payments to States	474(b)(5)(A)	8001(a)	2452	1067-1068	366, 903
Foster Care and Adoption Assistance-Payments to States	474(b)(5)(A)(ii)	8001(a)	2452	1067-1068	366, 903
Foster Care and Adoption Assistance-Payments to States	474(c)(1)	8001(a)	2452	1067-1068	366, 903
Foster Care and Adoption Assistance-Payments to States	474(c)(2)	8001(a)	2452	1067-1068	366, 903

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Foster Care and Adoption Assistance-Payments to States	474(c)(4)(B)	10401(a)	2487	932, 1067	402, 902-903
Foster Care and Adoption Assistance-Payments to States	474(c)(4)(C)	10401(a)	2487	932, 1067	402, 902-903
Foster Care and Adoption Assistance-Definitions (technical amendment)	475(1)	8007(a)(1)	2462	1070-1071	376, 905-906
Foster Care and Adoption Assistance-Definitions (technical amendment)	475(1)	8007(a)(2)	2462	1070-1071	376, 905-906
Foster Care and Adoption Assistance-Definitions (technical amendment)	475(1)(A)	8007(a)(3)	2462	1070-1071	376, 905-906
Foster Care and Adoption Assistance-Definitions (technical amendment)	475(1)(B)	8007(a)(3)	2462	1070-1071	376, 905-906
Foster Care and Adoption Assistance-Definitions	475(1)(C) New	8007(a)(4)	2462	1070-1071	376, 905-906
Foster Care and Adoption Assistance-Definitions (technical amendment)	475(1)	8007(a)(5)	2462	1070-1071	377, 905-906
Foster Care and Adoption Assistance-Definitions (technical amendment)	475(5)(B)	8007(b)(1)	2462	933, 1070-1071	377, 905-906
Foster Care and Adoption Assistance-Definitions (technical amendment)	475(5)(C)	8007(b)(2)	2462	933, 1070-1071	377, 905-906
Foster Care and Adoption Assistance-Definitions	475(5)(D) New	8007(b)(3)	2462	933, 1070-1071	377, 905-906
Foster Care and Adoption Assistance-Independent Living Initiatives	477(a)(1)	8002(a)(1)	2452	1071	366-367, 906-907

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Foster Care and Adoption Assistance-Independent Living Initiatives	477(c)	8002(a)(2)	2452	1071	366-367, 906-907
Foster Care and Adoption Assistance-Independent Living Initiatives	477(e)(1)	8002(a)(1)	2452	1071	366-367, 906-907
Foster Care and Adoption Assistance-Independent Living Initiative (technical amendment)	477(e)(1) Redesignated as 477(e)(1)(A)	8002(b)(1)	2452	1071	367, 906-907
Foster Care and Adoption Assistance-Independent Living Initiatives	477(e)(1)(A)	8002(b)(2)	2453	1071	367, 906-907
Foster Care and Adoption Assistance-Independent Living Initiatives	477(e)(1)(A)	8002(b)(3)	2453	1071	367, 906-907
Foster Care and Adoption Assistance-Independent Living Initiatives	477(e)(1)(A)	8002(b)(4)	2453	1071	367, 906-907
Foster Care and Adoption Assistance-Independent Living Initiatives	477(e)(1)(B) New	8002(b)(5)	2453	1071	367, 906-907
Foster Care and Adoption Assistance-Independent Living Initiatives	477(e)(1)(C) New	8002(b)(5)	2453	1071	367, 906-907
Materal and Child Health Services Block Grant-Authorization of Appropriations	501(a)	6501(a)(1)	2273	495-498, 627-629	177-179, 499-500
Maternal and Child Health Services Block Grant-Authorization of Appropriations	501(b)(3) New	6501(a)(2)	2274	495-498, 629	179, 499-500
Maternal and Child Health Services Block Grant-Authorization of Appropriations	501(b)(4) New	6501(a)(2)	2274	495-498, 629	179, 499-500

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Maternal and Child Health Services Block Grant-Allotments to States and Federal Set-aside	502(a)(1)	6502(a)(1)	2275	502-503, 629-630	179, 502-503-
Maternal and Child Health Services Block Grant-Allotments to States and Federal Set-aside	502(a)(3)	6502(a)(2)	2275	502-503, 630	179, 502-503
Maternal and Child Health Services Block Grant-Allotments to States and Federal Set-aside (technical amendment)	502(b) Redesignated as 502(c)	6502(a)(3)	2275	502-503, 632	179, 502-503
Maternal and Child Health Services Block Grant-Allotments to States and Federal Set-aside	502(b) New	6502(a)(3)	2275	502-503, 630	179-180, 502-503
Maternal and Child Health Services Block Grant-Allotments to States and Federal Set-aside (conforming amendment)	502(b)	6503(c)(4)	2278	505-506, 632-633	183, 503-505
Maternal and Child Health Services Block Grant-Allotments to States and Federal Set-aside	502(c) Stricken	6502(a)(3)	2275	502-503, 630-632	179, 502-503
Maternal and Child Health Services Block Grant-Allotments to States and Federal Set-aside	502(c)	6502(a)(4)(A)	2275	502-503, 632	180, 502-503
Maternal and Child Health Services Block Grant-Allotments to States and Federal Set-aside (conforming amendment)	502(c)	6503(c)(1)	2278	505-506, 632	183, 503-505
Maternal and Child Health Services Block Grant-Allotments to States and Federal Set-aside	502(c)(2)	6502(a)(4)(B)	2275	502-503, 632-633	180, 502-503

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Maternal and Child Health Services Block Grant-Allotments to States and Federal Set-aside (conforming amendment)	502(d)(1)	6502(c)(4)	2278	505-506, 633	183, 502-503
Maternal and Child Health Services Block Grant-Payments to States (conforming amendment)	503(a)	6502(b)	2276	502-503, 633	180, 502-503
Maternal and Child Health Services Block Grant-Payments to States (conforming amendment)	503(c)	6503(c)(4)	2278	505-506, 633	183, 502-503
Maternal and Child Health Services Block Grant-Use of Allotment Funds	504(a)	6503(a)(1)	2276	505-506	180, 503
Maternal and Child Health Services Block Grant-Use of Allotment Funds	504(a)	6503(c)(2)	2278	505-506	183, 503-505
Maternal and Child Health Services Block Grant-Use of Allotment Levels (conforming amendment)	504(a)	6503(c)(4)	2278	505-506	183, 503-505
Maternal and Child Health Services Block Grant-Use of Allotment Funds	504(a) New	6503(a)(2)	2276	505-506, 634	180, 503
Maternal and Child Health Services Block Grant-Applications	505 Heading	6503(b)(1)	2276	503-506, 634	180, 503-505
Maternal and Child Health Services Block Grant-Applications (technical amendment)	505 Redesignated as 505(a)	6503(b)(2)	2276	503-506, 634	180, 503-505
Maternal and Child Health Services Block Grant-Applications	505(a)	6503(b)(3)	2276	503-506	180, 503-505
Maternal and Child Health Services Block Grant-Applications	505(a)(1)	6503(b)(4)	2276	505-506, 634	180-181, 503-505

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Maternal and Child Health Services Block Grant-Applications (technical amendment)	505(a)(2) Redesignated as 505(a)(5)	6503(b)(4)	2276	505-506	180, 503-506
Maternal and Child Health Services Block Grant-Block Grant-Applications	505(a)(2) New	6503(b)(4)	2276	505-506	181, 503-505
Maternal and Child Health Services Block Grant-Applications	505(a)(3) New	6503(b)(4)	2276	505-506	181, 503-505
Maternal and Child Health Services Block Grant-Applications	505(a)(4) New	6503(b)(4)	2276	505-506	181, 503-505
Maternal and Child Health Services Block Grant-Applications	505(a)(5)	6503(b)(5)(A)	2277	505-506	181, 503-505
Maternal and Child Health Services Block Grant-Applications	505(a)(5)(A)	6503(b)(5)(B)	2277	505-506	181, 503-505
Maternal and Child Health Services Block Grant-Applications	505(a)(5)(C)(i)	6503(b)(5)(C)	2277	505-506, 635	181, 503-505
Maternal and Child Health Services Block Grant-Applications (technical amendment)	505(a)(5)(D)	6503(b)(5)(D)	2277	505-506, 635	182, 503-505
Maternal and Child Health Services Block Grant-Applications (technical amendment)	505(a)(5)(E) Redesignated as 505(a)(5)(F)	6503(b)(5)(E)	2277	505-506, 635	182, 503-505
Maternal and Child Health Services Block Grant-Applications	505(a)(5)(E) New	6503(b)(5)(E)	2277	505-506, 635	182, 503-505
Maternal and Child Health Services Block Grant-Applications	505(a)(5)(F)	6503(b)(5)(F)(i)	2277	505-506, 635	182, 503-505
Maternal and Child Health Services Block Grant-Applications	505(a)(5)(F)(i)	6503(b)(5)(F)(ii)	2277	505-506, 635	182, 503-505

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Maternal and Child Health Services Block Grant-Applications	505(a)(5)(F)(i)	6503(b)(5)(F)(iii)	2277	505-506, 635	182, 503-505
Maternal and Child Health Services Block Grant-Applications	505(a)(5)(F)(i)	6503(b)(5)(F)(iv)	2277	505-506, 635	182, 503-505
Maternal and Child Health Services Block Grant-Applications	505(a)(5)(F)(ii)	6503(b)(5)(F)(iv)	2277	505-506, 635	182, 503-505
Maternal and Child Health Services Block Grant-Applications (technical amendment)	505(a)(5)(F)(ii)	6503(b)(5)(F)(v)	2277	505-506, 635	182, 503-505
Maternal and Child Health Services Block Grant-Applications	505(a)(5)(F)(iii)	6503(b)(5)(F)(iv)	2277	505-506, 635	182, 503-505
Maternal and Child Health Services Block Grant-Applications (technical amendment)	505(a)(5)(F)(iii)	6503(b)(5)(F)(vi)	2277	505-506, 635	182, 503-505
Maternal and Child Health Services Block Grant-Application	505(a)(5)(F)(iv) New	6503(b)(5)(F)(vi)	2278	505-506, 635	182, 503-505
Maternal and Child Health Services Block Grant-Applications	505(a)	6503(b)(6)	2278	505-506, 635-636	182, 503-505
Maternal and Child Health Services Block Grant-Applications	505(b) New	6503(b)(7)	2278	505-506, 636	182, 183, 503-505
Maternal and Child Health Services Block Grant Applications	505(2)(C)(ii)	6501(b)	2275	496-497	179, 499
Maternal and Child Health Services Block Grant-Reports and Audits	506(a)(1)	6504(a)(1)(A)	2278	506-507, 636	183, 505-506

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Maternal and Child Health Services Block Grant-Reports and Audits	506(a)(1)	6504(a)(1)(B)	2278	506-507, 636	183, 505-506
Maternal and Child Health Services Block Grant-Reports and Audits	506(a)(1)	6504(a)(1)(C)	2279	506-507, 636	183, 505-506
Maternal and Child Health Services Block Grant-Reports and Audits (conforming amendment)	506(a)(_)(C)	6503(c)(3)	2278	505-506, 636	183, 503-505
Maternal and Child Health Services Block Grant-Reports and Audits (conforming amendment)	506(a)(1)(C)	6503(c)(4)	2278	505-506, 636	183, 503-505
Maternal and Child Health Services Block Grant-Reports and Audits (technical amendment)	506(a)(2) Redesignated as 506(a)(3)	6504(a)(2)	2279	506-507, 638	183, 505-506
Maternal and Child Health Services Block Grant-Reports and Audits	506(a)(2) New	6504(a)(3)	2279	506-507, 636-637	183-184, 505-506
Maternal and Child Health Services Block Grant-Reports and Audits	506(a)(3)	6504(b)	2280	506-507, 638-639	184-186, 507
Maternal and Child Health Services Block Grant-Nondiscrimination (conforming amendment	508(b)	6502(b)	2276	502-503, 639	180, 502-503
Maternal and Child Health Block Grant-Program Administration	509(a)(4)	6505(1)	2281	509, 640	186, 507
Maternal and Child Health Services Block Grant-Program Administration (technical amendment)	509(a)(5)	6505(2)	2281	507	186, 507

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Maternal and Child Health Services Block Grant-Program Administration (conforming amendment)	509(a)(6)	6503(c)(4)	2278	505-506, 640	183, 503-505
Maternal and Child Health Services Block Grant-Program (technical amendment)	509(a)(6)	6505(3)	2281	507	186, 507
Maternal and Child Health Services Block Grant-Program Administration	509(a)(7) New	6505(4)	2281	507	186, 507
Maternal and Child Health Services Block Grant-Program Administration	509(a)(8) New	6505(4)	2281	507	186, 507
Administration-Office of Rural Health Policy	711(b)(2)(A)	6213(g)(1)	2251	374, 640-641	155, 862-863, 868, 870
Administration-Office of Rural Health Policy	711(b)(2)(C)	6213(g)(2)	2251	374, 641	155, 862-863, 868, 870
Administration-Office of Rural Health Policy	711(b)(4)	6213(g)(3)	2252	374, 641	155, 862-863, 868, 870
General Provisions-Exclusion from Participation in Certain Programs	1128(b)(4)(A)	6411(d)(1)	2270	483, 641	175, 489-490
General Provisions-Civil Monetary Penalties (conforming amendment)	1128A(b)(1)	6003(g)(3)(D)(i)	2153	987, 989-992	51, 719, 722-726, 728-729

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
General Provisions - Criminal Penalties (conforming amendment)	1128B(c)	6003(g)(3)(D)(ii)	2153	987, 989-992	51, 719, 722-726, 728-729
General Provisions - Nonprofit Hospital Philanthropy (conforming amendment)	1134	6003(g)(3)(D)(iii)	2153	987, 989-992	51, 719, 722-726, 728-729
General Provisions (conforming amendment)	1138(a)(1)	6003(g)(3)(D)(iv)	2153	987, 989-992	51, 719, 722-726, 728-729
General Provisions - National Commission on Children	1139(d)	6221(1)(A)	2255	374	158, 862, 867-868, 870
General Provisions - National Commission on Children	1139(d)	6221(1)(B)	2255	374	158-862, 867-868, 870
General Provisions - National Commission on Children	1139(e)	6221(2)	2255	374	158-862, 867-868, 870
General Provisions - National Commission Children	1139(j)	6221(3)	2255	374	158-862, 867-868, 870

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
General Provisions - National Commission on Children	1139(k) New	6221(4)	2255	374	158-159, 862, 867-868, 870
General Provisions - National Commission on Children	1139(l) New	6221(4)	2255	374	159, 862, 867-868, 870
General Provisions - Research on Outcomes of Health Care Services and Procedures	1142 New	6103(b)(1)	2195	379, 643-645, 1030-1033	95-99, 870-898
General Provisions - Research on Outcomes of Health Care Services and Procedures	1142 New	10308	2485	---	401-402, 704
Peer Review - Organizations Functions	1154(a)(1)	6224(a)(1)	2257	367-369, 1046-1047, 1050	160, 857-860
Peer Review - Organizations Functions (conforming amendment)	1154(a)(3)(A)	6224(b)(1)(A)	2257	367, 369, 645, 1046-1047, 1050	160, 857-860
Peer Review - Organizations Functions	1154(a)(3)(B)	6224(b)(1)(B)	2257	367-369, 645, 1046-1047, 1050	160, 857-860
Peer Review - Organizations Functions	1154(a)(3)(D) New	6224(b)(1)(C)	2257	367-369, 646, 1046-1047, 1050	160-161, 857-860

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Peer Review - Organizations Functions	1154(a)(3)(E) New	6224(b)(1)(C)	2257	367-369, 646, 1046-1047, 1050	161, 857-860
Peer Review - Right to Hearing and Judicial Review	1155	6224(b)(2)	2257	367-369, 646, 1046-1047, 1050	161, 857-860
Peer Review - Certain Surgical Procedures (conforming amendment)	1164(e)	6003(g)(3)(D)(v)	2153	987, 989-992	51, 719, 722-726, 728-729
Supplemental Security Income - Limitation on Eligibility of Certain Individuals	1611(e)(1)(B)	8010(b)	2464	1080-1081	378, 917-918
Supplemental Security Income - Suspension of Payments to Individuals Outside U.S.	1611(f)	8009(a)	2463	934, 1080	378, 916-917
Supplemental Security Income - Exclusions from Income (technical amendment)	1612(b)(13)	8011(a)(1)	2464	935, 1085	378, 920
Supplemental Security Income - Exclusions from Income (technical amendment)	1612(b)(14)	8011(a)(2)	2464	935, 1085	379, 920
Supplemental Security Income - Exclusions from Income (technical amendment)	1612(b)(14)	8013(a)(1)	2464	936, 1086	379, 921
Supplemental Security Income - Exclusions from Income	1612(b)(15) New	8011(a)(3)	2464	935, 1085	379, 920

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Supplemental Security Income - Exclusions from Income (technical amendment)	1612(b)(15)	8013(a)(2)	2464	936, 1086	379, 921
Supplemental Security Income - Exclusions from Income	1612(b)(16) New	8013(a)(3)	2464	936, 1086	379, 921
Supplemental Security Income - Exclusions from Income	1613(a)(2) (B)	8013(b)	2465	936, 1086	379, 921
Supplemental Security Income - Exclusions from Resources	1613(a)(3)	8014(a)	2465	1081	379-380, 923-924
Supplemental Security Income - Aged, Blind, or Disabled Individual (technical amendment)	1614(a)(1) (B) Redesignated as 1614(a)(1) (B)(i)	8009(b)(1) (B)	2463	934, 1080	378, 916-917
Supplemental Security Income - Aged, Blind, or Disabled Individual (technical amendment)	1614(a)(1) (B)(i) Redesignated as 1614(a)(1)(B) (i)(I)	8009(b)(1)(A)	2463	934, 1080	378, 916-917
Supplemental Security Income - Aged, Blind, or Disabled Individual (technical amendment)	1614(a)(1) (B)(i)	8009(b)(1) (C)	2463	934, 1080	378, 916-917
Supplemental Security Income - Aged, Blind, or Disabled Individual (technical amendment)	1614(a)(1) (B)(ii) Redesignated as 1614(a)(1)(B) (i)(II)	8009(b)(1) (A)	2463	934, 1080	378, 916-917
Supplemental Security Income - Aged, Blind or Disabled Individual	1614(a)(1)(B) (ii) New	8009(b)(2)	2463	934, 1080	378, 916-917
Supplemental Security Income - Eligible Spouse	1614(b)	8012(a)	2464	936, 1085	379, 920-921

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Supplemental Security Income - Rules for Deeming Income and Resources to Children (technical amendment)	1614(f)(2) Redesignated as 1614(f)(2)(A)	8010(a)(1)	2463	1080-1081	378, 917-918
Supplemental Security Income - Rules for Deeming Income and Resources to Children	1614(f)(2)(B) New	8010(a)(2)	2463	1080-1081	378, 917-918
Supplemental Security Income - Hearings and Review	1631(c)(1)	10305(e)	2483	958, 961-963	399, 708
Supplemental Security Income - Representation of Claimants (technical amendment)	1631(d)(2) Redesignated as 1631(d)(2)(A)	10307(b)(2)(A)	2485	959, 962-964	401, 709-710
Supplemental Security Income - Representation of Claimants	1631(d)(2)(B) New	10307(b)(2)(B)	2485	959, 962-964	401, 709-710
Supplemental Security Income - Representation of Claimants	1631(d)(2)	10307(a)(2)	2485	959, 962-964	400, 709-710
Supplemental Security Income - Applications	1631(e)(5) New	10302(b)(1)	2482	960, 963-964	397, 707, 710-711
Supplemental Security Income - Same-Day Personal Interviews	1631(e)(6) New	10303(b)	2482	960, 963-964	398, 711
Supplemental Security Income - Outreach Program for Children	1635 New	8008(a)	2463	1077	377, 912-913
Medicare - Hospital Insurance - Scope of Benefits	1812(a)(1)	6003(g)(3)(B)(i)	2152	987, 989-992	50, 719, 722-726, 728-729

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Hospital Insurance Benefits - Requirement of Requests and Certifications	1814(a)(2)	6028(1)	2168	996, 998-999	67, 732-733, 736, 738
Medicare - Hospital Insurance Benefits Requirement of Requests and Certifications (technical amendment)	1814(a)(6)	6003(g)(3)(B)(ii)(I)	2152	987, 989-992	50, 719, 722-726, 728-729
Medicare - Hospital Insurance Benefits - Requirement of Requests and Certifications (technical amendment)	1814(a)(7)	6003(g)(3)(B)(ii)(II)	2152	987, 989, 992	50, 719, 722-726, 728-729
Medicare - Hospital Insurance Benefits - Requirement of Requests and Certifications	1814(a)(7)(A)(i)	6005(b)	2161	994-995	59, 730-731
Medicare - Hospital Insurance Benefits - Requirement of Requests and Certifications	1814(a)(8) New	6003(g)(3)(B)(ii)(III)	2152	987, 989-992	50, 719, 722-726, 728-729
Medicare - Hospital Insurance Benefits - Requirement of Requests and Certifications	1814(a)	6028(2)	2168	996, 998-999	67, 732-733, 736, 738
Medicare - Hospital Insurance Benefits - Amount Paid to Providers	1814(b)	6003(g)(3)(B)(iii)(I)	2152	987, 989-992	50, 719, 722-726, 728-729
Medicare - Hospital Insurance Benefits - Payment for Hospice Care	1814(i)(1)(A)	6005(a)(1)	2160	994-995	59, 730-731

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Hospital Insurance Benefits - Payment for Hospice Care	1814(i)(1)(C)	6005(a)(2)	2160	994-995	59, 730-731
Medicare - Hospital Insurance Benefits - Inpatient Rural Primary Care Services	1814(l) New	6003(g)(3)(B)(iii)(II)	2152	987, 989-992	50, 719, 722-726, 728-729
Medicare - Hospital Insurance Benefits - Payment to Providers of Services	1815(e)(4) New	6021(a)	2166	918, 996, 998-999	65-66, 733, 736, 738
Medicare - Hospital Insurance Benefits - Fiscal Intermediary Agreements	1816(c)(1)	6202(d)(1)	2234	1020-1024	136, 818-826
Medicare - Hospital Insurance Benefits Fiscal Intermediary Agreements (conforming amendment)	1816(c)(2)(C)	6003(g)(3)(D)(vi)	2153	987, 989-992	51, 719, 722, 726, 728-729
Medicare - Hospital Insurance Benefits - Uninsured Elderly Individuals	1818 Heading	6012(a)(1)	2161	995, 998-999	60, 732, 735, 737-738
Medicare - Hospital Insurance Benefits - Uninsured Elderly Individuals	1818(g) New	6013(a)	2163	917, 995, 998-999	62, 732, 735, 737-738
Medicare - Hospital Insurance Benefits - Disabled Individuals	1818A New	6012(a)(2)	2161	995, 998-999	60-62, 732, 735, 737-738

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Hospital Insurance Benefits - Skilled Nursing Facilities	1819(b)(5)(A)	6901(b)(1)(A)	2298	456-476	203, 475-478
Medicare - Hospital Insurance Benefits - Skilled Nursing Facilities	1819(b)(5)(B)	6901(b)(1)(B)	2298	456-476	203, 475-478
Medicare - Hospital Insurance Benefits - Skilled Nursing Facilities (technical amendment)	1819(c)(1)(A)(ii)(II)	6901(d)(4)(A)	2301	456-476	206, 475-478
Medicare - Hospital Insurance Benefits - Skilled Nursing Facilities (technical amendment)	1819(c)(1)(A)(v)(i)	6901(d)(4)(B)	2301	456-476	206, 475-478
Medicare - Hospital Insurance Benefits - Skilled Nursing Facilities (technical amendment)	1819(f)(2)(A)(i)	6901(d)(4)(C)	2301	456-476	206, 475-478
Medicare - Hospital Insurance Benefits - Skilled Nursing Facilities	1819(f)(2)(A)(i)(I)	6901(b)(3)(A)	2298	456-476	204, 475-478
Medicare - Hospital Insurance Benefits - Skilled Nursing Facilities	1819(f)(2)(A)(ii)	6901(b)(3)(B)	2298	456-476	204, 475-478
Medicare - Hospital Insurance Benefits - Skilled Nursing Facilities (technical amendment)	1819(f)(2)(A)(iii)	6901(b)(3)(C)	2298	456-476	204, 475-478
Medicare - Hospital Insurance Benefits - Skilled Nursing Facilities	1819(f)(2)(A)(iv) New	6901(b)(3)(D)	2298	456-476	204, 475-478

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Hospital Insurance Benefits - Skilled Nursing Facilities (technical amendment)	1819(b)(2) (C)	6901(d)(4) (D)	2301	456-476	206, 475-478
Medicare - Hospital Insurance Benefits - Essential Access Community Hospitals	1820 New	6003(g)(1) (A)	2145	916-917, 987, 989-992	43-48, 719, 722-726, 728-729
Medicare - Supplementary Medical Insurance Benefits-Scope of Benefits (technical amendment)	1832(a)(2) (F)	6116(a)(2) (A)	2219	1017-1018, 1020	121, 800-804
Medical - Supplementary Medical Insurance Benefits-Scope of Benefits (technical amendment)	1832(a)(2) (G)	6116(a)(2) (B)	2219	1017-1018, 1020	121, 800-804
Medicare - Supplementary Medical Insurance Benefits-Scope of Benefits	1832(a)(2) (H) New	6116(a)(2) (C)	2219	1017-1018, 1020	121, 800-804
Medicare - Supplementary Medical Insurance Benefits-Payment of Benefits	1833(a)(1) (F) New	6113(b)(3) (A)	2217	361	118, 787-790
Medicare - Supplementary Medical Insurance Benefits-Payment of Benefits	1833(a)(1) (H)	6102(e)(5)	2187	337-353, 919, 1002-1008	87-88, 738-754, 757-760
Medicare - Supplementary Medical Insurance Benefits	1833(a)(1) (J)	6102(e)(6) (A)	2188	337-353, 919, 1002-1008	88, 738-754, 757-760
Medicare - Supplementary Medical Insurance Benefits	1833(a)(1) (J)	6102(f)(2) (A)	2189	352, 650	766, 768-769

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Supplementary Medical Insurance Benefits	1833(a)(1) (J)	6102(f)(2) (B)	2189	352, 650	766-768, 769
Medicare - Supplementary Medical Insurance Benefits	1833(a)(1) (K)	6102(e)(7)	2188	337-353, 650, 1002-1008	88, 738-754, 757-760
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1833(a)(1) (L)	6102(e)(1) (A)	2187	337-353, 1002-1008	87, 738-754, 757-760
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1833(a)(1) (M)	6102(e)(1) (B)	2187	337-353, 1002-1008	87, 738-754, 757-760
Medicare - Supplementary Medical Insurance Benefits	1833(a)(1) (N) New	6102(e)(1) (B)	2187	337-353, 1002-1008	87, 738-754, 757-760
Medicare - Supplementary Medical Insurance Benefits (conforming amendment)	1833(a)(2)	6116(b)(1) (A)	2219	1017-1018, 1020	121, 800-804
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1833(a)(4)	6116(b)(1) (B)	2219	1017-1018, 1020	121, 800-804
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1833(a)(5)	6116(b)(1) (C)	2220	1017-1018, 1020	121, 800-804
Medicare - Supplementary Medical Insurance Benefits	1833(a)(6) New	6116(b)(1) (D)	2220	1017-1018, 1020	121, 800-804
Medicare - Supplementary Medical Insurance Benefits	1833(d)(1)	6113(d)	2217	652, 922, 1015	119, 787-789

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Supplementary Medical Insurance Benefits	1833(g)	6133(a)	2222	359, 652	124, 801, 803, 804
Medicare - Supplementary Medical Insurance Benefits	1833(h)(1) (B)	6111(a)(1)	2213	355-356, 652, 1014-1015	115, 783-786
Medicare - Supplementary Medical Insurance Benefits	1833(h)(1) (C)	6111(a)(1)	2213	355-356, 652, 1014-1015	115, 783-786
Medicare - Supplementary Medical Insurance Benefits	1833(h)(1) (D)	6003(e)(2) (A)	2143	986-989, 992	41, 718, 721, 725-728
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1833(h)(4) (B)(i)	6111(a)(2)	2214	355-356, 652, 1014-1015	115, 783-786
Medicare - Supplementary Medical Insurance Benefits	1833(h)(4) (B)(ii)	6111(a)(3) (A)	2214	355-356, 652, 1014-1015	115, 783-786
Medicare - Supplementary Medical Insurance Benefits	1833(h)(4) (B)(ii)	6111(a)(3) (B)	2214	355-356, 652, 1014-1015	115, 783-786
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1833(h)(4) (B)(ii)	6111(a)(3) (C)	2214	355-356, 653, 1014-1015	115, 783-786

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Supplementary Medical Insurance Benefits	1833(h)(4)(B)(iii) New	6111(a)(4)	2214	355-356, 653, 1014-1015	115, 783-786
Medicare - Supplementary Medical Insurance Benefits	1833(h)(5)(A)(ii)	6111(b)(1)	2214	356, 653	115, 783-786
Medicare - Supplementary Medical Insurance Benefits (conforming amendment)	1833(h)(5)(A)(iii)	6003(g)(3)(D)(vii)(I)	2153	987, 989-992	51, 719, 722-726, 728-729
Medicare - Supplementary Medical Insurance Benefits (conforming amendment)	1833(i)(1)(A)	6003(g)(3)(D)(vii)(II)	2153	987, 989-992	51, 719, 722-726, 728-729
Medicare - Supplementary Medical Insurance Benefits (conforming amendment)	1833(i)(3)(A)	6003(g)(3)(D)(vii)(III)	2153	987, 989-992	51, 719, 722-726, 728-729
Medicare - Supplementary Medical Insurance Benefits (conforming amendment)	1833(l)(5)(A)	6003(g)(3)(D)(vii)(IV)	2153	987, 989-992	51, 719, 722-726, 728-729
Medicare - Supplementary Medical Insurance Benefits (conforming amendment)	1833(l)(5)(C)	6003(g)(3)(D)(vii)(V)	2153	987, 989-992	51, 719, 722-726, 728-729
Medicare - Supplementary Medical Insurance Benefits	1833(m)	6102(c)(1)(A)	2184	1002-1011	84, 740, 754, 762

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Supplementary Medical Insurance Benefits	1833(m)	6102(c)(1)(B)	2184	1002-1011	84, 740, 754, 762
Medicare - Supplementary Medical Insurance Benefits	1833(o)(1)	6131(a)(1)(C)	2221	923, 1017-1018, 1020	123, 798-800
Medicare - Supplementary Medical Insurance Benefits	1833(o)(1)(A)	6131(a)(1)(A)	2221	923, 1017-1018, 1020	122, 798-800
Medicare - Supplementary Medical Insurance Benefits	1833(o)(1)(B)	6131(a)(1)(B)	2221	923, 1017-1018, 1020	122, 798-800
Medicare - Supplementary Medical Insurance Benefits	1833(o)(2)(A)	6131(a)(1)(B)	2221	923, 1017-1018, 1020	122, 798-800
Medicare - Supplementary Medical Insurance Benefits	1833(o)(2)(A)(i)	6131(a)(1)(D)	2221	923, 1017-1018, 1020	123, 798-800
Medicare - Supplementary Medical Insurance Benefits	1833(o)(2)(A)(ii)(II)	6131(a)(1)(E)	2221	923, 1017-1018, 1020	123, 798-800
Medicare - Supplementary Medical Insurance Benefits	1833(o)(2)(D) New	6131(b)	2221	1017-1018, 1020	123, 798-800
Medicare - Supplementary Medical Insurance Benefits	1833(p)	6113(b)(3)(B)(i)	2217	361	118, 787-790
Medicare - Supplementary Medical Insurance Benefits	1833(p)	6113(b)(3)(B)(ii)	2217	361	118, 787-790

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Supplementary Medical Insurance Benefits	1833(q) New	6204(b)	2241	1037-1046	144-145, 852, 855-856
Medicare - Supplementary Medical Insurance Benefits	1834(a)(1) (D) New	6112(c)	2215	353-354, 654, 1011-1014	116, 775, 778, 781-782
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1834(a)(2) (A)(i)	6112(d)(1) (A)	2215	354-355, 654, 922	117, 776, 780-782
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1834(a)(2) (A)(ii)	6112(d)(1) (B)	2215	354-355, 654, 922	117, 776, 780-782
Medicare - Supplementary Medical Insurance Benefits	1834(a)(2) (A)(iii) New	6112(d)(1) (C)	2215	354-355, 654, 922	117, 776, 780-782
Medicare - Supplementary Medical Insurance Benefits	1834(a)(2) (B)(i)	6112(a)(1)	2214	1011-1014	115, 775, 777, 781-782
Medicare - Supplementary Medical Insurance Benefits	1834(a)(3) (B)(i)	6112(a)(1)	2214	1011-1014	115, 775, 777, 781-782
Medicare - Supplementary Medical Insurance Benefits	1834(a)(7) (A)(i)	6112(a)(4) (A)	2214	1011-1014	116, 775, 777, 781-782
Medicare - Supplementary Medical Insurance Benefits	1834(a)(7) (B)(i)	6112(a)(4) (B)	2214	1011-1014	116, 775, 777, 782

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Supplementary Medical Insurance Benefits	1834(a)(7)(B)(ii)	6112(a)(4)(C)	2215	1011-1014	116, 775, 777, 781-782
Medicare - Supplementary Medical Insurance Benefits	1834(a)(8)(A)(ii)(I)	6112(a)(2)(A)	2214	1011-1014	116, 775, 777, 781-782
Medicare - Supplementary Medical Insurance Benefits	1834(a)(8)(A)(ii)(II)	6112(a)(2)(B)	2214	654, 1011-1014	116, 775, 777, 781-782
Medicare - Supplementary Medical Insurance Benefits	1834(a)(8)(D)(i)	6140(1)	2224	353-355, 655	126, 776, 780-782
Medicare - Supplementary Medical Insurance Benefits	1834(a)(8)(D)(ii)	6140(2)	2225	353-355, 655	126, 776, 780-782
Medicare - Supplementary Medical Insurance Benefits	1834(a)(9)(A)(ii)(I)	6112(a)(3)(A)	2214	921, 1011-1014	116, 775, 777, 781-782
Medicare - Supplementary Medical Insurance Benefits	1834(a)(9)(A)(ii)(II)	6112(a)(3)(B)	2214	656, 921, 1011-1014	116, 775, 777, 781-782
Medicare - Supplementary Medical Insurance Benefits	1834(a)(9)(D)(i)	6140(1)	2224	353-355, 656	126, 776, 780-782
Medicare - Supplementary Medical Insurance Benefits	1834(a)(9)(D)(ii)	6140(2)	2225	353-355, 657	126, 776, 780-782

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Supplementary Medical Insurance Benefits	1834(a)(13)	6112(e)(2)	2216	353-355	117, 776-777, 780-782
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1834(b)(4)(C) Redesignated as 1834(b)(4)(D)	6105(a)(1)	2210	350, 1000-1002	111, 765-769
Medicare - Supplementary Medical Insurance Benefits	1834(b)(4)(C) New	6105(a)(2)	2210	350, 1000-1002	111, 765-769
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1834(b)(4)(D) Redesignated as 1834(b)(4)(E)	6105(a)(1)	2210	350, 1000-1002	111, 765-769
Medicare - Supplementary Medical Insurance Benefits	1834(f) New	6102(f)(1)	2188	352, 657-658	88-89, 766, 768-769
Medicare - Supplementary Medical Insurance Benefits	1834(g) New	6116(b)(2)	2220	1017-1018, 1020	121-122, 800-804
Medicare - Supplementary Medical Insurance Benefits (conforming amendment)	1835(c)	6003(g)(3)(D)(viii)	2153	987, 989-992	51, 719, 722-726, 728-729
Medicare - Supplementary Medical Insurance Benefits	1837(i)	6202(b)(4)(C)	2233	1020-1024	136, 818-826
Medicare - Supplementary Medical Insurance Benefits	1837(i)(1)(A) Stricken	6202(c)(1)(A)(i)	2234	1020-1024	136, 818-826
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1837(i)(1)(B) Redesignated as 1837(i)(1)(A)	6202(c)(1)(A)(ii)	2234	1020-1024	136, 818-826

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1837(i)(1)(C) Redesignated as 1837(i)(1)(B)	6202(c)(1)(A) (iii)	2234	1020-1024	136, 818-826
Medicare - Supplementary Medical Insurance Benefits	1837(i)(1)	6202(c)(1)(A) (iii)	2234	1020-1024	136, 818-826
Medicare - Supplementary Medical Insurance Benefits	1837(i)(2)(A) Stricken	6202(c)(1)(B) (ii)	2234	1020-1024	136, 818-826
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1837(i)(2)(B) Redesignated as 1837(i)(2)(A)	6202(c)(1) (B)(iii)	2234	1020-1024	136, 818-826
Medicare - Supplementary Medical Insurance Benefits	1837(i)(2)(B) (i)	6202(c)(1)(B) (i)	2234	1020-1024	136, 818-826
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1837(i)(2)(C) Redesignated as 1837(i)(2)(B)	6202(c)(1)(B) (iii)	2234	1020-1024	136, 818-826
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1837(i)(2)(D) Redesignated as 1837(i)(2)(C)	6202(c)(1)(B) (iii)	2234	1020-1024	136, 818-826
Medicare - Supplementary Medical Insurance Benefits	1837(i)(2)	6202(c)(1)(B) (iv)	2234	1020-1024	136, 818-826
Medicare - Supplementary Medical Insurance Benefits	1839(b)	6202(b)(4)(C)	2233	1020-1024	136, 818-826
Medicare - Supplementary Medical Insurance Benefits	1839(b)	6202(c)(2)	2234	1020-1024	136, 818-826
Medicare - Supplementary Medical Insurance Benefits	1839(e)	6301	2258	1050-1051	161, 898-899

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Supplementary Medical Insurance Benefits	1842(b)(2)(A)	6202(d)(2)	2234	1020-1024	136, 818-826
Medicare - Supplementary Medical Insurance Benefits	1842(b)(2)(C) New	6114(c)(2)	2218	361-362	119-120, 791, 794-795, 798
Medicare - Supplementary Medical Insurance Benefits	1842(b)(3)(G)	6102(c)(2)	2187	337-353, 658, 1002-1008	87, 738-754, 757-760
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1842(b)(3)(J)	6102(b)(1)	2184	1003, 1007-1008, 1010	84, 740, 754, 762
Medicare - Supplementary Medical Insurance Benefits (technical amendment)	1842(b)(3)(K)	6102(b)(2)	2184	1003, 1007-1008, 1010	84, 740, 754, 762
Medicare - Supplementary Medical Insurance Benefits	1842(b)(3)(L) New	6102(b)(3)	2184	1003, 1007-1008, 1010	84, 740, 754, 762
Medicare - Supplementary Medical Insurance Benefits	1842(b)(4)(A)(iv)	6102(e)(3)	2187	337-353, 1002-1008	87, 738-754, 757-760
Medicare - Supplementary Medical Insurance Benefits	1842(b)(4)(E)(iv) New	6107(b)	2212	349-350, 658, 919, 1002	113, 770-771
Medicare - Supplementary Medical Insurance Benefits	1842(b)(4)(F)	6108(a)(1)(A)	2212	921, 1010-1011	113, 771-772

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Supplementary Medical Insurance Benefits	1842(b)(4)(F)	6108(a)(1)(B)	2212	921, 1010-1011	113, 771-772
Medicare - Supplementary Medical Insurance Benefits (conforming amendment)	1842(b)(6)(A)(ii)	6003(g)(3)(D)(ix)	2153	987, 989-992	51, 719, 722-726, 728-729
Medicare - Supplementary Medical Insurance Benefits	1842(b)(6)(C)	6114(c)(1)	2218	361-362, 659	119-120, 791, 794-795, 798
Medicare - Supplementary Medical Insurance Benefits	1842(b)(12)(A)	6114(b)	2218	361-362, 659	119, 791, 794-795, 798
Medicare - Supplementary Medical Insurance Benefits	1842(b)(2)(A)(ii)(II)	6102(e)(4)	2187	337-353, 660, 1002-1008	87, 738-754, 757-760
Medicare - Supplementary Medical Insurance Benefits	1842(b)(14) New	6104(a)	2208	999-1002	109-111, 763-765
Medicare - Supplementary Medical Insurance Benefits	1842(b)(15) New	6108(b)(1)	2212	921, 1010-1011	114, 771-773
Medicare - Supplementary Medical Insurance Benefits	1842(j)(1)(B)(ii)	6102(e)(9)	2188	337-353, 1002-1008	88, 738-754, 757-760
Medicare - Supplementary Medical Insurance Benefits (conforming amendment)	1842(j)(1)(D)(ii)(II)	6104(b)(1)	2209	999-1002	111, 763-765

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Supplementary Medical Insurance Benefits	1842(j)(1)(D)(ii)(IV)	6108(b)(2)(A)	2213	352-353, 921	114, 771-773
Medicare - Supplementary Medical Insurance Benefits	1842(j)(1)(D)(iii)(II)	6104(b)(2)	2209	999-1002	111, 763-765
Medicare - Supplementary Medical Insurance Benefits	1842(j)(1)(D)(iii)(II)	6108(b)(2)(B)	2213	352-353, 921	114, 771-773
Medicare - Supplementary Medical Insurance Benefits	1842(j)(1)(D)(v)	6102(e)(9)	2188	337-353, 1002-1008	88, 738-754, 757-760
Medicare - Supplementary Medical Insurance Benefits	1842(q) New	6106(a)	2210	350-352, 1000, 1002	111-112, 765-769
Medicare - Supplementary Medical Insurance Benefits	1843(i) New	6013(b)	2164	995, 998-999	62, 732, 735, 737-738
Medicare - Supplementary Medical Insurance Benefits	1848 New	6102(a)	2169	337-353, 919-921, 1002-1008	68-84, 738-754, 757-761
Medicare - Definitions - Hospital (conforming amendment)	1861(e)	6003(g)(3)(D)(x)(I)	2153	987, 989-992	51-52, 719, 722-726, 728-729
Medicare - Definitions - Home Health Services	1861(m)(5)	6112(e)(1)	2215	353-355, 675	117, 776-777, 780-782

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Definitions - Medical and Other Health Services	1861(s)(2)(H)(ii)	6113(b)(2)(A)	2216	361, 676	118, 787-790
Medicare - Definitions - Medical and Other Health Services	1861(s)(2)(J)	6114(a)(1)	2217	361-362	119, 791, 794-795, 798
Medicare - Definitions - Medical and Other Health Services (technical amendment)	1861(s)(2)(K)(i)	6114(a)(2)(A)	2217	361-362	119, 791, 794-795, 798
Medicare - Definitions - Medical and Other Health Services	1861(s)(2)(K)(ii)	6114(a)(2)(B)	2217	361-362	119, 791, 794-795, 798
Medicare - Definitions - Medical and Other Health Services (technical amendment)	1861(s)(2)(K)(ii) Redesignated as 1861(s)(2)(K)(iii)	6114(a)(2)(C)	2217	361-362	119, 791, 794-795, 798
Medicare - Definitions - Medical and Other Health Services	1861(s)(2)(K)(ii) New	6114(a)(2)(D)	2217	361-362	119, 791, 794-795, 798
Medicare - Definitions - Medical and Other Health Services (technical amendment)	1861(s)(2)(L)	6113(b)(1)(A)	2216	361, 676	118, 787-790
Medicare - Definitions - Medical and Other Health Services (technical amendment)	1861(s)(2)(M)	6113(b)(1)(B)	2216	361, 676	118, 787-790
Medicare - Definitions - Medical and Other Health Services	1861(s)(2)(N) New	6113(b)(1)(C)	2216	361, 676	118, 787-790

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Definitions - Medical and Other Health Services (technical amendment)	1861(s)(12)	6115(a)(1)	2218	362, 677	120, 798-800
Medicare - Definitions - Medical and Other Health Services (conforming amendment)	1861(s)(12)	6131(a)(2)	2221	1017-1018, 1020	123, 798-800
Medicare - Definitions - Medical and Other Health Services (technical amendment)	1861(s)(13)	6115(a)(1)(B)	2219	362, 677	120, 798-800
Medicare - Definitions - Medical and Other Health Services (technical amendment)	1861(s)(14) Redesignated as 1861(s)(15)	6115(a)(1)(C)	2219	362, 677	120, 798-800
Medicare - Definitions - Medical and Other Health Services	1861(s)(14) New	6115(a)(1)(D)	2219	362, 677	120, 798-800
Medicare - Definitions - Medical and Other Health Services	1861(s)	6141(a)(1)	2225	355, 357	126, 784-786
Medicare - Definitions - Medical and Other Health Services (technical amendment)	1861(s)(15) Redesignated as 1861(s)(16)	6115(a)(1)(C)	2219	362, 677	120, 798-800
Medicare - Definitions - Medical and Other Health Services (technical amendment)	1861(s)(16) Redesignated as 1861(s)(16)(B)	6141(a)(2)	2225	355, 367	127, 784-786
Medicare - Definitions - Medical and Other Health Services	1861(s)(16)(A) New	6141(a)(3)	2225	355, 357	127, 784-786
Medicare - Definitions - Provider of Services	1861(u)	6003(g)(3)(C)(i)	2152	987, 989-992	51, 719, 722-726, 728-729

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Definitions - Reasonable Cost (technical amendment)	1861(v)(1)(S) Redesignated as 1861(v)(1)(S)(i)	6110(1)	2213	358, 921, 1011	114, 773-774
Medicare - Definitions - Reasonable Cost	1861(v)(1)(S)(ii) New	6110(2)	2213	358, 677, 921, 1011	114-115, 773-774
Medicare - Definitions - Arrangements for Certain Services (conforming amendment)	1861(w)(1)	6003(g)(3)(D)(x)(II)	2153	987, 989-992	51-52, 719, 722-726, 728-729
Medicare - Definitions - Arrangements for Certain Services (conforming amendment)	1861(w)(2)	6003(g)(3)(D)(x)(III)	2154	987, 989-992	51, 719, 722-726, 728-729
Medicare - Definitions - Rural Health Clinic Services (technical amendment)	1861(aa)(1)(B)	6213(b)(1)	2251	363, 678	154, 793, 797-798
Medicare - Definitions - Rural Health Clinic Services	1861(aa)(1)(B)	6213(b)(2)	2251	363, 678	154, 793, 797-798
Medicare - Definitions - Rural Health Clinic Services	1861(aa)(2)	6213(c)(1)	2251	363	154, 793, 797-798
Medicare - Definitions - Rural Health Clinic Services	1861(aa)(2)	6213(c)(2)	2251	363	154, 793, 797-798
Medicare - Definitions - Rural Health Clinic Services (technical amendment)	1861(aa)(2)(I)	6213(a)(1)	2250	363, 678	153, 793, 797-798

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Definitions - Rural Health Clinic Services (technical amendment)	1861(aa)(2)(J) Redesignated as 1861(aa)(2)(K)	6213(a)(2)	2250	363, 678	153, 793, 797-798
Medicare - Definitions - Rural Health Clinic Services	1861(aa)(2)(J) New	6213(a)(3)	2250	363, 678	154, 793, 797-798
Medicare - Definitions - Rural Health Clinic Services	1861(aa)(2)(i)(II)	6213(c)(3)	2251	363, 678	154, 793, 797-798
Medicare - Definitions - Rural Health Clinic Services	1861(aa)(2)(i)(III) New	6213(c)(3)	2251	363, 678	154, 793, 797-798
Medicare - Definitions - Rural Health Clinic Services	1861(aa)(2)(i)(IV) New	6213(c)(3)	2251	363, 678	154, 793, 797-798
Medicare - Definitions - Rural Health Clinic Services	1861(aa)(4) New	6114(d)	2218	361-362	120, 791, 794-795, 798
Medicare - Definitions - Clinical Social Worker	1861(hh) Heading	6113(b)(2)(B)(i)	2216	361, 679	118, 787-790
Medicare - Definitions - Clinical Social Worker (technical amendment)	1861(hh) Redesignated as 1861(hh)(1)	6113(b)(2)(B)(v)	2216	361, 679	118, 787-790
Medicare - Definitions - Clinical Social Worker (technical amendment)	1861(hh)(1) Redesignated as 1861(hh)(1)(A)	6113(b)(2)(B)(iv)	2216	361, 679	118, 787-790
Medicare - Definitions - Clinical Social Worker (technical amendment)	1861(hh)(2) Redesignated as 1861(hh)(1)(B)	6113(b)(2)(B)(iv)	2216	361, 679	118, 787-790

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Definitions - Clinical Social Worker	1861(hh)(2) New	6113(b)(2) (B)(vi)	2217	361, 680	118, 787-790
Medicare - Definitions - Clinical Social Worker (technical amendment)	1861(hh)(3) Redesignated as 1861(hh)(1)(C)	6113(b)(2) (B)(iv)	2216	361	118, 787-790
Medicare - Definitions - Clinical Social Worker (technical amendment)	1861(hh)(3)(A) Redesignated as 1861(hh)(1) (C)(i)	6113(b)(2) (B)(iii)	2216	361	118, 787-790
Medicare - Definitions - Clinical Social Worker (technical amendment)	1861(hh)(3)(B) Redesignated as 1861(hh)(1) (C)(ii)	6113(b)(2) (B)(iii)	2216	361	118, 787-790
Medicare - Definitions - Clinical Social Worker (technical amendment)	1861(hh)(3)(B)(i) Redesignated as 1861(hh)(1)(C) (ii)(I)	6113(b)(2) (B)(iii)	2216	361	118, 787-790
Medicare - Definitions - Clinical Social Worker (technical amendment)	1861(hh)(3) (B)(ii) Redesignated as 1861(hh)(1)(C) (ii)(II)	6113(b)(2) (B)(ii)	2216	361	118, 787-790
Medicare - Definitions - Qualified Psychologist Services	1861(ii)	6113(a)	2216	361, 680, 922, 1015	117, 786-789
Medicare - Definitions - Rural Primary Care Hospital	1861(mm) New	6003(g)(3) (A)	2151	987, 989-992	49-50, 719, 722-726, 728-729
Medicare - Definitions - Outpatient Rural Primary Care Hospital Services	1861(mm)(3) New	6116(a)(1)	2219	1017-1018, 1020	121, 800-804

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Definitions - Screening Pap Smear	1861(nn) New	6115(a)(2)	2219	362	120, 798-800
Medicare - Exclusions from Coverage	1862 Heading	6202(b)(1)(A)	2229	1020-1024	131, 818-826
Medicare - Exclusions from Coverage (conforming amendment)	1862(a)(1)(E)	6103(b)(3)(B)	2199	375-381	99, 870-898
Medicare - Exclusions from Coverage	1862(a)(1)(F)	6115(b)	2219	362, 681	120, 798-800
Medicare - Exclusions from Coverage (conforming amendment)	1862(a)(14)	6003(g)(3)(D)(xi)	2154	987, 989-992	52, 719, 722-726, 728-729
Medicare - Medicare as Secondary Payer	1862(b)	6202(b)(1)(B)	2229	1020-1024	131-135, 818-826
Medicare - Medicare as Secondary Payer	1862(b)(1)(D) New	6202(e)(1)	2234	1020-1024	139, 818-826
Medicare - Medicare as Secondary Payer	1862(b)(5) New	6202(a)(2)(A)	2228	1020-1024	130-131, 818-826
Medicare - Exclusions from Coverage	1862(e)(1)	6411(d)(2)	2271	483, 681	175, 490
Medicare - Conditions of Participation for Providers of Services	1863	6003(g)(3)(C)(ii)	2152	987, 989-992	51, 719, 722-726, 728-729

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Use of State Agencies in Determination of Compliance by Providers (conforming amendment)	1864(a)	6115(c)	2219	362, 682	121, 798-800
Medicare - Use of State Agencies for Determination of Compliance by Providers	1864(a)	6003(g)(3)(C)(iii)	2152	987, 989 992	51, 719, 722-726, 728-729
Medicare - Effect of Accreditation	1865(a)	6019(b)	2166	918, 995, 998-999	64-65, 732, 735-736, 738
Medicare - Effect of Accreditation (conforming amendment)	1865(a)	6115(c)	2219	362, 683	121, 798-800
Medicare - Effect of Accreditation	1865(a)	6003(g)(3)(C)(iv)	2153	987, 989-992	51, 719, 722-726, 728-729
Medicare - Effect of Accreditation (technical amendment)	1865(a)(2) Redesignated as 1865(a)(2)(A)	6019(a)(1)	2165	918, 995, 998-999	64, 732, 735-736, 738
Medicare - Effect of Accreditation	1865(a)(2)(A)	6019(a)(2)	2165	918, 995, 998-999	64, 732, 735-736, 738
Medicare - Effect of Accreditation	1865(a)(2)(A)	6019(a)(3)	2165	918, 995, 998-999	64, 732, 735-736, 738

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Effect of Accreditation	1865(a)(2)(B) New	6019(a)(4)	2165	918, 995, 998-999	64, 732, 735-736, 738
Medicare - Effect of Accreditation	1865(b)	6019(c)	2166	918, 995, 998-999	65, 732, 735-736, 738
Medicare - Agreements with Providers of Services (conforming amendment)	1866(a)(1)(F)(ii)	6003(g)(3)(D)(xii)(I)	2154	987, 989-992	52, 719, 722-726, 728-729
Medicare - Agreements with Providers of Services (conforming amendment)	1866(a)(1)(H)	6003(g)(3)(D)(xii)(II)	2154	987, 989-992	52, 719, 722-726, 728-729
Medicare - Agreements with Providers of Services (conforming amendment)	1866(a)(1)(I)	6003(g)(3)(D)(xii)(III)	2154	987, 989-992	52, 719, 722-726, 728-729
Medicare - Agreements with Providers of Services	1866(a)(1)(I)	6018(a)(1)	2165	995, 997-999	64, 732, 734-735, 737
Medicare - Agreements with Providers of Services (conforming amendment)	1866(a)(1)(N)	6003(g)(3)(D)(xii)(IV)	2154	987, 989-992	52, 719, 722-726, 728-729

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Agreements with Providers of Services (technical amendment)	1866(a)(1)(N)	6112(e)(3)(A)	2216	353-355, 684	117, 776-777, 780-782
Medicare - Agreements with Providers of Services (technical amendment)	1866(a)(1)(N)(i)	6018(a)(2)(A)	2165	995, 997-999	64, 732, 734-735, 737
Medicare - Agreements with Providers of Services (technical amendment)	1866(a)(1)(N)(ii)	6018(a)(2)(B)	2165	995, 997-999	64, 732, 734-735, 737
Medicare - Agreements with Providers of Services	1866(a)(1)(N)(iii) New	6018(a)(2)(C)	2165	995, 997-999	64, 732, 734-735, 737
Medicare - Agreements with Providers of Services	1866(a)(1)(N)(iv) New	6018(a)(2)(C)	2165	995, 997-999	64, 732, 734-735, 737
Medicare - Agreements with Providers of Services (technical amendment)	1866(a)(1)(O)	6112(e)(3)(B)	2216	353-355, 684	117, 776-777, 780-782
Medicare - Agreements with Providers of Services	1866(a)(1)(P) New	6112(e)(3)(C)	2216	353-355, 684	117, 776-777, 782
Medicare - Agreements with Providers of Services (technical amendment)	1866(a)(2)(B)(i) Redesignated as 1866(a)(2)(B)	6017(1)	2165	---	63, 738
Medicare - Agreements with Providers of Services	1866(a)(2)(B)(ii) Stricken	6017(2)	2165	---	63, 738

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Agreements with Providers of Services (conforming amendment)	1866(a)(3)(A)	6033(g)(3)(D)(xiii)(I)	2154	987, 989-992	52, 719, 722-726, 728-729
Medicare - Agreements with Providers of Services (conforming amendment)	1866(a)(3)(B)	6003(g)(3)(D)(xiii)(I)	2154	987, 989-992	52, 719, 722-726, 728-729
Medicare - Agreements with Providers of Services (conforming amendment)	1866(a)(3)(C)(ii)(II)	6003(g)(3)(D)(xiii)(II)	2154	987, 989-992	52, 719, 722-726, 728-729
Medicare - Agreements with Providers of Services	1866(i) New	6020	2166	918, 995, 998-999	65, 732, 736, 738
Medicare - Hospital Patient Protection	1867	6211(h)(2)(A)	2249	1033-1035	152, 834-839
Medicare - Hospital Patient Protection	1867(a)	6211(h)(2)(B)	2249	1033-1035	152, 834-839
Medicare - Hospital Patient Protection	1867(a)	6211(a)	2245	1033-1035	148, 834-839
Medicare - Hospital Patient Protection (conforming amendment)	1867(b) Heading	6211(h)(2)(C)	2249	1033-1035	152, 834-839
Medicare - Hospital Patient Protection (conforming amendment)	1867(b)(1)	6211(h)(2)(D)(i)	2249	1033-1035	152, 834-839
Medicare - Hospital Patient Protection (conforming amendment)	1867(b)(1)(A)	6211(h)(2)(D)(ii)	2249	1033-1035	152, 834-839

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Hospital Patient Protection	1867(b)(2)	6211(b)(1)(A)	2245	1033-1035	148, 834-839
Medicare - Hospital Patient Protection	1867(b)(2)	6211(b)(1)(B)	2245	1033-1035	148, 834-839
Medicare - Hospital Patient Protection	1867(b)(2)	6211(b)(1)(C)	2245	1033-1035	148, 834-839
Medicare - Hospital Patient Protection	1867(b)(3)	6211(b)(2)(A)	2245	1033-1035	148, 834-839
Medicare - Hospital Patient Protection	1867(b)(3)	6211(b)(2)(B)	2246	1033-1035	148, 834-839
Medicare - Hospital Patient Protection	1867(c)	6211(g)(1)(A)	2248	1033-1035	151, 834-839
Medicare - Hospital Patient Protection	1867(c)	6211(g)(1)(B)	2248	1033-1035	151, 834-839
Medicare - Hospital Patient Protection (conforming amendment)	1867(c)(1)	6211(h)(2)(E)	2249	1033-1035	152, 834-839
Medicare - Hospital Patient Protection	1867(c)(1)(A)(i)	6211(c)(1)	2246	1033-1035	148-149, 834-839
Medicare - Hospital Patient Protection (technical amendment)	1867(c)(1)(A)(i)	6211(c)(2)(A)	2246	1033-1035	149, 834-839
Medicare - Hospital Patient Protection	1867(c)(1)(A)(ii)	6211(c)(2)(B)(i)	2246	1033-1035	149, 834-839
Medicare - Hospital Patient Protection	1867(c)(1)(A)(ii)	6211(c)(2)(B)(ii)	2246	1033-1035	149, 834-839

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Hospital Patient Protection (technical amendment)	1867(c)(1)(A) (ii)	6211(c)(2)(C)	2246	1033-1035	149, 834-839
Medicare - Hospital Patient Protection	1867(c)(1)(A) (ii)	6211(c)(3)(A)	2246	1033-1035	149, 834-839
Medicare - Hospital Patient Protection	1867(c)(1)(A) (ii)	6211(c)(3)(B)	2246	1033-1035	149, 834-839
Medicare - Hospital Patient Protection	1867(c)(1)(A) (iii) New	6211(c)(2)(D)	2246	1033-1035	149, 834-839
Medicare - Hospital Patient Protection	1867(c)(1)	6211(c)(4)	2246	1033-1035	149, 834-839
Medicare - Hospital Patient Protection (technical amendment)	1867(c)(2)(A) Redesignated as 1867(c)(2)(B)	6211(c)(5)(A)	2246	1033-1035	149, 834-839
Medicare - Hospital Patient Protection	1867(c)(2)(A) New	6211(c)(5)(B)	2246	1033-1035	149, 834-839
Medicare - Hospital Patient Protection (technical amendment)	1867(c)(2)(B) Redesignated as 1867(c)(2)(C)	6211(c)(5)(A)	2246	1033-1035	149, 834-839
Medicare - Hospital Patient Protection (technical amendment)	1867(c)(2)(C) Redesignated as 1867(c)(2)(D)	6211(c)(5)(A)	2246	1033-1035	149, 834-839
Medicare - Hospital Patient Protection	1867(c)(2)(C)	6211(d)(1)	2246	1033-1035	149, 834-839
Medicare - Hospital Patient Protection	1867(c)(2)(C)	6211(d)(2)	2247	1033-1035	149-150, 834-839
Medicare - Hospital Patient Protection (technical amendment)	1867(c)(2)(D) Redesignated as 1867(c)(2)(E)	6211(c)(5)(A)	2246	1033-1035	149, 834-839

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Hospital Patient Protection	1867(d)(2)(B)	6211(e)(1)	2247	1033-1035	150, 834-839
Medicare - Hospital Patient Protection	1867(d)(2)(C)	6211(e)(2)	2247	1033-1035	150, 834-839
Medicare - Hospital Patient Protection	1867(e)(1)	6211(h)(1)(A)	2248	1033-1035	151, 834-839
Medicare - Hospital Patient Protection	1867(e)(2) Stricken	6211(h)(1)(B)	2248	1033-1035	151, 834-839
Medicare - Hospital Patient Protection (technical amendment)	1867(e)(3) Redesignated as 1867(e)(2)	6211(h)(1)(E)	2249	1033-1035	152, 834-839
Medicare - Hospital Patient Protection (technical amendment)	1867(e)(4) Redesignated as 1867(e)(3)(D)	6211(h)(1)(E)	2249	1033-1035	152, 834-839
Medicare - Hospital Patient Protection	1867(e)(4)(A)	6211(h)(1)(C)(i)	2248	1033-1035	151, 834-839
Medicare - Hospital Patient Protection	1867(e)(4)(A)	6211(h)(1)(C)(ii)	2248	1033-1035	151, 834-839
Medicare - Hospital Patient Protection	1867(e)(4)(A)	6211(h)(1)(C)(iii)	2248	1033-1035	151, 834-839
Medicare - Hospital Patient Protection	1867(e)(4)(B)	6211(h)(1)(D)(i)	2249	1033-1035	152, 834-839
Medicare - Hospital Patient Protection	1867(e)(4)(B)	6211(h)(1)(D)(ii)	2249	1033-1035	152, 834-839
Medicare - Hospital Patient Protection	1867(e)(4)(B)	6211(h)(1)(D)(iii)	2249	1033-1035	152, 834-839

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Hospital Patient Protection	1867(e)(5)	6211(g)(2)	2248	1033-1035	151, 834-839
Medicare - Hospital Patient Protection (technical amendment)	1867(e)(5) Redesignated as 1867(e)(4)	6211(h)(1)(E)	2249	1033-1035	152, 834-839
Medicare - Hospital Patient Protection	1867(e)(6) New	6003(g)(3)(D) (xiv)	2154	987, 989-992	52, 719, 722-726, 728-729
Medicare - Hospital Patient Protection (technical amendment)	1867(e)(6) Redesignated as 1867(e)(5)	6211(h)(1)(E)	2249	1033-1035	152, 834-839
Medicare - Hospital Patient Protection	1867(g) New	6211(f)	2247	1033-1035	150-151, 834-839
Medicare - Hospital Patient Protection	1867(h) New	6211(f)	2247	1033-1035	151, 834-839
Medicare - Hospital Patient Protection	1867(i) New	6211(f)	2247	1033-1035	151, 834-839
Medicare - Studies and Recommendations	1875(c) Repealed	6103(b)(3)(A)	2199	375-381	99, 870-898
Medicare - Payments to Health Maintenance Organizations and Competitive Medical Plans	1876(a)(1)(F) New	6206(a)(1)	2244	365-367, 685, 1035-1037	147, 839, 841-842
Medicare - Payments to Health Maintenance Organizations and Competitive Medical Plans	1876(c)(3)(A)(i)	6206(b)(1)(A)	2244	365-367, 1035-1037	147, 839, 841-842

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Payments to Health Maintenance Organizations and Competitive Medical Plans	1876(c)(3)(A)(ii)	6206(b)(1)(B)	2244	365-367, 1035-1037	147, 839, 841-842
Medicare - Payments to Health Maintenance Organizations and Competitive Medical Plans	1876(g)(5)	6212(c)(2)	2250	365-367, 1035-1037	153, 839-843
Medicare - Payments to Health Maintenance Organizations and Competitive Medical Plans (technical amendment)	1876(i)(6)(A)(v)	6411(d)(3)(A)(i)	2271	483	175, 489-490
Medicare - Payments to Health Maintenance Organizations and Competitive Medical Plans (technical amendment)	1876(i)(6)(A)(vi)	6411(d)(3)(A)(ii)	2271	483	175, 489-490
Medicare - Payments to Health Maintenance Organizations and Competitive Medical Plans	1876(i)(6)(A)(vii) New	6411(d)(3)(A)(iii)	2271	483	175, 489-490
Medicare - Payments to Health Maintenance Organizations and Competitive Medical Plans	1876(j) New	6212(b)(1)	2250	365-367, 685, 1035-1037	153, 839-843
Medicare - Limitation on Certain Physician Referrals	1877 New	6204(a)	2236	927-928, 1037-1046	138-144, 843-856
Medicare - Limitation on Liability Where Claims Disallowed	1879(f)(1)	6214(a)(1)	2252	1046-1048, 1050	155, 860, 863, 868
Medicare - Limitation on Liability Where Claims Disallowed (technical amendment)	1879(f)(4) Redesignated as 1879(f)(4)(A)	6214(a)(2)	2252	1046-1048, 1050	155, 860, 863, 868

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Limitation on Liability Where Claims Disallowed	1879(f)(4)(B) New	6214(a)(2)	2252	1046-1048, 1050	155, 860, 863, 868
Medicare - Limitation on Liability Where Claims Disallowed	1881(f)(6) New	6214(b)	2252	1046-1048, 1050	155, 860, 863, 868
Medicare - Coverage for End Stage Renal Disease Patients	1881(b)(3)(A)	6102(c)(8)	2188	337-353, 686, 1002-1008	88, 738-754, 757-760
Medicare - Coverage for End Stage Renal Disease Patients (technical amendment)	1881(b)(4) Redesignated as 1881(b)(4)(A)	6203(b)(2)(A)	2235	369-370, 1024-1025, 1030	137-826, 828, 832-834
Medicare - Coverage for End Stage Renal Disease Patients	1881(b)(4)(B) New	6203(b)(2)(B)	2235	369-370, 1024-1025, 1030	137-138, 826, 828, 833-834
Medicare - Coverage for End Stage Renal Disease Patients	1881(b)(7)	6203(b)(1)	2235	369-370, 1024-1025, 1030	137, 826, 828, 833-834
Medicare - Coverage for End Stage Renal Disease Patients	1881(b)(7)	6219(a)	2254	370-371, 1024-1030	157, 826, 828, 834
Medicare - Coverage for End Stage Renal Disease Patients	1881(c)(8) New	6219(b)	2254	370-371, 1024-1030	157, 826, 828, 834
Medicare - Payment to Hospitals for Inpatient Services (technical Amendment	1886(a)(4)	6011(a)(1)	2161	360-361	60, 802, 804-805

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Payment to Hospitals for Inpatient Services	1886(a)(4)	6011(a)(2)	2161	360-361	60, 802, 804-805
Medicare - Payment to Hospitals for Inpatient Services	1886(b)(3)(A)	6003(e)(1)(B)	2143	986-989, 992	40, 718, 721, 725-728
Medicare - Payment to Hospitals for Inpatient Services	1886(b)(3)(A)	6003(f)(2)(i)	2145	986, 989, 992	42, 718, 721, 725-728
Medicare - Payment to Hospitals for Inpatient Services (conforming amendment)	1886(b)(3)(A)	6004(b)(1)(A)	2160	993-994	58, 729-730
Medicare - Payment to Hospitals for Inpatient Services (technical amendment)	1886(b)(3)(B)(i)(IV)	6003(a)(1)(A)	2140	915, 985-987, 992	37, 717, 720, 725-727
Medicare - Payment to Hospitals for Inpatient Services	1886(b)(3)(B)(i)(V)	6003(a)(1)(B)	2140	915, 985-987, 992	37, 717, 720, 725-727
Medicare - Payment to Hospitals for Inpatient Services (technical amendment)	1886(b)(3)(B)(i)(V) Redesignated as 1886(b)(3)(B)(i)(VI)	6003(a)(1)(B)	2140	915, 985-987, 992	37, 717, 720, 725-727
Medicare - Payment to Hospitals for Inpatient Services	1886(b)(3)(B)(i)(V) New	6003(a)(1)(C)	2140	915, 985-987, 992	37, 717, 720, 725-727
Medicare - Payment to Hospitals for Inpatient Services (conforming amendment)	1886(b)(3)(B)(ii)	6004(b)(1)(B)	2160	993-994	58, 729-730

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Payment to Hospitals for Inpatient Services	1886(b)(3)(C) New	6003(e)(1)(B) (ii)	2143	986-989, 992	40, 718, 721, 725-728
Medicare - Payment to Hospitals for Inpatient Services	1886(b)(3)(D) New	6003(f)(2)(ii)	2145	986-989, 992	42, 718, 721, 725-728
Medicare - Payment to Hospitals for Inpatient Services	1886(b)(3)(E) New	6004(b)(1)(C)	2160	993-994	58-59, 729-730
Medicare - Payment to Hospitals for Inpatient Services	1886(b)(4)(A)	6015(a)	2164	993-994	63, 729-730
Medicare - Payment to Hospitals for Inpatient Services	1886(c)(4)	6022	2167	918, 996, 998-999	66, 733, 736-738
Medicare - Payment to Hospitals for Inpatient Services (technical amendment)	1886(d)(1)(B) (iii)	6004(a)(1)(A)	2159	993-994	58, 729-730
Medicare - Payment to Hospitals for Inpatient Services (technical amendment)	1886(d)(1)(B) (iv)	6004(a)(1)(B)	2159	993-994	58, 729-730
Medicare - Payment to Hospitals for Inpatient Services	1886(d)(1)(B) (v) New	6004(a)(1)(C)	2159	993-994	58, 729-730
Medicare - Payment to Hospitals for Inpatient Services	1886(d)(3)(E)	6003(h)(6)(A)	2157	987, 989, 992	56, 718-719, 721-722, 725, 728

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Payment to Hospitals for Inpatient Services	1886(d)(3)(E)	6003(h)(6)(B)	2158	987, 989, 992	56, 718-719, 721-722, 725, 728
Medicare - Payment to Hospitals for Inpatient Services (technical amendment)	1886(d)(4)(C) Redesignated as 1886(d)(4)(C)(i)	6003(b)(1)	2140	986-988, 992	38, 717, 720, 725-727
Medicare - Payment to Hospitals for Inpatient Services	1886(d)(4)(C)(ii) New	6003(b)(2)	2141	986-988, 992	38, 717, 720, 725-727
Medicare - Payment to Hospitals for Inpatient Services	1886(d)(4)(C)(iii) New	6003(b)(2)	2141	986-988, 992	38, 717, 720, 725-727
Medicare - Payment to Hospitals for Inpatient Services	1886(d)(4)(C)(iv) New	6003(b)(2)	2141	986-988, 992	38, 717, 720, 725-727
Medicare - Payment to Hospitals for Inpatient Services (conforming amendment)	1886(d)(5)(C)(i)(I) Redesignated as 1886(d)(5)(C)(i)	6003(e)(2)(B)(i)	2143	916, 986-989, 992	41, 718, 721, 725-728
Medicare - Payment to Hospitals for Inpatient Services (technical amendment)	1886(d)(5)(C)(i)(II) Redesignated as 1886(d)(5)(C)(ii)	6003(e)(2)(B)(ii)	2144	916, 986-989, 992	41, 718, 721, 725-728
Medicare - Payment to Hospitals for Inpatient Services (technical amendment)	1886(d)(5)(C)(ii) Redesignated as 1886(d)(5)(D)	6003(c)(1)(A)(iv)	2142	916, 986-989, 992	40, 718, 721, 725-728

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Payment to Hospitals for Inpatient Services (technical amendment)	1886(d)(5)(C) (iii) Redesignated as 1886(d)(5)(I)	6003(e)(1)(A) (ii)	2142	916, 986-989, 992	40, 718, 721, 725-728
Medicare - Payment to Hospitals for Inpatient Services (technical amendment)	1886(d)(5)(C) (iv) Redesignated as 1886(d)(5)(H)	6003(e)(1)(A) (i)	2142	916, 986-989, 992	40, 718, 721, 725-728
Medicare - Payment to Hospitals for Inpatient Services (technical amendment)	1886(d)(5)(D) Redesignated as 1886(d)(5)(E)	6003(e)(1)(A) (iii)	2142	916, 986-989, 992	40, 718, 721, 725-728
Medicare - Payment to Hospitals for Inpatient Services (technical amendment)	1886(d)(5)(D) (iii)(I)	6003(g)(2)(A) (i)	2151	987, 989-992	49, 719, 722-726, 728-729
Medicare - Payment to Hospitals for Inpatient Services (technical amendment)	1886(d)(5)(D) (iii)(II)	6003(g)(2)(A) (ii)	2151	987, 989-992	49, 719, 722-726, 728-729
Medicare - Payment to Hospitals for Inpatient Services	1886(d)(5)(D) (iii)(III) New	6003(g)(2)(A) (iii)	2151	987, 989-992	49, 719, 722-726, 728-729
Medicare - Payment to Hospitals for Inpatient Services	1886(d)(5)(D) (v) New	6003(g)(2)(B)	2151	987, 989-992	49, 719, 722-726, 728-729

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Payment to Hospitals for Inpatient Services	1886(d)(5)(F)(iii)	6003(c)(3)	2142	986, 988, 992	39, 717-718, 720, 725-727
Medicare - Payment to Hospitals for Inpatient Services	1886(d)(5)(F)(iv)(I)	6003(c)(1)(A)	2141	915, 986, 988, 992	38, 717-718, 720, 728-729
Medicare - Payment to Hospitals for Inpatient Services (technical amendment)	1886(d)(5)(F)(iv)(II)	6003(c)(2)(A)(i)	2141	915-916, 986, 988, 992	38, 717-718, 720, 725-727
Medicare - Payment to Hospitals for Inpatient Services (conforming amendment)	1886(d)(5)(F)(iv)(III)	6003(c)(2)(A)(ii)	2141	915-916, 986, 987, 992	38, 717-718, 720, 725-727
Medicare - Payment to Hospitals for Inpatient Services (technical amendment)	1886(d)(5)(F)(iv)(III)	6003(c)(2)(A)(iii)	2141	915-916, 986, 988, 992	39, 717-718, 720, 725-727
Medicare - Payment to Hospitals for Inpatient Services	1886(d)(5)(F)(iv)(IV) New	6003(c)(2)(A)(iv)	2141	915-916, 986, 988, 992	39, 717-718, 720, 725-727
Medicare - Payment to Hospitals for Inpatient Services	1886(d)(5)(F)(iv)(V) New	6003(c)(2)(A)(iv)	2141	915-916, 986, 988, 992	39, 717-718, 720, 725-727

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Payment to Hospitals for Inpatient Services	1886(d)(5)(F) (iv)(VI) New	6003(c)(2)(A) (iv)	2141	915-916, 986, 988, 992	39, 717-718, 720, 725-727
Medicare - Payment to Hospitals for Inpatient Services (technical amendment)	1886(d)(5)(F) (v)(II) Redesignated as 1886(d)(5)(F) (v)(III)	6003(c)(2)(B) (ii)	2142	915-916, 986, 989, 992	39, 717-718, 720, 725-727
Medicare - Payment to Hospitals for Inpatient Services	1886(d)(5)(F) (v)(II) New	6003(c)(2)(B) (iii)	2142	915-916, 986, 988, 992	39, 717-718, 720, 725-727
Medicare - Payment to Hospitals for Inpatient Services (conforming amendment)	1886(d)(5))(F) (v)(III)	6003(c)(2)(B) (i)	2141	915-916, 986, 988, 992	39, 717-718, 720, 725-727
Medicare - Payment to Hospitals for Inpatient Services (technical amendment)	1886(d)(5)(F) (v)(III) Redesignated as 1886(d)(5)(F) (v)(IV)	6003(c)(2)(B) (ii)	2142	915-916, 986, 988, 992	39, 717-718, 720, 725-727
Medicare - Payment to Hospitals for Inpatient Services	1886(d)(5)(F) (vii) New	6003(c)(1)(B)	2141	915, 986, 988, 992	38, 717-718, 720, 725-727
Medicare - Payment to Hospitals for Inpatient Services	1886(d)(5)(F) (viii) New	6003(c)(2)(C)	2142	915-916, 986, 988, 992	39, 717-718, 720, 725-727

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Payment to Hospitals for Inpatient Services	1886(d)(5)(G) New	6003(f)(1)	2144	986-989, 992	41, 718, 721, 725-728
Medicare - Payment to Hospitals for Inpatient Services	1886(d)(5)(I)	6004(a)(2)	2159	993-994	58, 729-730
Medicare - Payment to Hospitals for Inpatient Services	1886(d)(8)(C)	6003(h)(3)	2156	987, 989, 992	54-55, 718-719, 721-722, 725, 728
Medicare - Payment to Hospitals for Inpatient Services	1886(d)(8)(C)(i)	6003(h)(2)(A)	2156	987, 989, 992	54, 718-719, 721-722, 725-728
Medicare - Payment to Hospitals for Inpatient Services	1886(d)(8)(C)(iv) New	6003(h)(4)	2157	987, 989, 992	55, 718-719, 721-722, 725-728
Medicare - Payment to Hospitals for Inpatient Services	1886(d)(8)(D)	6003(h)(2)(B)	2156	987, 989, 992	54, 718-719, 721-722, 725-728
Medicare - Payment to Hospitals for Inpatient Services (conforming amendment)	1886(d)(9)(B)(ii)(IV)	6003(e)(2)(C)	2144	916, 986-989, 992	41, 718, 721, 725-728

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Payment to Hospitals for Inpatient Services (technical amendment)	1886(d)(9)(D) (iii) Redesignated as 1886(d)(9)(D) (iv)	6003(e)(2)(D) (ii)	2144	916, 986-989, 992	41, 718, 721, 725-728
Medicare - Payment to Hospitals for Inpatient Services	1886(d)(9)(D) (iv) Stricken	6003(e)(2)(D) (i)	2144	916, 986-989, 992	41, 718, 721, 725-728
Medicare - Payment to Hospitals for Inpatient Services (technical amendment)	1886(d)(9)(D) (v) Redesignated as 1886(d)(9)(D) (iii)	6003(e)(2)(D) (iii)	2144	916, 986-989, 992	41, 718, 721, 725-728
Medicare - Payment to Hospitals for Inpatient Services	1886(d)(10) New	6003(h)(1)	2154	916, 987, 989, 992	52-54, 718-719, 721-722, 725, 728
Medicare - Payment to Hospitals for Inpatient Services (technical amendment)	1886(g)(3)(A) (iii)	6002(1)	2140	985	37, 716-717
Medicare - Payment to Hospitals for Inpatient Services (technical amendment)	1886(g)(3)(A) (iv)	6002(2)	2140	985	37, 716-717
Medicare - Payment to Hospitals for Inpatient Services	1886(g)(3)(A) (v) New	6002(3)	2140	985	37, 716-717
Medicare - Payment to Hospitals for Inpatient Services (conforming amendment)	1886(g)(3)(B)	6003(e)(2)(E)	2144	916, 986-989, 992	41, 718, 721, 725-728

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicare - Payment to Hospitals for Inpatient Services	1886(i) New	6003(g)(4)	2154	987, 989-992	52, 719, 722-726, 728-729
Medicaid - State Plans (conforming amendment)	1902(a)(9)(C)	6115(c)	2219	362, 689	121, 798-800
Medicaid - State Plans	1902(a)(10)(A)	6405(b)	2265	361-362	169, 794-796, 798
Medicaid - State Plans (technical amendment)	1902(a)(10)(A)(i)(IV)	6401(a)(1)(A)	2258	395-397, 689	161, 444-445, 450-451
Medicaid - State Plans (technical amendment)	1902(a)(10)(A)(i)(V)	6401(a)(1)(B)	2258	395-397, 689	161, 444-445, 450-451
Medicaid - State Plans	1902(a)(10)(A)(i)(VI) New	6401(a)(1)(C)	2258	395-397, 689	161, 444-445, 450-451
Medicaid - State Plans	1902(a)(10)(A)(ii)(IX)	6401(a)(2)	2258	395-397, 690	161, 444-445, 450, 451
Medicaid - State Plans (technical amendment)	1902(a)(10)(E) Redesignated as 1902(a)(10)(E)(i)	6408(d)(1)(A)	2268	476-477, 691	172, 486
Medicaid - State Plans (technical amendment)	1902(a)(10)(E)(i)	6408(d)(1)(B)	2268	476-477, 693	172, 486

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicaid - State Plans	1902(a)(10)(E) (ii) New	6408(d)(1)(C)	2268	476- 477, 693	172, 486
Medicaid - State Plans (technical amendment)	1902(a)(11)(A)	6406(a)(1)	2265	394, 693	169, 450
Medicaid - State Plans (technical amendment)	1902(a)(11)(B)	6406(a)(1)	2265	394, 693	169, 450
Medicaid - State Plans	1902(a)(11)(C) New	6406(a)(1)	2265	394, 693	169, 450
Medicaid - State Plans	1902(a)(13)(D)	6408(c)(1)(A)	2268	454- 456, 694	171- 172, 473- 474
Medicaid - State Plans	1902(a)(13)(D)	6408(c)(1)(B)	2268	454- 456, 695	172, 473- 474
Medicaid - State Plans	1902(a)(13)(D)	6408(c)(1)(C)	2268	454- 456, 695	172, 473- 474
Medicaid - State Plans	1902(a)(13)(E)	6402(c)(2)	2261	389- 393, 695	165, 448- 449
Medicaid - State Plans	1902(a)(13)(E)	6404(c)	2264	392- 393	168, 449
Medicaid - State Plans	1902(a)(30)(A)	6402(a)	2260	389- 393, 697	163, 448- 449
Medicaid - State Plans (conforming amendment)	1902(a)(43)(A)	6403(d)(1)	2263	398- 401, 699	167, 453- 454
Medicaid - State Plans (technical amendment)	1902(a)(43)(B)	6403(b)(1)	2263	398- 401, 699	167, 453- 454
Medicaid - State Plans (technical amendment)	1902(a)(43)(C)	6403(b)(2)	2263	398- 401, 699	167, 453- 454

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicaid - State Plans	1902(a)(43)(D) New	6403(b)(3)	2263	398-401, 699	167, 453-454
Medicaid - State Plans (technical amendment)	1902(a)(51)	6406(a)(2)	2265	394, 710	169, 450
Medicaid - State Plans (technical amendment)	1902(a)(52)	6406(a)(3)	2265	394, 900	169, 450
Medicaid - State Plans	1902(a)(53) New	6406(a)(4)	2265	394, 700	169, 450
Medicaid - State Plans	1902(e)(7)	6401(o)(8)	2259	395-397	162, 444-445, 450-451
Medicaid - State Plans	1902(f)	6408(d)(4)(C)	2269	476-478	173, 486
Medicaid - State Plans	1902(f)	6411(e)(2)	2271	491, 702	176, 496-497
Medicaid - State Plans	1902(f)	6411(a)(1)	2270	477-478, 702	174, 486-487
Medicaid - State Plans (technical amendment)	1902(l)(1)(B)	6401(a)(3)(A)	2258	395-397	162, 444-445, 450-451
Medicaid - State Plans	1902(l)(1)(C)	6401(a)(3)(B)	2258	395-397	162, 444-445, 450-451
Medicaid - State Plans	1902(l)(1)(D) New	6401(a)(3)(B)	2258	395-397	162, 444-445, 450-451

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicaid - State Plans	1902(l)(2)(A)(ii)(II)	6401(a)(4)(A)	2258	395-397, 705	162, 444-445, 450-451
Medicaid - State Plans	1902(l)(2)(A)(iv) New	6401(a)(4)(B)	2258	395-397, 705	162, 444-445, 450-451
Medicaid - State Plans	1902(l)(2)(B)	6401(a)(5)(A)	2259	395-397	162, 444-445, 450-451
Medicaid - State Plans (technical amendment)	1902(l)(2)(B) Redesignated as 1902(l)(2)(C)	6401(a)(5)(B)	2259	395-397	162, 444-445, 450-451
Medicaid - State Plans	1902(l)(2)(B) New	6401(a)(6)	2259	395-397, 705	162, 444-445, 450-451
Medicaid - State Plans	1902(l)(3)	6401(a)(6)(A)	2259	395-397, 705	162, 444-445, 450-451
Medicaid - State Plans	1902(l)(3)(C)	6401(a)(6)(B)	2259	395-397	162, 444-445, 450-451
Medicaid - State Plans	1902(l)(4)(A)	6401(a)(7)(A)	2259	395-397, 706	162, 444-445, 450-451

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicaid - State Plans	1902(l)(4)(B)	6401(a)(7)(B)	2259	395-397, 707	162, 444-445, 450-451
Medicaid - State Plans (technical amendment)	1902(p)(2)(A)	6411(d)(3)(B)(i)	2271	483	175, 489-490
Medicaid - State Plans (technical amendment)	1902(p)(2)(B)	6411(d)(3)(B)(ii)	2271	483	175, 489-490
Medicaid - State Plans	1902(p)(2)(C) New	6411(d)(3)(B)(iii)	2271	483	175, 489-490
Medicaid - State Plans	1902(r)(2)(A)	6401(a)(9)	2259	395-397, 707	162, 444-445, 450-451
Medicaid - Payment to States	1903(a)(2)(B)	6901(b)(5)(A)(i)	2299	456-476, 708	205, 475-478
Medicaid - Payment to States	1903(a)(2)(B)	6901(b)(5)(A)(ii)	2299	456-476, 708	205, 475-478
Medicaid - Payment to States (conforming amendment)	1902(f)(4)	6401(b)	2259	395-397	162, 444-445, 450-451
Medicaid - Payment to States	1903(i)(2)	6411(d)(2)	2271	483, 711	173, 489-490
Medicaid - Definitions (technical amendment)	1905(a)(2)(A)	6402(c)(1)	2261	389-393, 715	165, 449
Medicaid - Definitions (technical amendment)	1905(a)(2)(A)	6404(a)(1)	2264	392-393	167, 449

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicaid - Definitions (technical amendment)	1905(a)(2)(B)	6402(c)(1)	2261	389-393, 715	165, 449
Medicaid - Definitions	1905(a)(2)(B)	6404(a)(2)	2264	392, 393	167, 449
Medicaid - Definitions (technical amendment)	1905(a)(2)(B)	6404(a)(3)	2264	392-393	168, 449
Medicaid - Definitions	1905(a)(2)(C) New	6402(c)(1)	2261	389-393	165, 448-449
Medicaid - Definitions	1905(a)(2)(C) New	6404(a)(3)	2264	392-393	168, 448-449
Medicaid - Definitions	1905(a)(4)(B)	6403(d)(2)	2264	398-401, 715	167, 453-454
Medicaid - Definitions (technical amendment)	1905(a)(20)	6405(a)(1)	2265	361-362, 715	169, 794-795, 798
Medicaid - Definitions (technical amendment)	1905(a)(21) Redesignated as 1905(a)(22)	6405(a)(2)	2265	361-362	169, 794-796, 798
Medicaid - Definitions	1905(a)(21) New	6405(a)(3)	2265	361-362	169, 794-796, 798
Medicaid - Definitions (technical amendment)	1905(l) Redesignated as 1905(l)(1)	6404(b)(2)	2264	392-393	168, 449
Medicaid - Definitions (technical amendment)	1905(l)(1) Redesignated as 1905(l)(1)(A)	6404(b)(1)	2264	392-393	168, 449
Medicaid - Definitions (technical amendment)	1905(l)(2) Redesignated as 1905(l)(1)(B)	6404(b)(1)	2264	392-393	168, 449

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicaid - Definitions	1905(l)(2) New	6404(b)(3)	2264	392-393	168, 449
Medicaid - Definitions	1905(p)(1)(A)	6408(d)(4)(B)	2269	476-479, 718	173, 486
Medicaid - Definitions	1905(p)(3)(A)	6408(d)(4)(A)(i)	2269	476-477	173, 486
Medicaid - Definitions	1905(p)(3)(A)	6408(d)(4)(A)(ii)	2269	476-477, 718	173, 486
Medicaid - Definitions	1905(r) New	6403(a)	2262	398-401, 718-720	165-167, 453-454
Medicaid - Definitions	1905(r)	6403(c)	2263	398-401	167, 453-454
Medicaid - Definitions	1905(s) New	6408(d)(2)	2268	471-477	172, 486
Medicaid - Rural Health Clinics and Intermediate Care Facilities	1910 Heading	6901(d)(5)(A)	2301	456-476	206-207, 474-477
Medicaid - Rural Health Clinics and Intermediate Care Facilities	1910(b)(1)	6901(d)(5)(B)	2301	456-476	207, 474-477
Medicaid - Rural Health Clinics and Intermediate Care Facilities	1910(b)(1)	6901(d)(5)(C)	2301	456-476	207, 474-477
Medicaid - Rural Health Clinics and Intermediate Care Facilities	1910(b)(1)	6901(d)(5)(D)	2301	456-476	207, 474-477
Medicaid - Rural Health Clinics and Intermediate Care Facilities	1910(b)(2)	6901(d)(5)(D)	2301	456-476	207, 474-477

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicaid - Inapplicability and Waiver of Certain Requirements (conforming amendment)	1915(a)(1)(B)(ii)(I)	6115(c)	2219	362, 723	121, 798-800
Medicaid - Inapplicability and Waiver of Certain Requirements	1915(b)(4)	6411(c)(12)	2270	481-482, 723-724	174, 488-489
Medicaid - Use of Enrollment Fees, Premiums, Deductions, Cost Sharing, and Similar Charges	1916(a)	6408(d)(3)(A)	2269	476-478, 726	173, 486
Medicaid - Use of Enrollment Fees, Premiums, Deductions, Cost Sharing, and Similar Charges (technical amendment)	1916(d) Redesignated as 1916(e)	6408(d)(3)(B)	2269	476-478, 728	173, 486
Medicaid - Use of Enrollment Fees, Premiums, Deductions, Cost Sharing, and Similar Charges	1916(d) New	6408(d)(3)(C)	2269	476-477, 727-728	173, 486
Medicaid - Use of Enrollment Fees, Premiums, Deductions, Cost Sharing, and Similar Charges (technical amendment)	1916(e) Redesignated as 1916(f)	6408(d)(3)(B)	2269	476-477, 728	173, 486
Medicaid - Liens, Adjustments and Recoveries, and Transfers of Assets	1917(c)(1)	6411(e)(1)(A)	2271	491, 729	175, 496-497
Medicaid - Liens, Adjustments and Recoveries and Transfers of Assets	1917(c)(2)(B)(i)	6411(e)(1)(B)(i)	2271	491, 729	175-176, 496-497
Medicaid - Liens, Adjustments and Recoveries, and Transfers of Assets (technical amendment)	1917(c)(2)(B)(ii)	6411(e)(1)(B)(ii)	2271	491, 729	176, 496-497

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicaid - Liens, Adjustments and Recoveries, and Transfers of Assets	1917(c)(2)(B) (iii) Stricken	6411(e)(1)(B) (ii)	2271	491, 729	176, 496-497
Medicaid - Requirements for Nursing Facilities	1919(b)(5)(A)	6901(b)(1)(A)	2298	456-476, 731	203, 475-477
Medicaid - Requirements for Nursing Facilities	1919(b)(5)(B)	6901(b)(1)(B)	2298	456-476, 731	203, 475-477
Medicaid - Requirements for Nursing Facilities (technical amendment)	1919(c)(1)(A) (ii)(II)	6901(d)(4)(A)	2301	456-476, 732	206, 474-477
Medicaid - Requirements for Nursing Facilities	1919(c)(1)(A) (v)(I)	6901(d)(4)(B)	2301	456-476, 732	206, 474-477
Medicaid - Requirements for Nursing Facilities (technical amendment)	1919(f)(2)(A) (i)	6901(d)(4)(C)	2301	456-476, 738	206, 474-477
Medicaid - Requirements for Nursing Facilities	1919(f)(2)(A) (i)(I)	6901(b)(3)(A)	2298	456-476, 738	204, 475-477
Medicaid - Requirements for Nursing Facilities	1919(f)(2)(A) (ii)	6901(b)(3)(B)	2298	456-476, 738	204, 475-477
Medicaid - Requirements for Nursing Facilities (technical amendment)	1919(f)(2)(A) (iii)	6901(b)(3)(C)	2298	456-476-738	204, 475-477
Medicaid - Requirements for Nursing Facilities	1919(f)(2)(A) (iv) New	6901(b)(3)(D)	2298	456-476, 738-739	204, 475-477
Medicaid - Requirements for Nursing Facilities	1919(f)(2)(B) (ii)	6901(b)(4)(A)	2299	474-478, 739	204, 475-478
Medicaid - Requirements for Nursing Facilities (technical amendment)	1919(h)(3)(D)	6901(d)(4)(D)	2301	456-476, 740	206, 474-477

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Medicaid - Requirements for Nursing Facilities	1919(h)(8)	6901(d)(1)	2300	456-476, 740-741	206, 484
Medicaid - Disproportionate Share Hospitals	1923(e)(1)	6411(c)(1)(A)	2270	481-482, 745	174, 488-489
Medicaid - Disproportionate Share Hospitals	1923(e)(1)	6411(c)(1)(B)	2270	481-482, 745	174, 488-489
Medicaid - Treatment of Income and Resources for Certain Institutionalized Spouses	1924(b)(2)	6411(e)(3)	2271	---	176, 496-497
Medicaid - Treatment of Income and Resources for Certain Institutionalized Spouses	1924(d)(1)	6411(e)(3)	2271	---	176, 496-497
Medicaid - Extension of Eligibility for Medical Assistance	1925(a)(3)(A)	6411(i)(1)	2273	397-398, 746	177, 452
Medicaid - Extension of Eligibility for Medical Assistance	1925(a)(3)(C)	6411(i)(3)	2273	397-398, 746	177, 452
Medicaid - Extension of Eligibility for Medical Assistance	1925(b)(3)(A)(i)	6411(i)(1)	2273	397-398, 747	177, 452
Medicaid - Extension of Eligibility for Medical Assistance	1925(b)(3)(C)(i)	6411(i)(3)	2273	397-398, 747	177, 452
Medicaid - Assuring Adequate Payment Levels for Obstetrical and Pediatric Services	1926 Redesignated as 1927	6402(b)	2260	389-393	163, 448-449
Medicaid - Assuring Adequate Payment Levels for Obstetrical and Pediatric Services	1926 New	6402(b)	2260	389-393, 748-749	163-165, 448-449

P.L. 101-239

Subject	S.S. Act Section	P.L. Section	103 Stat.	H.Rep. 101-247	H.C.Rep. 101-386
Block Grants to States for Social Services - Allotments	2003(c)(3)	8016(1)	2470	932, 943, 1066, 1468-1473	385, 671-679, 901
Block Grants to States for Social Services - Allotments (technical amendment)	2003(c)(4)	8016(2)	2470	932, 943, 1066, 1468-1473	385, 671-679, 901
Block Grants to States for Social Services - Allotments	2003(c)(5) New	8016(3)	2470	932, 943, 1066, 1468-1473	385, 671-679, 901

PUBLIC LAW 101-239—DEC. 19, 1989

OMNIBUS BUDGET RECONCILIATION ACT OF 1989

Public Law 101-239
101st Congress

An Act

Dec. 19, 1989
[H.R. 3299]

To provide for reconciliation pursuant to section 5 of the concurrent resolution on the budget for the fiscal year 1990.

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

Omnibus Budget Reconciliation Act of 1989.

SECTION 1. SHORT TITLE.

This Act may be cited as the "Omnibus Budget Reconciliation Act of 1989".

SEC. 2. TABLE OF CONTENTS.

Agricultural Reconciliation Act of 1989.

TITLE I—AGRICULTURE AND RELATED PROGRAMS

SEC. 1001. SHORT TITLE; TABLE OF CONTENTS.

7 USC 1421 note.

(a) SHORT TITLE.—This title may be cited as the "Agricultural Reconciliation Act of 1989".

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

SEC. 1002. SOYBEAN, SUNFLOWER, AND SAFFLOWER PLANTING PROGRAM; FEED GRAIN ACREAGE LIMITATION PROGRAM.

(a) PLANTING OF SOYBEANS, SUNFLOWERS, AND SAFFLOWERS ON PERMITTED ACREAGE.—Effective only for the 1990 crops, subsection (e) of section 504 of the Agricultural Act of 1949 (7 U.S.C. 1464(e)) is amended to read as follows:

"(e) Notwithstanding any other provision of this Act—

the total so credited to any revolving fund for a fiscal year shall offset outlays attributed to such revolving fund during such fiscal year.".

(b) EFFECTIVE DATE.—Subsection (e) of section 1833 of title 38, United States Code, as added by subsection (a), shall apply with respect to amounts referred to in such subsection (e) received on or after October 1, 1989. 38 USC 1833 note.

TITLE VI—MEDICARE, MEDICAID, MATERNAL AND CHILD HEALTH, AND OTHER HEALTH PROVISIONS

TABLE OF CONTENTS OF TITLE

Subtitle A—Medicare

PART 1—PROVISIONS RELATING TO PART A

Subpart A—General Provisions

SEC. 6001. EXTENSION OF REDUCTIONS UNDER ORIGINAL SEQUESTER ORDER AND APPLICABILITY OF NEW SEQUESTER ORDER. 2 USC 902 note.

Notwithstanding any other provision of law (including section 11002 or any other provision of this Act, other than section 6201),

the reductions in the amount of payments required under title XVIII of the Social Security Act made by the final sequester order issued by the President on October 16, 1989, pursuant to section 252(b) of the Balanced Budget and Emergency Deficit Control Act of 1985 shall continue to be effective (as provided by sections 252(a)(4)(B) and 256(d)(2) of such Act) through December 31, 1989, with respect to payments for items and services under part A of such title (including payments under section 1886 of such title attributable or allocated to such part). Each such payment made for items and services provided during fiscal year 1990 after such date shall be increased by 1.42 percent above what it would otherwise be under this Act.

SEC. 6002. REDUCTION IN PAYMENTS FOR CAPITAL-RELATED COSTS OF INPATIENT HOSPITAL SERVICES FOR FISCAL YEAR 1990.

Section 1886(g)(3)(A) of the Social Security Act (42 U.S.C. 1395ww(g)(3)(A)) is amended—

(1) in clause (iii), by striking "and";

(2) in clause (iv), by striking the period at the end and inserting ", and"; and

(3) by adding at the end the following new clause:

"(v) 15 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during the period beginning January 1, 1990, and ending September 30, 1990.".

Rural areas.

SEC. 6003. PROSPECTIVE PAYMENT HOSPITALS.

(a) CHANGES IN HOSPITAL UPDATE FACTORS.—

(1) IN GENERAL.—Section 1886(b)(3)(B)(i) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended—

(A) by striking "and" at the end of subclause (IV),

(B) in subclause (V), by striking "1990" and inserting "1991" and redesignating such subclause as subclause (VI), and

(C) by inserting after subclause (IV) the following new subclause:

Urban areas.

"(V) for fiscal year 1990, the market basket percentage increase plus 4.22 percentage points for hospitals located in a rural area, the market basket percentage increase plus 0.12 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 0.53 percentage points for hospitals located in other urban areas, and".

42 USC 1395ww note.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to payments for discharges occurring on or after January 1, 1990.

42 USC 1395ww note.

(3) INDEXING OF FUTURE APPLICABLE PERCENTAGE INCREASES.—For discharges occurring on or after October 1, 1990, the applicable percentage increase (described in section 1886(b)(3)(B) of the Social Security Act) for discharges occurring during fiscal year 1990 is deemed to have been such percentage increase as amended by paragraph (1).

(b) REDUCTION IN DRG WEIGHTING FACTORS FOR FISCAL YEAR 1990; FUTURE ANNUAL RECALIBRATION OF DRG WEIGHTS ON BUDGET-NEUTRAL BASIS.—Section 1886(d)(4)(C) of such Act (42 U.S.C. 1395ww(d)(4)(C)) is amended—

(1) by striking "(C)" and inserting "(C)(i)"; and

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

"(ii) For discharges in fiscal year 1990, the Secretary shall reduce the weighting factor for each diagnosis-related group by 1.22 percent.

"(iii) Any such adjustment under clause (i) for discharges in a fiscal year (beginning with fiscal year 1991) shall be made in a manner that assures that the aggregate payments under this subsection for discharges in the fiscal year are not greater or less than those that would have been made for discharges in the year without such adjustment.

"(iv) The Secretary shall include recommendations with respect to adjustments to weighting factors under clause (i) in the annual report to Congress required under subsection (e)(3)(B).". Reports.

(c) INCREASE IN DISPROPORTIONATE SHARE ADJUSTMENT.—

(1) CHANGE IN FORMULA.—Section 1886(d)(5)(F) of such Act (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(A) in clause (iv)(I), by striking "the following formula" and all that follows through "(as defined in clause (vi));" and inserting "the applicable formula described in clause (vii);", and

(B) by adding at the end the following new clause:

"(vii) The formula used to determine the disproportionate share adjustment percentage for a cost reporting period for a hospital described in clause (iv)(I) is—

"(I) in the case of such a hospital with a disproportionate patient percentage (as defined in clause (vi)) greater than 20.2, (P-20.2)(.65)+5.62, or

"(II) in the case of any other such hospital, (P-15)(.6)+2.5, where 'P' is the hospital's disproportionate patient percentage (as defined in clause (vi)).".

(2) TREATMENT OF RURAL HOSPITALS FOR DISPROPORTIONATE SHARE CALCULATION.—Section 1886(d)(5)(F) of such Act (42 U.S.C. 1395ww(d)(5)(F)), as amended by paragraph (1), is amended—

(A) in clause (iv)—

(i) in subclause (II), by striking "or",

(ii) in subclause (III), by inserting "in subclause (IV) or (V) or" after "described",

(iii) by striking the period at the end of subclause (III) and inserting a semicolon, and

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

"(IV) is located in a rural area, is classified as a rural referral center under subparagraph (C), and is classified as a sole community hospital under subparagraph (D), is equal to 10 percent or, if greater, the percent determined in accordance with the applicable formula described in clause (viii);

"(V) is located in a rural area, is classified as a rural referral center under subparagraph (C), and is not classified as a sole community hospital under subparagraph (D), is equal to the percent determined in accordance with the applicable formula described in clause (viii); or

"(VI) is located in a rural area, is classified as a sole community hospital under subparagraph (D), and is not classified as a rural referral center under subparagraph (C), is 10 percent.",

(B) in clause (v)—

(i) in subclause (III), by striking "area" and inserting "area and is not described in subclause (II)",

(ii) by redesignating subclauses (II) and (III) as subclauses (III) and (IV), and

(iii) by inserting after subclause (I) the following new subclause:

"(II) 30 percent, if the hospital is located in a rural area and has more than 100 beds, or is located in a rural area and is classified as a sole community hospital under subparagraph (D),", and

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

"(viii) The formula used to determine the disproportionate share adjustment percentage for a cost reporting period for a hospital described in clause (iv)(IV) or (iv)(V) is the percentage determined in accordance with the following formula: (P-30)(.6)+4.0, where 'P' is the hospital's disproportionate patient percentage (as defined in clause (vi)).".

(3) INCREASE FOR HOSPITALS WITH DISPROPORTIONATE INDIGENT CARE REVENUES.—Section 1886(d)(5)(F)(iii) of such Act (42 U.S.C. 1395ww(d)(5)(F)(iii)) is amended by striking "25 percent" and inserting "30 percent".

42 USC 1395ww note.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to discharges occurring on or after April 1, 1990.

42 USC 1395ww note.

(d) EXTENSION OF REGIONAL REFERRAL CENTER CLASSIFICATION.—Any hospital that is classified as a regional referral center under section 1886(d)(5)(C) of the Social Security Act as of September 30, 1989, including a hospital so classified as a result of section 9302(d)(2) of the Omnibus Budget Reconciliation Act of 1986, shall continue to be classified as a regional referral center for cost reporting periods beginning on or after October 1, 1989, and before October 1, 1992.

(e) CRITERIA AND PAYMENT FOR SOLE COMMUNITY HOSPITALS.—

(1) IN GENERAL.—(A) Section 1886(d)(5) of the Social Security Act (42 U.S.C. 1395ww(d)(5)) is amended—

(i) by transferring clause (iv) of subparagraph (C) to the end and by redesignating it as subparagraph (H),

(ii) by transferring clause (iii) of subparagraph (C) to the end and by redesignating it as subparagraph (I),

(iii) in subparagraph (D), by striking "(D)(i)" and inserting "(E)(i)", and

(iv) by amending clause (ii) of subparagraph (C) to read as follows:

"(D)(i) For any cost reporting period beginning on or after April 1, 1990, with respect to a subsection (d) hospital which is a sole community hospital, payment under paragraph (1)(A) shall be—

"(I) an amount based on 100 percent of the hospital's target amount for the cost reporting period, as defined in subsection (b)(3)(C), or

"(II) the amount determined under paragraph (1)(A)(iii),

whichever results in greater payment to the hospital.

"(ii) In the case of a sole community hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than under paragraph (9)) as may be necessary to fully compensate the hospital for the fixed costs it incurs in the

period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

"(iii) The term 'sole community hospital' means any hospital—

"(I) that the Secretary determines is located more than 35 road miles from another hospital, or

"(II) that, by reason of factors such as the time required for an individual to travel to the nearest alternative source of appropriate inpatient care (in accordance with standards promulgated by the Secretary), location, weather conditions, travel conditions, or absence of other like hospitals (as determined by the Secretary), is the sole source of inpatient hospital services reasonably available to individuals in a geographic area who are entitled to benefits under part A.

"(iv) The Secretary shall promulgate a standard for determining whether a hospital meets the criteria for classification as a sole community hospital under clause (iii)(II) because of the time required for an individual to travel to the nearest alternative source of appropriate inpatient care.".

(B) Section 1886(b)(3) of such Act (42 U.S.C. 1395ww(b)(3)) is amended—

(i) in subparagraph (A), by striking "(A) For purposes of this subsection" and inserting "(A) Except as provided in subparagraph (C), for purposes of this subsection", and

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

"(C) In the case of a hospital that is a sole community hospital (as defined in subsection (d)(5)(D)(iii)), 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—

"(I) 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 (in this subparagraph referred to as the 'base cost reporting period') preceding the first cost reporting period for which this subsection was in effect with respect to such hospital, increased (in a compounded manner) by—

"(II) the applicable percentage increases applied to such hospital under this paragraph for cost reporting periods after the base cost reporting period and up to and including such first 12-month cost reporting period, or

"(ii) with respect to a later cost reporting period, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase under subparagraph (B)(i) for discharges occurring in the fiscal year in which that later cost reporting period begins.

There shall be substituted for the base cost reporting period described in clause (i) a hospital's cost reporting period (if any) beginning during fiscal year 1987 if such substitution results in an increase in the target amount for the hospital.".

(2) CONFORMING AMENDMENTS.—Such Act is further amended—

(A) in section 1833(h)(1)(D), by striking "the last sentence of section 1886(d)(5)(C)(ii)" and inserting "section 1886(d)(5)(D)(iii)"; 42 USC 1395*l*.

(B) in section 1886(d)(5)(C)(i)— 42 USC 1395ww.

(i) by striking "(C)(i)(I)" and inserting "(C)(i)", and

(ii) by redesignating subclause (II) as clause (ii) and by striking "subclause (I)" each place it appears in such clause and inserting "clause (i)";

42 USC 1395ww. (C) in section 1886(d)(9)(B)(ii)(IV), by striking "(D)(v)" and inserting "(D)(iii)";

(D) in section 1886(d)(9)(D)—

(i) by striking clause (iv),

(ii) by transferring clause (iii) to the end and redesignating it as clause (iv), and by striking "(C)(iii)" and inserting "(H)", and

(iii) by redesignating clause (v) as clause (iii); and

(E) in section 1886(g)(3)(B), by striking "(d)(5)(C)(ii)" and inserting "(d)(5)(D)(iii)".

42 USC 1395ww note. (3) CONTINUATION OF SOLE COMMUNITY HOSPITAL DESIGNATION FOR CURRENT SOLE COMMUNITY HOSPITALS.—Any hospital classified as a sole community hospital under section 1886(d)(5)(C)(ii) of the Social Security Act on the date of the enactment of this Act that will no longer be classified as a sole community hospital after such date as a result of the amendments made by paragraph (1) shall continue to be classified as a sole community hospital for purposes of section 1886(d)(5)(D) of such Act.

(f) CRITERIA AND PAYMENT FOR MEDICARE-DEPENDENT, SMALL RURAL HOSPITALS.—

(1) CRITERIA.—Section 1886(d)(5) of the Social Security Act (42 U.S.C. 1395ww(d)(5)), as amended by subsection (e)(1)(A), is further amended by inserting after subparagraph (F) the following new subparagraph:

"(G)(i) For any cost reporting period beginning on or after April 1, 1990, and ending on or before March 31, 1993, with respect to a subsection (d) hospital which is a medicare-dependent, small rural hospital, payment under paragraph (1)(A) shall be—

"(I) an amount based on 100 percent of the hospital's target amount for the cost reporting period, as defined in subsection (b)(3)(D), or

"(II) the amount determined under paragraph (1)(A)(iii),

whichever results in the greater payment to the hospital.

"(ii) In the case of a medicare dependent, small rural hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than under paragraph (9)) as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

"(iii) The term 'medicare-dependent, small rural hospital' means, with respect to any cost reporting period to which clause (i) applies, any hospital—

"(I) located in a rural area,

"(II) that has not more than 100 beds,

"(III) that is not classified as a sole community hospital under subparagraph (D), and

"(IV) for which not less than 60 percent of its inpatient days or discharges during the cost reporting period beginning in fiscal year 1987 were attributable to inpatients entitled to benefits under part A.".

(2) PAYMENT.—Section 1886(b)(3) of such Act (42 U.S.C. 1395ww(b)(3)), as amended by subsection (e)(1)(B), is further amended—

(i) in subparagraph (A), by striking "subparagraph (C)" and inserting "subparagraphs (C) and (D)", and

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

"(D) For cost reporting periods ending on or before March 31, 1993, in the case of a hospital that is a medicare-dependent, small rural hospital (as defined in subsection (d)(5)(G)), 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—

"(I) 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 (in this subparagraph referred to as the 'base cost reporting period') preceding the first cost reporting period for which this subsection was in effect with respect to such hospital, increased (in a compounded manner) by—

"(II) the applicable percentage increases applied to such hospital under this paragraph for cost reporting periods after the base cost reporting period and up to and including such first 12-month cost reporting period, or

"(ii) with respect to a later cost reporting period, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase under subparagraph (B)(i) for discharges occurring in the fiscal year in which that later cost reporting period begins.

There shall be substituted for the base cost reporting period described in clause (i) a hospital's cost reporting period (if any) beginning during fiscal year 1987 if such substitution results in an increase in the target amount for the hospital.".

(g) ESSENTIAL ACCESS COMMUNITY HOSPITAL PROGRAM.—

(1) ESTABLISHMENT OF PROGRAM.—

(A) IN GENERAL.—Part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.) is amended by adding at the end the following new section:

"ESSENTIAL ACCESS COMMUNITY HOSPITAL PROGRAM

Grants.
State and local governments.
42 USC 1395i-4.

"SEC. 1820. (a) IN GENERAL.—There is hereby established a program under which the Secretary—

"(1) shall make grants to not more than 7 States to carry out the activities described in subsection (d)(1);

"(2) shall make grants to eligible hospitals and facilities (or consortia of hospitals and facilities) to carry out the activities described in subsection (d)(2); and

"(3) shall designate (under subsection (i)) hospitals and facilities located in States receiving grants under paragraph (1) as essential access community hospitals or rural primary care hospitals.

"(b) ELIGIBILITY OF STATES FOR GRANTS.—A State is eligible to receive a grant under subsection (a)(1) only if the State submits to the Secretary, at such time and in such form as the Secretary may require, an application containing—

"(1) assurances that the State—

"(A) has developed, or is in the process of developing, a State rural health care plan that—

"(i) provides for the creation of one or more rural health networks (as defined in subsection (g)) in the State,

"(ii) promotes regionalization of rural health services in the State,

"(iii) improves access to hospital and other health services for rural residents of the State, and

"(iv) enhances the provision of emergency and other transportation services related to health care;

"(B) has developed the rural health care plan described in subparagraph (A) in consultation with the hospital association of the State and rural hospitals located in the State (or, in the case of a State in the process of developing such plan, that assures the Secretary that it will consult with its State hospital association and rural hospitals located in the State in developing such plan); and

"(C) has designated, or is in the process of designating, rural non-profit or public hospitals or facilities located in the State as essential access community hospitals or rural primary care hospitals within such networks; and

"(2) such other information and assurances as the Secretary may require.

"(c) ELIGIBILITY OF HOSPITALS AND CONSORTIA FOR GRANTS.—

"(1) IN GENERAL.—Except as provided in paragraph (3), a hospital or facility is eligible to receive a grant under subsection (a)(2) only if the hospital or facility—

"(A) is located in a State receiving a grant under subsection (a)(1);

"(B) is designated as an essential access community hospital or a rural primary care hospital by the State in which it is located or is a member of a rural health network (as defined in subsection (g));

"(C) submits to the State in which it is located and to the Secretary, at such time and in such form as the Secretary may require, an application containing such information and assurances as the Secretary may require; and

"(D) the State in which the hospital or facility is located certifies to the Secretary that—

"(i) the receiving of such a grant by the hospital or facility is consistent with the State's rural health care plan (described in subsection (b)(1)(A)), and

"(ii) the State has approved the application submitted under subparagraph (C).

"(2) TREATMENT OF CONSORTIA.—A consortium of hospitals or facilities each of which is part of the same rural health network is eligible to receive a grant under subsection (a)(2) if each of its members would individually be eligible to receive such a grant.

"(3) ELIGIBILITY OF RPC HOSPITALS NOT LOCATED IN A STATE RECEIVING GRANT.—A facility designated as a rural primary care hospital by the Secretary under subsection (i)(2)(C) shall be eligible to receive a grant under subsection (a)(2).

"(d) ACTIVITIES FOR WHICH GRANTS MAY BE USED.—

Communications and telecommunications. Transportation.

"(1) GRANTS TO STATES.—A State shall use a grant received under subsection (a)(1) to carry out the demonstration program established under this section in the State. Such grant may be

used for engaging in activities relating to planning and implementing a rural health care plan and rural health networks, designating hospitals or facilities in the State as essential access community hospitals or rural primary care hospitals, and developing and supporting communication and emergency transportation systems.

"(2) GRANTS TO HOSPITALS, FACILITIES, AND CONSORTIA.—A hospital or facility shall use a grant received under subsection (a)(2) to finance the costs it incurs in converting itself to a rural primary care hospital or an essential access community hospital or in becoming part of a rural health network in the State in which it is located, including capital costs, costs incurred in the development of necessary communications systems, and costs incurred in the development of an emergency transportation system. A consortium shall use a grant received under subsection (a)(2) to finance the costs it incurs in converting hospitals or facilities that are part of the consortium into rural primary care hospitals or in developing and implementing a rural health network consisting of its members in the State in which it is located, including capital costs, costs incurred in the development of necessary communications systems, and costs incurred in the development of an emergency transportation system.

"(e) DESIGNATION BY STATE OF ESSENTIAL ACCESS COMMUNITY HOSPITALS.—A State may designate a hospital as an essential access community hospital only if the hospital—

"(1) is located in a rural area (as defined in section 1886(d)(2)(D));

"(2)(A) is located more than 35 miles from any hospital that either (i) has been designated as an essential access community hospital, (ii) is classified by the Secretary as a rural referral center under section 1886(d)(5)(C), or (iii) is located in an urban area that meets the criteria for classification as a regional referral center under such section, or (B) meets such other criteria relating to geographic location as the State may impose with the approval of the Secretary;

"(3) has at least 75 inpatient beds or is located more than 35 miles from any other hospital;

"(4) has in effect an agreement to provide emergency and medical backup services to rural primary care hospitals participating in the rural health network of which it is a member and throughout its service area; Contracts.

"(5) has in effect an agreement, with each rural primary care hospital participating in the rural health network of which it is a member, to accept patients transferred from such primary care hospital, to receive data from and transmit data to such primary care hospital, and to provide staff privileges to physicians providing care at such primary care hospital; and

"(6) meets any other requirements imposed by the State with the approval of the Secretary.

"(f) DESIGNATION BY STATE OF RURAL PRIMARY CARE HOSPITALS.—

"(1) CRITERIA FOR DESIGNATION.—A State may designate a facility as a rural primary care hospital only if the facility—

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

"(B) at the time such facility applies to the State for designation as a rural primary care hospital, is a hospital with a participation agreement in effect under section

1866(a) and had not been found, on the basis of a survey under section 1864, to be in violation of any requirement to participate as a hospital under this title;

"(C) has ceased, or agrees (upon the approval of such application) to cease, providing inpatient care (except as required under subparagraph (F));

Contracts.
Communications and telecommunications.

"(D) in the case of a facility that is a member of a rural health network, has in effect an agreement to participate with other hospitals and facilities in the communications system of such network, including the network's system for the electronic sharing of patient data, including telemetry and medical records, if the network has in operation such a system;

"(E) makes available 24-hour emergency care;

"(F) provides not more than 6 inpatient beds (meeting such conditions as the Secretary may establish) for providing inpatient care for a period not to exceed 72 hours (unless a longer period is required because transfer to a hospital is precluded because of inclement weather or other emergency conditions) to patients requiring stabilization before discharge or transfer to a hospital;

"(G) 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 subparagraph (E),

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

"(iii) the inpatient care described in subparagraph (F) may be provided by a physician's assistant or nurse practitioner, subject to the oversight of a physician; and

"(H) meets the requirements of subparagraphs (C) through (J) of paragraph (2) of section 1861(aa) and of clauses (ii) and (iv) of the second sentence of that paragraph.

"(2) PREFERENCE GIVEN TO HOSPITALS OR FACILITIES PARTICIPATING IN RURAL HEALTH NETWORK.—In designating facilities as rural primary care hospitals under paragraph (1), the State shall give preference to hospitals or facilities participating in a rural health network.

"(3) PERMITTING RURAL PRIMARY CARE HOSPITALS TO MAINTAIN SWING BEDS.—Nothing in this subsection shall be construed to prohibit a State from designating a facility as a rural primary care hospital solely because the facility has entered into an agreement with the Secretary under section 1883 under which the facility's inpatient hospital facilities may be used for the furnishing of extended care services.

"(g) RURAL HEALTH NETWORK DEFINED.—For purposes of this section, the term 'rural health network' means, with respect to a State, an organization—

"(1) consisting of—

"(A) at least 1 hospital that—

"(i) the State has designated or plans to designate as an essential access community hospital under subsection (b)(1)(C),

"(ii) is classified by the Secretary as a rural referral center under section 1886(d)(5)(C), or

"(iii) is located in an urban area and meets the criteria for classification as a regional referral center under such section, and

"(B) at least 1 facility that the State has designated or plans to designate as a rural primary care hospital, and

"(2) the members of which have entered into agreements regarding—

"(A) patient referral and transfer,

"(B) the development and use of communications systems, including (where feasible) telemetry systems and systems for electronic sharing of patient data, and

"(C) the provision of emergency and non-emergency transportation among the members.

"(h) LIMIT ON AMOUNT OF GRANT TO HOSPITAL OR FACILITY.—A grant made to a hospital or facility under subsection (a)(2) may not exceed $200,000.

"(i) ELIGIBILITY OF HOSPITALS OR FACILITIES FOR DESIGNATION BY SECRETARY.—

"(1) ESSENTIAL ACCESS COMMUNITY HOSPITAL.—(A) The Secretary shall designate a hospital as an essential access community hospital if the hospital—

"(i) is located in a State receiving a grant under subsection (a)(1);

"(ii) is designated as an essential access community hospital by the State in which it is located (except as provided in subparagraph (B)); and

"(iii) meets such other criteria as the Secretary may require.

"(B) In the case of a hospital that is not eligible for designation as an essential access community hospital under this paragraph solely because it is not designated as an essential access community hospital by the State in which it is located, the Secretary may designate such hospital as an essential access community hospital under this paragraph if the hospital is not so designated by the State in which it is located solely because of its failure to meet the criteria described in paragraph (3) of subsection (e).

"(2) RURAL PRIMARY CARE HOSPITAL.—(A) The Secretary shall designate a facility as a rural primary care hospital if the facility—

"(i) is located in a State receiving a grant under subsection (a)(1);

"(ii) is designated as a rural primary care hospital by the State in which it is located (except as provided in subparagraph (B)); and

"(iii) meets such other criteria as the Secretary may require.

"(B) In the case of a facility that is not eligible for designation as a rural primary care hospital under this paragraph solely because it is not designated as a rural primary care hospital by

the State in which it is located, the Secretary may designate such facility as a rural primary care hospital under this paragraph if the facility is not so designated by the State in which it is located solely because of its failure to meet the criteria described in subparagraphs (C), (F), or (G) of subsection (f)(1).

"(C) The Secretary may designate not more than 15 facilities as rural primary care hospitals under this paragraph that do not meet the requirements of clauses (i) and (ii) of subparagraph (A) if such a facility meets the criteria described in subparagraphs (A), (B), and (E) of subsection (f)(1), except that nothing in this subparagraph shall be construed to prohibit the Secretary from designating a facility as a rural primary care hospital solely because the facility has entered into an agreement with the Secretary under section 1883 under which the facility's inpatient hospital facilities may be used for the furnishing of extended care services.

"(j) WAIVER OF CONFLICTING PART A PROVISIONS.—The Secretary is authorized to waive such provisions of this part as are necessary to conduct the program established under this section.

"(k) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated from the Federal Hospital Insurance Trust Fund for each of the fiscal years 1990, 1991, and 1992—

"(1) $10,000,000 for grants to States under subsection (a)(1); and

"(2) $15,000,000 for grants to hospitals, facilities, and consortia under subsection (a)(2).".

(B) MODIFICATION OF RURAL HEALTH CARE TRANSITION GRANT PROGRAM.—(i) Section 4005(e) of the Omnibus Budget Reconciliation Act of 1987 is amended— 42 USC 1395ww note.

(I) in paragraph (1), by adding at the end the following new sentence: "Grants under this paragraph may be used to provide instruction and consultation (and such other services as the Administrator determines appropriate) via telecommunications to physicians in such rural areas (within the meaning of section 1886(d)(2)(D) of the Social Security Act) as are designated either class 1 or class 2 health manpower shortage areas under section 332(a)(1)(A) of the Public Health Service Act.",

(II) in paragraph (3)(A), by striking "an application to the Governor" and inserting "an application to the Administrator and a copy of such application to the Governor",

(III) in paragraph (3)(B), by striking "any application" and all that follows through "accompanied by" and inserting "to the Administrator, within a reasonable time after receiving a copy of an application pursuant to subparagraph (A),",

(IV) in paragraph (6), by striking "2 years" and inserting "3 years",

(V) in paragraph (7)(A), by striking "(D)" and inserting "(B)",

(VI) in paragraph (7)(C), by striking the period at the end and inserting the following: ", except that this limitation shall not apply with respect to a grant used for the purposes described in subparagraph (D).",

(VII) by adding at the end of paragraph (7) the following new subparagraph:

"(D) A hospital may use a grant received under this subsection to develop a plan for converting itself to a rural primary care hospital (as described in section 1820 of the Social Security Act) or to develop a rural health network (as defined in section 1820(g) of such Act) in the State in which it is located if the State is receiving a grant under section 1820(a)(1).", and

(VIII) in paragraph (9), by striking "each of the fiscal years 1989 and 1990" and inserting "fiscal year 1989 and $25,000,000 for each of the fiscal years 1990, 1991, and 1992".

(ii) The amendments made by clause (i) shall apply with respect to applications for grants under the Rural Health Care Transition Grant Program described in section 4005(e) of the Omnibus Budget Reconciliation Act of 1987 submitted on or after October 1, 1989, except that the amendments made by subclauses (V) and (VII) of such clause shall take effect on the date of the enactment of this Act. Effective date. 42 USC 1395ww note.

(2) TREATMENT OF ESSENTIAL ACCESS COMMUNITY HOSPITALS AS SOLE COMMUNITY HOSPITALS.—Section 1886(d)(5)(D) of such Act (42 U.S.C. 1395ww(d)(5)(D)) (as redesignated and amended by subsection (e)(1)(A)) is further amended—

(A) in clause (iii)—

(i) in subclause (I), by striking "or",

(ii) in subclause (II), by striking the period at the end and inserting ", or", and

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

"(III) that is designated by the Secretary as an essential access community hospital under section 1820(i)(1).", and

(B) by adding at the end the following new clause:

"(v) If the Secretary determines that, in the case of a hospital designated by the Secretary as an essential access community hospital under section 1820(i)(1), the hospital has incurred increases in reasonable costs during a cost reporting period as a result of becoming a member of a rural health network (as defined in section 1820(g)) in the State in which it is located, and in incurring such increases, the hospital will increase its costs for subsequent cost reporting periods, the Secretary shall increase the hospital's target amount under subsection (b)(3)(C) to account for such incurred increases.".

(3) COVERAGE OF, AND PAYMENT FOR, INPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—

(A) DEFINITIONS.—Section 1861 of such Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

"Rural Primary Care Hospital; Rural Primary Care Hospital Services

"(mm)(1) The term 'rural primary care hospital' means a facility designated by the Secretary as a rural primary care hospital under section 1820(i)(2).

"(2) The term 'inpatient rural primary care hospital services' means items and services, furnished to an inpatient of a rural primary care hospital by such a hospital, that would be inpatient

hospital services if furnished to an inpatient of a hospital by a hospital.".

(B) COVERAGE AND PAYMENT.—(i) Section 1812(a)(1) of such Act (42 U.S.C. 1395d(a)(1)), as restored by the Medicare Catastrophic Coverage Repeal Act of 1989, is amended by inserting "and inpatient rural primary care hospital services" before the semicolon.

(ii) Section 1814(a) of such Act (42 U.S.C. 1395f(a)) is amended—

(I) by striking "and" at the end of paragraph (6),

(II) by striking the period at the end of paragraph (7) and inserting "; and", and

(III) by inserting after paragraph (7) the following new paragraph:

"(8) in the case of inpatient rural primary care hospital services, a physician certifies that such services were required to be immediately furnished on a temporary, inpatient basis.".

(iii) Section 1814 of such Act is further amended—

(I) in subsection (b), by inserting ", other than a rural primary care hospital providing inpatient rural primary care hospital services," after "providing hospice care", and

(II) by adding at the end the following new subsection:

"Payment for Inpatient Rural Primary Care Hospital Services

"(l)(1) The amount of payment under this part for inpatient rural primary care hospital services—

"(A) in the case of the first 12-month cost reporting period for which the facility operates as such a hospital, is the reasonable costs of the facility in providing inpatient rural primary care hospital services during such period, as such costs are determined on a per diem basis, and

"(B) in the case of a later reporting period, is the per diem payment amount established under this paragraph for the preceding 12-month cost reporting period, increased by the applicable percentage increase under section 1886(b)(3)(B)(i) for that particular cost reporting period applicable to hospitals located in a rural area.

The payment amounts otherwise determined under this paragraph shall be reduced, to the extent necessary, to avoid duplication of any payment made under section 1820(a)(2) (or under section 4005(e) of the Omnibus Budget Reconciliation Act of 1987) to cover the provision of inpatient rural primary care hospital services.

"(2) The Secretary shall develop a prospective payment system for determining payment amounts for inpatient rural primary care hospital services under this part furnished on or after January 1, 1993.".

(C) TREATMENT OF RURAL PRIMARY CARE HOSPITALS AS PROVIDERS OF SERVICES.—(i) Section 1861(u) of such Act (42 U.S.C. 1395x(u)) is amended by inserting "rural primary care hospital," after "hospital,".

(ii) Section 1863 of such Act (42 U.S.C. 1395z) is amended by striking "and (jj)(3)" and inserting "(jj)(3), and (mm)(1)".

(iii) The first sentence of section 1864(a) of such Act (42 U.S.C. 1395aa(a)) is amended by inserting ", a rural primary

care hospital, as defined in section 1861(mm)(1),'' after ''1861(aa)(2)''.

(iv) The third sentence of section 1865(a) of such Act (42 U.S.C. 1395bb(a)) is amended by striking ''or 1861(dd)(2)'' and inserting ''1861(dd)(2), or 1861(mm)(1)''.

(D) CONFORMING AMENDMENTS.—(i) Section 1128A(b)(1) of such Act (42 U.S.C. 1320a-7a(b)(1)) is amended by striking ''hospital'' each place it appears and inserting ''hospital or a rural primary care hospital''.

(ii) Section 1128B(c) of such Act (42 U.S.C. 1320a-7b(c)) is amended by inserting ''rural primary care hospital,'' after ''hospital,''.

(iii) Section 1134 of such Act (42 U.S.C. 1320b-4) is amended by striking ''hospitals'' each place it appears and inserting ''hospitals or rural primary care hospitals''.

(iv) Section 1138(a)(1) of such Act (42 U.S.C. 1320b-8(a)(1)) is amended by striking ''hospital'' each place it appears in the matter preceding clause (i) of subparagraph (A) and inserting ''hospital or rural primary care hospital''.

(v) Section 1164(e) of such Act (42 U.S.C. 1320c-13(e)) is amended by inserting ''rural primary care hospitals,'' after ''hospitals,''.

(vi) Section 1816(c)(2)(C) of such Act (42 U.S.C. 1395h(c)(2)(C)) is amended by inserting ''rural primary care hospital,'' after ''hospital,''.

(vii) Section 1833 of such Act (42 U.S.C. 1395l) is amended—

(I) in subsection (h)(5)(A)(iii), by striking ''hospital,'' each place it appears and inserting ''hospital or rural primary care hospital,'';

(II) in subsection (i)(1)(A), by inserting '', rural primary care hospital,'' after ''1832(a)(2)(F)(i))'';

(III) in subsection (i)(3)(A), by inserting ''or rural primary care hospital services'' after ''facility services'';

(IV) in subsection (l)(5)(A), by inserting ''rural primary care hospital,'' after ''hospital,'' each place it appears; and

(V) in subsection (l)(5)(C), by striking ''hospital'' each place it appears and inserting ''hospital or rural primary care hospital''.

(viii) Section 1835(c) of such Act (42 U.S.C. 1395n(c)) is amended by adding at the end the following: ''A rural primary care hospital shall be considered a hospital for purposes of this subsection.''.

(ix) Section 1842(b)(6)(A)(ii) of such Act (42 U.S.C. 1395u(b)(6)(A)(ii)) is amended by inserting ''rural primary care hospital,'' after ''hospital,''.

(x) Section 1861 of such Act (42 U.S.C. 1395x) is amended—

(I) in subsection (e), by adding at the end the following:

''The term 'hospital' does not include, unless the context otherwise requires, a rural primary care hospital (as defined in section 1861(mm)(1)).'',

(II) in subsection (w)(1), by inserting ''rural primary care hospital,'' after ''hospital,'', and

(III) in subsection (w)(2), by striking "hospital" each place it appears and inserting "hospital or rural primary care hospital".

(xi) Section 1862(a)(14) of such Act (42 U.S.C. 1395y(a)(14)) is amended by striking "hospital" each place it appears and inserting "hospital or rural primary care hospital".

(xii) Section 1866(a)(1) of such Act (42 U.S.C. 1395cc(a)(1)) is amended—

(I) in subparagraph (F)(ii), by inserting "rural primary care hospitals," after "hospitals,";

(II) in subparagraph (H), by inserting after "this title" the first place it appears the following: "and in the case of rural primary care hospitals which provide rural primary care hospital services";

(III) in subparagraph (I), by inserting "and in the case of a rural primary care hospital" after "hospital"; and

(IV) in subparagraph (N), by striking "hospitals" and "hospital," and inserting "hospitals and rural primary care hospitals" and "hospital or rural primary care hospital,", respectively.

(xiii) Section 1866(a)(3) of such Act (42 U.S.C. 1395cc(a)(3)) is amended—

(I) by striking "hospital," each place it appears in subparagraphs (A) and (B) and inserting "hospital, rural primary care hospital,", and

(II) in subparagraph (C)(ii)(II), by striking "facilities" each place it appears and inserting "facilities, rural primary care hospitals,".

(xiv) Section 1867(e) of such Act (42 U.S.C. 1395dd(e)) is amended by adding at the end the following new paragraph:

"(6) The term 'hospital' includes a rural primary care hospital (as defined in section 1861(mm)(1))."

(4) AVOIDING DUPLICATIVE PAYMENTS TO HOSPITALS PARTICIPATING IN RURAL HEALTH CARE TRANSITION GRANTS.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

"(i) AVOIDING DUPLICATIVE PAYMENTS TO HOSPITALS PARTICIPATING IN RURAL DEMONSTRATION PROGRAMS.—The Secretary shall reduce any payment amounts otherwise determined under this section to the extent necessary to avoid duplication of any payment made under section 4005(e) of the Omnibus Budget Reconciliation Act of 1987.".

(h) GEOGRAPHIC CLASSIFICATION OF HOSPITALS.—

(1) ESTABLISHMENT OF MEDICARE GEOGRAPHICAL CLASSIFICATION BOARD.—Section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) is amended by adding at the end the following new paragraph:

"(10)(A) There is hereby established the Medicare Geographical Classification Review Board (hereinafter in this paragraph referred to as the 'Board').

"(B)(i) The Board shall be composed of 5 members appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. Two of such members shall be representatives of subsection (d) hospitals located in a rural area under paragraph (2)(D). At least 1 member shall be a member of the Prospective Payment Assessment

Commission, and at least 1 member shall be knowledgeable in the field of analyzing costs with respect to the provision of inpatient hospital services.

"(ii) The Secretary shall make all appointments to the Board as provided in this paragraph within 180 days after the date of the enactment of this paragraph.

"(C)(i) The Board shall consider the application of any subsection (d) hospital requesting that the Secretary change the hospital's geographic classification for purposes of determining for a fiscal year—

"(I) the hospital's average standardized amount under paragraph (2)(D), or

"(II) the area wage index applicable to such hospital under paragraph (3)(E).

"(ii) A hospital requesting a change in geographic classification under clause (i) for a fiscal year shall submit its application to the Board not later than the first day of the preceding fiscal year.

"(iii)(I) The Board shall render a decision on an application submitted under clause (i) not later than 180 days after the deadline referred to in clause (ii).

"(II) A decision of the Board shall be final unless the unsuccessful applicant appeals such decision to the Secretary by not later than 15 days after the Board renders its decision. The Secretary in considering the appeal of an applicant shall receive no new evidence but shall consider the record as a whole as such record appeared before the Board. The Secretary shall issue a decision on such an appeal not later than 90 days after the appeal is filed. The decision of the Secretary shall be final and shall not be subject to judicial review.

"(D)(i) The Secretary shall publish guidelines to be utilized by the Board in rendering decisions on applications submitted under this paragraph, and shall include in such guidelines the following:

"(I) Guidelines for comparing wages, taking into account occupational mix, in the area in which the hospital is classified and the area in which the hospital is applying to be classified.

"(II) Guidelines for determining whether the county in which the hospital is located should be treated as being a part of a particular Metropolitan Statistical Area.

"(III) Guidelines for considering information provided by an applicant with respect to the effects of the hospital's geographic classification on access to inpatient hospital services by medicare beneficiaries.

"(IV) Guidelines for considering the appropriateness of the criteria used to define New England County Metropolitan Areas.

"(ii) The Secretary shall publish the guidelines described in clause (i) by July 1, 1990.

"(E)(i) The Board shall have full power and authority to make rules and establish procedures, not inconsistent with the provisions of this title or regulations of the Secretary, which are necessary or appropriate to carry out the provisions of this paragraph. In the course of any hearing the Board may administer oaths and affirmations. The provisions of subsections (d) and (e) of section 205 with respect to subpenas shall apply to the Board to the same extent as such provisions apply to the Secretary with respect to title II.

"(ii) The Board is authorized to engage such technical assistance and to receive such information as may be required to carry out its functions, and the Secretary shall, in addition, make available to the

Board such secretarial, clerical, and other assistance as the Board may require to carry out its functions.

"(F)(i) Each member of the Board who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for grade GS-18 of the General Schedule under section 5332 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Board. Each member of the Board who is an officer or employee of the United States shall serve without compensation in addition to that received for service as an officer or employee of the United States.

"(ii) Members of the Board shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Board.".

(2) EFFECT OF DECISIONS OF BOARD ON PAYMENTS TO HOSPITALS.—Section 1886(d)(8) of such Act (42 U.S.C. 1395ww(d)(8)) is amended—

(A) in subparagraph (C)(i), by striking "subparagraph (B)" each place it appears and inserting "subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10),", and

(B) in subparagraph (D), by striking "(B) and (C)" each place it appears and inserting "(B) and (C) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10)".

Urban areas.
42 USC 1395ww.

(3) REVISION OF RULES FOR TREATMENT OF RECLASSIFIED HOSPITALS.—Section 1886(d)(8)(C) of such Act is amended to read as follows:

"(C)(i) If the application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10), by treating hospitals located in a rural county or counties as being located in an urban area—

"(I) reduces the wage index for that urban area (as applied under this subsection) by 1 percentage point or less, the Secretary, in calculating such wage index under this subsection, shall exclude those hospitals so treated, or

"(II) reduces the wage index for that urban area by more than 1 percentage point (as applied under this subsection), the Secretary shall calculate and apply such wage index under this subsection separately to hospitals located in such urban area (excluding all the hospitals so treated) and to the hospitals so treated (as if each affected rural county were a separate urban area).

"(ii) If the application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10), by reclassifying a county from a rural to an urban area or by reclassifying an urban county from one urban area to another urban area—

"(I) reduces the wage index for the urban area within which the county or counties is reclassified by 1 percentage point or less (as applied under this subsection), the Secretary, in calculating such wage index under this subsection, shall exclude those counties so reclassified, or

"(II) reduces the wage index for the urban area within which the county or counties is reclassified by more than 1 percentage point (as applied under this subsection), the Secretary shall calculate and apply such wage index under this subsection separately to hospitals located in such urban area (excluding all the hospitals so reclassified) and to hospitals located in the counties so reclassified (as if each affected county were a separate area).

"(iii) If the application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10), by treating hospitals located in a rural county or counties as not being located in the rural area in a State, reduces the wage index for that rural area (as applied under this subsection), the Secretary shall calculate and apply such wage index under this subsection as if the hospitals so treated had not been excluded from calculation of the wage index for that rural area.".

(4) FLOOR FOR AREA WAGE INDICES.—Section 1886(d)(8)(C) of such Act (as amended by paragraph (3)) is further amended by adding at the end the following new clause:

"(iv) The application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10) may not result in the reduction of any county's wage index to a level below the wage index for rural areas in the State in which the county is located.".

(5) ADDITIONAL PAYMENT RESULTING FROM CORRECTIONS OF ERRONEOUSLY DETERMINED WAGE INDEX.— 42 USC 1395ww note.

(A) IN GENERAL.—If the Secretary of Health and Human Services (hereinafter referred to as the "Secretary") discovers an error with respect to the determination, adjustment, or computation of the area wage index described in section 1886(d)(3)(E) of the Social Security Act and subsequently corrects such error, the Secretary shall make an additional payment under title XVIII of such Act to a hospital affected by such error for inpatient hospital discharges occurring during the period when the erroneously determined, adjusted, or computed wage index was in effect.

(B) CONDITIONS FOR ADDITIONAL PAYMENT.—A hospital is eligible for an additional payment under subparagraph (A) only if—

(i) the error resulted from the submission of erroneous data, except that a hospital is not eligible for such additional payment if it submitted such erroneous data;

(ii) the error was made with respect to the survey of the 1984 wages and wage-related costs of hospitals in the United States conducted under section 1886(d)(3)(E) of the Social Security Act; and

(iii) the correction of the error resulted in an adjustment to the area wage index of not less than 3 percentage points.

(C) PERIOD OF APPLICABILITY.—A hospital may not receive an additional payment under subparagraph (A) for discharges occurring after October 1, 1990.

(6) UPDATES TO WAGE INDEX SURVEY.—Section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) is amended—

(A) by striking "October 1, 1990 (and at least every 36 months thereafter)" and inserting "October 1, 1990, and

October 1, 1993 (and at least every 12 months thereafter)", and

(B) by adding at the end the following new sentence: "Any adjustments or updates made under this subparagraph for a fiscal year (beginning with fiscal year 1991) shall be made in a manner that assures that the aggregate payments under this subsection in the fiscal year are not greater or less than those that would have been made in the year without such adjustment.".

42 USC 1395ww note.

(7) EFFECTIVE DATE.—The amendments made by paragraphs (3) and (4) shall apply to discharges occurring on or after April 1, 1990.

Urban areas. 42 USC 1395ww note.

(i) LEGISLATIVE PROPOSAL ELIMINATING SEPARATE AVERAGE STANDARDIZED AMOUNTS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (hereinafter referred to as the "Secretary") shall design a legislative proposal eliminating the system of determining separate average standardized amounts for subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act) classified as being located in large urban, other urban, or rural areas under section 1886(d)(2)(D) of such Act, and shall include in such proposal the following:

(A) A transition period beginning in fiscal year 1992 during which a single rate for determining payment to hospitals in all areas shall be phased in with such single rate to be completely in effect by fiscal year 1995.

(B) Recommendations, where appropriate, for modifying or maintaining additional payments or adjustments made under title XVIII of the Social Security Act for teaching hospitals, rural referral centers, sole community hospitals, disproportionate share hospitals, and outlier cases, and for creating additional payments or adjustments where deemed appropriate by the Secretary.

(C) Recommendations with respect to recalculating standardized amounts to reflect information from more recent cost reporting periods.

(D) Recommendations, where appropriate, for modifying reimbursement for hospitals that are not subsection (d) hospitals under title XVIII of such Act.

(E) A recommendation for a methodology to reflect the severity of illness of different patients within the same diagnosis-related group (as determined in section 1886(d)(4)(B) of such Act).

(2) REPORT TO CONGRESS AND PROPAC.—(A) Not later than October 1, 1990, the Secretary shall submit the proposal described in paragraph (1) and an accompanying analysis of the impact of the proposed elimination of separate average standardized amounts on various categories of hospitals to Congress and the Prospective Payment Assessment Commission.

(B) Not later than February 1, 1991, the Prospective Payment Assessment Commission and the Director of the Congressional Budget Office shall each prepare and submit to Congress a report analyzing the legislative proposal submitted under subparagraph (A), and shall include in such report an analysis of the probable impact of such legislation on hospitals participating in the medicare program.

(j) PROPAC STUDY OF PAYMENTS TO RURAL SOLE COMMUNITY HOSPITALS AND SMALL RURAL HOSPITALS.—

(1) STUDY.—The Prospective Payment Assessment Commission (hereinafter referred to as the "Commission") shall conduct a study of the feasibility and desirability of—

(A) using a cost-based reimbursement system to determine the amount of payments to be made under the medicare program to small rural hospitals and rural sole community hospitals for the operating costs of inpatient hospital services;

(B) developing and applying alternative definitions of market share for use in determining the eligibility of hospitals for classification as sole community hospitals under section 1886(d)(5) of the Social Security Act; and

(C) developing and applying a method for accounting for decreases in the number of inpatients served in determining payment to small rural hospitals under section 1886(d) of the Social Security Act for the operating costs of inpatient hospital services.

(2) REPORT.—By not later than May 1, 1990, the Commission shall submit a report to Congress on the study conducted under paragraph (1).

SEC. 6004. PPS-EXEMPT HOSPITALS.

(a) EXEMPTION OF CANCER HOSPITALS FROM PROSPECTIVE PAYMENT SYSTEM.—

(1) IN GENERAL.—Section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)) is amended—

(A) in clause (iii), by striking "or";

(B) in clause (iv), by striking the semicolon at the end and inserting ", or"; and

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

"(v) a hospital that the Secretary has classified, at any time on or before December 31, 1990, (or, in the case of a hospital that, as of the date of the enactment of this clause, is located in a State operating a demonstration project under section 1814(b), on or before December 31, 1991) for purposes of applying exceptions and adjustments to payment amounts under this subsection, as a hospital involved extensively in treatment for or research on cancer;".

(2) CONFORMING AMENDMENT.—Section 1886(d)(5)(I) of such Act (as redesignated by section 6003(e)(1)(A)) is amended by striking "(including" and all that follows through "cancer)".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to cost reporting periods beginning on or after October 1, 1989, except that— 42 USC 1395ww note.

(A) in the case of a hospital classified by the Secretary of Health and Human Services as a hospital involved extensively in treatment for or research on cancer under section 1886(d)(5)(I) of the Social Security Act (as redesignated by section 6003(e)(1)(A)) after the date of the enactment of this Act, such amendments shall apply with respect to cost reporting periods beginning on or after the date of such classification,

(B) in the case of a hospital that is not described in subparagraph (A), such amendments shall apply with respect to portions of cost reporting periods or discharges

occurring during and after fiscal year 1987 for purposes of section 1886(g) of the Social Security Act, and

(C) such amendments shall take effect 30 days after the date of the enactment of this Act for purposes of determining the eligibility of a hospital to receive periodic interim payments under section 1815(e)(2) of the Social Security Act.

(b) REBASING FOR CANCER HOSPITALS.—

(1) IN GENERAL.—Section 1886(b)(3) of such Act (42 U.S.C. 1395ww(b)(3)), as amended by subsections (e)(1)(B) and (f)(2) of section 6003, is further amended—

(A) in subparagraph (A), by striking "(C) and (D)" and inserting "(C), (D), and (E)",

(B) in subparagraph (B)(ii), by striking "For purposes of subparagraph (A)" and inserting "For purposes of subparagraphs (A) and (E)", and

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

"(E) In the case of a hospital described in clause (v) of subsection (d)(1)(B), 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—

"(I) 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 (in this subparagraph referred to as the 'base cost reporting period') preceding the first cost reporting period for which this subsection was in effect with respect to such hospital, increased (in a compounded manner) by—

"(II) the sum of the applicable percentage increases applied to such hospital under this paragraph for cost reporting periods after the base cost reporting period and up to and including such first 12-month cost reporting period, or

"(ii) with respect to a later cost reporting period, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase under subparagraph (B)(ii) for that later cost reporting period.

There shall be substituted for the base cost reporting period described in clause (i) a hospital's cost reporting period (if any) beginning during fiscal year 1987 if such substitution results in an increase in the target amount for the hospital.".

42 USC 1395ww note.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply with respect to cost reporting periods beginning on or after April 1, 1989.

SEC. 6005. PAYMENTS FOR HOSPICE CARE.

(a) INCREASE IN CURRENT RATES.—Section 1814(i)(1) of the Social Security Act (42 U.S.C. 1395f(i)(1)) is amended—

(1) in subparagraph (A), by inserting "and except as otherwise provided in this paragraph" after "1813(a)(4)", and

(2) by striking subparagraph (C) and inserting the following:

"(C)(i) With respect to routine home care and other services included in hospice care furnished during fiscal year 1990, the payment rates for such care and services shall be 120 percent of such rates in effect as of September 30, 1989.

"(ii) With respect to routine home care and other services included in hospice care furnished during a subsequent fiscal year, the payment rates for such care and services shall be the payment rates in effect under this subparagraph during the previous fiscal year increased by the market basket percentage increase (as defined in section 1886(b)(3)(B)(iii)) otherwise applicable to discharges occurring in the fiscal year.".

(b) REQUIREMENT OF CERTIFICATION OF TERMINAL ILLNESS FOR HOSPICE CARE MODIFIED.—Section 1814(a)(7)(A)(i) of the Social Security Act (42 U.S.C. 1395f(a)(7)(A)(i)) is amended by striking "certify," and all that follows through "initiated," and inserting the following: "certify in writing, not later than 2 days after hospice care is initiated (or, if each certify verbally not later than 2 days after hospice care is initiated, not later than 8 days after such care is initiated),".

(c) EFFECTIVE DATE.—The amendments made by subsection (a) shall become effective with respect to care and services furnished on or after January 1, 1990. 42 USC 1395f note.

Subpart B—Technical and Miscellaneous Provisions

SEC. 6011. PASS THROUGH PAYMENT FOR HEMOPHILIA INPATIENTS.

(a) PASS THROUGH PAYMENT FOR HEMOPHILIA INPATIENTS.—The second sentence of section 1886(a)(4) of the Social Security Act (42 U.S.C. 1395ww(d)(4)) is amended—

(1) by striking "or,"; and

(2) by striking "October 1, 1987)" and inserting "October 1, 1987), or costs with respect to administering blood clotting factors to individuals with hemophilia".

(b) DETERMINING PAYMENT AMOUNT.—The Secretary of Health and Human Services shall determine the amount of payment made to hospitals under part A of title XVIII of the Social Security Act for the costs of administering blood clotting factors to individuals with hemophilia by multiplying a predetermined price per unit of blood clotting factor (determined in consultation with the Prospective Payment Assessment Commission) by the number of units provided to the individual. 42 USC 1395ww note.

(c) RECOMMENDATIONS ON PAYMENTS.—The Prospective Payment Assessment Commission and the Health Care Financing Administration shall develop recommendations with respect to payments to hospitals under part A of title XVIII of the Social Security Act for the costs of administering blood clotting factors to individuals with hemophilia, and shall submit such recommendations to Congress not later than 18 months after the date of enactment of this Act. 42 USC 1395ww note.

(d) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to items furnished 6 months after the date of enactment of this Act and shall expire 2 years after the date of enactment of this Act. 42 USC 1395ww note.

SEC. 6012. MEDICARE BUY-IN FOR CONTINUED BENEFITS FOR DISABLED INDIVIDUALS.

(a) IN GENERAL.—Title XVIII of the Social Security Act is amended—

(1) in the heading of section 1818, by inserting "ELDERLY" after "UNINSURED"; and 42 USC 1395i-2.

(2) by inserting after section 1818 the following new section:

"HOSPITAL INSURANCE BENEFITS FOR DISABLED INDIVIDUALS WHO HAVE EXHAUSTED OTHER ENTITLEMENT

42 USC 1395i-2a.

"SEC. 1818A. (a) Every individual who—

"(1) has not attained the age of 65;

"(2)(A) has been entitled to benefits under this part under section 226(b), and

"(B)(i) continues to have the disabling physical or mental impairment on the basis of which the individual was found to be under a disability or to be a disabled qualified railroad retirement beneficiary, or (ii) is blind (within the meaning of section 216(i)(1)), but

"(C) whose entitlement under section 226(b) ends due solely to the individual having earnings that exceed the substantial gainful activity amount (as defined in section 223(d)(4)); and

"(3) is not otherwise entitled to benefits under this part, shall be eligible to enroll in the insurance program established by this part.

"(b)(1) An individual may enroll under this section only in such manner and form as may be prescribed in regulations, and only during an enrollment period prescribed in or under this section.

"(2) The individual's initial enrollment period shall begin with the month in which the individual receives notice that the individual's entitlement to benefits under section 226(b) will end due solely to the individual having earnings that exceed the substantial gainful activity amount (as defined in section 223(d)(4)) and shall end 7 months later.

"(3) There shall be a general enrollment period during the period beginning on January 1 and ending on March 31 of each year (beginning with 1990).

"(c)(1) The period (in this subsection referred to as a 'coverage period') during which an individual is entitled to benefits under the insurance program under this part shall begin on whichever of the following is the latest:

"(A) In the case of an individual who enrolls under subsection (b)(2) before the month in which the individual first satisfies subsection (a), the first day of such month.

"(B) In the case of an individual who enrolls under subsection (b)(2) in the month in which the individual first satisfies subsection (a), the first day of the month following the month in which the individual so enrolls.

"(C) In the case of an individual who enrolls under subsection (b)(2) in the month following the month in which the individual first satisfies subsection (a), the first day of the second month following the month in which the individual so enrolls.

"(D) In the case of an individual who enrolls under subsection (b)(2) more than one month following the month in which the individual first satisfies subsection (a), the first day of the third month following the month in which the individual so enrolls.

"(E) In the case of an individual who enrolls under subsection (b)(3), the July 1 following the month in which the individual so enrolls.

"(2) An individual's coverage period under this section shall continue until the individual's enrollment is terminated as follows:

"(A) As of the month following the month in which the Secretary provides notice to the individual that the individual no longer meets the condition described in subsection (a)(2)(B).

"(B) As of the month following the month in which the individual files notice that the individual no longer wishes to participate in the insurance program established by this part.

"(C) As of the month before the first month in which the individual becomes eligible for hospital insurance benefits under section 226(a) or 226A.

"(D) As of a date, determined under regulations of the Secretary, for nonpayment of premiums.

The regulations under subparagraph (D) may provide a grace period of not longer than 90 days, which may be extended to not to exceed 180 days in any case where the Secretary determines that there was good cause for failure to pay the overdue premiums within such 90-day period. Termination of coverage under this section shall result in simultaneous termination of any coverage affected under any other part of this title.

"(3) The provisions of subsections (h) and (i) of section 1837 apply to enrollment and nonenrollment under this section in the same manner as they apply to enrollment and nonenrollment and special enrollment periods under section 1818.

"(d)(1)(A) Premiums shall be paid to the Secretary at such times, and in such manner, as the Secretary shall by regulations prescribe, and shall be deposited in the Treasury to the credit of the Federal Hospital Insurance Trust Fund.

"(B)(i) Subject to clause (ii), such premiums shall be payable for the period commencing with the first month of an individual's coverage period and ending with the month in which the individual dies or, if earlier, in which the individual's coverage period terminates.

"(ii) Such premiums shall not be payable for any month in which the individual is eligible for benefits under this part pursuant to section 226(b).

"(C) For purposes of applying section 1839(g) of this title and section 59B(f)(1)(B)(i) of the Internal Revenue Code of 1986, any reference to section 1818 shall be deemed to include a reference to this section.

"(2) The provisions of subsections (d) through (f) of section 1818 (relating to premiums) shall apply to individuals enrolled under this section in the same manner as they apply to individuals enrolled under that section.".

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act, but shall not apply so as to provide for coverage under part A of title XVIII of the Social Security Act for any month before July 1990. 42 USC 1395i-2a note.

SEC. 6013. BUY-IN UNDER PART A FOR QUALIFIED MEDICARE BENEFICIARIES.

(a) IN GENERAL.—Section 1818 of the Social Security Act (42 U.S.C. 1395i-2) is amended by adding at the end the following:

"(g)(1) The Secretary shall, at the request of a State made after 1989, enter into a modification of an agreement entered into with the State pursuant to section 1843(a) under which the agreement provides for enrollment in the program established by this part of qualified medicare beneficiaries (as defined in section 1905(p)(1)). Contracts.

"(2)(A) Except as provided in subparagraph (B), the provisions of subsections (c), (d), (e), and (f) of section 1843 shall apply to qualified medicare beneficiaries enrolled, pursuant to such agreement, in the program established by this part in the same manner and to the

same extent as they apply to qualified medicare beneficiaries enrolled, pursuant to such agreement, in part B.

"(B) For purposes of this subsection, section 1843(d)(1) shall be applied by substituting 'section 1818' for 'section 1839' and 'subsection (c) (with reference to subsection (b) of section 1839)' for 'subsection (b).'.".

(b) CONFORMING AMENDMENT.—Section 1843 of such Act (42 U.S.C. 1395v) is amended by adding at the end the following:

"(i) For provisions relating to enrollment of qualified medicare beneficiaries under part A, see section 1818(g).".

42 USC 1395i-2 note.

(c) EFFECTIVE DATE.—The amendments made by this section shall become effective January 1, 1990.

SEC. 6014. PROPAC STUDY ON MEDICARE-DEPENDENT HOSPITALS.

(a) STUDY.—The Prospective Payment Assessment Commission shall conduct a study of the appropriateness of making an adjustment to the methodology for determining the amount of payment to hospitals for which individuals entitled to benefits under part A of title XVIII of the Social Security Act represent a high proportion of discharges.

(b) REPORT.—Not later than June 1, 1990, the Commission shall include a report on the study conducted under subsection (a) in its annual report submitted to Congress.

SEC. 6015. PROVISIONS RELATING TO TARGET AMOUNT ADJUSTMENTS.

(a) INCLUDING NEW BASE PERIOD IN TARGET ADJUSTMENTS.—Section 1886(b)(4)(A) of the Social Security Act (42 U.S.C. 1395ww(b)(4)(A)) is amended by striking "deems appropriate," and inserting "deems appropriate, including the assignment of a new base period which is more representative, as determined by the Secretary, of the reasonable and necessary cost of inpatient services and".

42 USC 1395ww note.

(b) PUBLICATION OF INSTRUCTIONS RELATING TO EXCEPTIONS AND ADJUSTMENTS IN TARGET AMOUNTS.—By not later than 180 days after the date of enactment of this Act, the Secretary of Health and Human Services shall publish instructions specifying the application process to be used in providing exceptions and adjustments under section 1886(b)(4)(A) of the Social Security Act.

42 USC 1395ww note.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall become effective with respect to cost reporting periods beginning on or after April 1, 1990.

42 USC 1395f note.

SEC. 6016. STUDY OF METHODS TO COMPENSATE HOSPICES FOR HIGH-COST CARE.

(a) STUDY.—The Secretary of Health and Human Services shall—

(1) conduct a study of high-cost hospice care provided to medicare beneficiaries under the medicare program, and evaluate the ability of hospice programs participating in the medicare program to provide such high-cost care to such patients; and

(2) based on such study, develop methods to compensate such programs for providing such high-cost care.

(b) REPORT TO CONGRESS.—Not later than April 1, 1991, the Secretary shall submit a report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate on the study conducted under subsection (a) and shall include in the report any recommendations developed by the Sec-

retary to compensate hospice programs for providing high-cost hospice care to medicare beneficiaries.

SEC. 6017. PROHIBITION ON NURSING HOME BALANCE BILLING.

Section 1866(a)(2)(B) of the Social Security Act (42 U.S.C. 1395cc(a)(2)(B)) is amended—

(1) in clause (i), by striking "(i)"; and

(2) by striking clause (ii).

SEC. 6018. HOSPITAL ANTI-DUMPING PROVISIONS.

(a) HOSPITAL OBLIGATIONS WITH RESPECT TO TREATMENT OF EMERGENCY MEDICAL CONDITIONS AND INDIGENT CARE.—Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

(1) by amending subparagraph (I) to read as follows:

"(I) in the case of a hospital or rural primary care hospital—

"(i) to adopt and enforce a policy to ensure compliance with the requirements of section 1867,

"(ii) to maintain medical and other records related to individuals transferred to or from the hospital for a period of five years from the date of the transfer, and

"(iii) to maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition;"; and

(2) in subparagraph (N)—

(A) by striking "and" at the end of clause (i),

(B) by striking "and" at the end of clause (ii), and

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

"(iii) to post conspicuously in any emergency department a sign (in a form specified by the Secretary) specifying rights of individuals under section 1867 with respect to examination and treatment for emergency medical conditions and women in labor, and

"(iv) to post conspicuously (in a form specified by the Secretary) information indicating whether or not the hospital participates in the medicaid program under a State plan approved under title XIX, and".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on the first day of the first month that begins more than 180 days after the date of the enactment of this Act, without regard to whether regulations to carry out such amendments have been promulgated by such date. 42 USC 1395cc note.

SEC. 6019. RELEASE AND USE OF HOSPITAL ACCREDITATION SURVEYS.

(a) REQUIRING ALL INSTITUTIONS AND JCAHO TO RELEASE SURVEYS TO SECRETARY.—Section 1865(a)(2) of the Social Security Act (42 U.S.C. 1395bb(a)(2)) is amended—

(1) by striking "(2) such institution" and inserting "(2)(A) such institution";

(2) by striking "(if it is included within a survey described in section 1864(c))";

(3) by striking the comma at the end and inserting the following: ", together with any other information directly related to the survey as the Secretary may require (including corrective action plans),"; and

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

"(B) such Commission releases such a copy and any such information to the Secretary,".

42 USC 1395bb.

(b) AUTHORIZING SECRETARY TO RELEASE CERTAIN INFORMATION.—Section 1865(a) of such Act is further amended by striking the period at the end of the last sentence and inserting the following: ", except that the Secretary may disclose such a survey and information related to such a survey to the extent such survey and information relate to an enforcement action taken by the Secretary.".

(c) PERMITTING SECRETARY TO WITHDRAW HOSPITAL'S STATUS BASED UPON INFORMATION OTHER THAN SURVEYS.—Section 1865(b) of such Act is amended by striking "following a survey made pursuant to section 1864(c)".

42 USC 1395bb note.

(d) EFFECTIVE DATE.—(1) Except as provided in paragraph (2), the amendments made by this section shall take effect on the date of the enactment of this Act.

(2) The amendments made by subsection (a) shall take effect 6 months after the date of the enactment of this Act.

SEC. 6020. INTERMEDIATE SANCTIONS FOR PSYCHIATRIC HOSPITALS.

Contracts.

Section 1866 of the Social Security Act (42 U.S.C. 1395cc) is amended by adding at the end the following new subsection:

"(i)(1) If the Secretary determines that a psychiatric hospital which has an agreement in effect under this section no longer meets the requirements for a psychiatric hospital under this title and further finds that the hospital's deficiencies—

"(A) immediately jeopardize the health and safety of its patients, the Secretary shall terminate such agreement; or

"(B) do not immediately jeopardize the health and safety of its patients, the Secretary may terminate such agreement, or provide that no payment will be made under this title with respect to any individual admitted to such hospital after the effective date of the finding, or both.

"(2) If a psychiatric hospital, found to have deficiencies described in paragraph (1)(B), has not complied with the requirements of this title—

"(A) within 3 months after the date the hospital is found to be out of compliance with such requirements, the Secretary shall provide that no payment will be made under this title with respect to any individual admitted to such hospital after the end of such 3-month period, or

"(B) within 6 months after the date the hospital is found to be out of compliance with such requirements, no payment may be made under this title with respect to any individual in the hospital until the Secretary finds that the hospital is in compliance with the requirements of this title.".

SEC. 6021. ELIGIBILITY OF MERGED OR CONSOLIDATED HOSPITALS FOR PERIODIC INTERIM PAYMENTS.

(a) IN GENERAL.—Section 1815(e) of the Social Security Act (42 U.S.C. 1395g(e)) is amended by adding at the end the following new paragraph:

"(4) A hospital created by the merger or consolidation of 2 or more hospitals or hospital campuses shall be eligible to receive periodic interim payment on the basis described in paragraph (1)(B) if—

"(A) at least one of the hospitals or campuses received periodic interim payment on such basis prior to the merger or consolidation; and

"(B) the merging or consolidating hospitals or campuses would each meet the requirement of paragraph (1)(B)(i) if such hospitals or campuses were treated as independent hospitals for purposes of this title.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to payments made for discharges occurring on or after the expiration of the 30-day period that begins on the date of the enactment of this Act, regardless of the date of the merger or consolidation involved. 42 USC 1395g note.

SEC. 6022. EXTENSION OF WAIVER FOR FINGER LAKES AREA HOSPITAL CORPORATION.

Section 1886(c)(4) of the Social Security Act (42 U.S.C. 1395ww(c)(4)) is amended in the second sentence by striking "the aggregate payment or payments" and all that follows and inserting "the aggregate rate of increase from October 1, 1984, to the most recent date for which annual data are available.".

SEC. 6023. CLARIFICATION OF CONTINUATION OF AUGUST 1987 HOSPITAL BAD DEBT RECOGNITION POLICY.

(a) IN GENERAL.—Section 4008(c) of the Omnibus Budget Reconciliation Act of 1987 is amended by adding at the end the following: "The Secretary may not require a hospital to change its bad debt collection policy if a fiscal intermediary, in accordance with the rules in effect as of August 1, 1987, with respect to criteria for indigency determination procedures, record keeping, and determining whether to refer a claim to an external collection agency, has accepted such policy before that date, and the Secretary may not collect from the hospital on the basis of an expectation of a change in the hospital's collection policy.". 42 USC 1395f note.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987. 42 USC 1395f note.

SEC. 6024. USE OF MORE RECENT DATA REGARDING ROUTINE SERVICE COSTS OF SKILLED NURSING FACILITIES. 42 USC 1395yy note.

The Secretary of Health and Human Services shall determine mean per diem routine service costs for freestanding and hospital based skilled nursing facilities under section 1888(a) of the Social Security Act for cost reporting periods beginning on or after October 1, 1989, in accordance with regulations published by the Secretary that require the use of cost reports submitted by skilled nursing facilities for cost reporting periods beginning not earlier than October 1, 1985.

SEC. 6025. PERMITTING DENTIST TO SERVE AS HOSPITAL MEDICAL DIRECTOR. 42 USC 1395x note.

Notwithstanding the requirement that the responsibility for organization and conduct of the medical staff of an institution be assigned only to a doctor of medicine or osteopathy in order for the institution to participate as a hospital under the medicare program, an institution that has a doctor of dental surgery or of dental medicine serving as its medical director shall be considered to meet such requirement if the laws of the State in which the institution is located permit a doctor of dental surgery or of dental medicine to serve as the medical staff director of a hospital.

SEC. 6026. GAO STUDY OF HOSPITAL-BASED AND FREESTANDING SKILLED NURSING FACILITIES.

(a) STUDY.—The Comptroller General shall conduct a study to assess the differences in costs and case-mix between hospital-based and freestanding skilled nursing facilities participating in the medicare program.

(b) REPORT.—By not later than June 1, 1990, the Comptroller General shall submit a report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate on the study conducted under paragraph (1) and shall include in the report any recommendations, including recommendations regarding the payment differential between hospital-based and freestanding skilled nursing facilities, the Comptroller General considers appropriate.

SEC. 6027. MASSACHUSETTS MEDICARE REPAYMENT.

The Secretary of Health and Human Services may not, on or after the date of the enactment of this Act and before May 1, 1990, recoup from, or otherwise reduce payments to, hospitals in the State of Massachusetts because of alleged overpayments to such hospitals under part A of title XVIII of the Social Security Act which occurred during the period of the statewide hospital reimbursement demonstration project conducted in that State between October 1, 1982, and June 30, 1986, under section 402 of the Social Security Amendments of 1967 and section 222 of the Social Security Amendments of 1972. Interest shall not accrue on any such alleged overpayments during the period beginning on the date of the enactment of this Act and ending on May 1, 1990.

SEC. 6028. ALLOWING CERTIFICATIONS AND RECERTIFICATIONS BY NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS FOR CERTAIN SERVICES.

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

(1) in paragraph (2) by striking "(2) a physician" and inserting "(2) a physician, or, in the case of services described in subparagraph (B), a physician, or a nurse practitioner or clinical nurse specialist who does not have a direct or indirect employment relationship with the facility but is working in collaboration with a physician,"; and

(2) in the matter following the final paragraph by striking "a physician makes" and inserting "a physician, nurse practitioner, or clinical nurse specialist (as the case may be) makes".

PART 2—PROVISIONS RELATING TO PART B

Subpart A—General Provisions

2 USC 902 note.

SEC. 6101. EXTENSION OF REDUCTIONS UNDER SEQUESTER ORDER.

Notwithstanding any other provision of law (including any other provision of this Act, other than section 6201), the reductions in the amount of payments required under title XVIII of the Social Security Act made by the final sequester order issued by the President on October 16, 1989, pursuant to section 252(b) of the Balanced Budget and Emergency Deficit Control Act of 1985 shall continue to be effective (as provided by sections 252(a)(4)(B) and 256(d)(2) of such

Act) through March 31, 1990, with respect to payments for items and services under part B of such title.

SEC. 6102. PHYSICIAN PAYMENT REFORM.

(a) IN GENERAL.—Part B of title XVIII of the Social Security Act is amended by adding at the end the following new section:

"PAYMENT FOR PHYSICIANS' SERVICES

"SEC. 1848. (a) PAYMENT BASED ON FEE SCHEDULE.— 42 USC 1395w-4.

"(1) IN GENERAL.—Effective for all physicians' services (as defined in subsection (j)(3)) furnished under this part during a year (beginning with 1992) for which payment is otherwise made on the basis of a reasonable charge or on the basis of a fee schedule under section 1834(b) or 1834(f), payment under this part shall instead be based on the lesser of—

"(A) the actual charge for the service, or

"(B) subject to the succeeding provisions of this subsection, the amount determined under the fee schedule established under subsection (b) for services furnished during that year (in this subsection referred to as the 'fee schedule amount').

"(2) TRANSITION TO FULL FEE SCHEDULE.—

"(A) LIMITING REDUCTIONS AND INCREASES TO 15 PERCENT IN 1992.—

"(i) LIMIT ON INCREASE.—In the case of a service in a fee schedule area (as defined in subsection (j)(2)) for which the adjusted historical payment basis (as defined in subparagraph (D)) is less than 85 percent of the fee schedule amount for services furnished in 1992, there shall be substituted for the fee schedule amount an amount equal to the adjusted historical payment basis plus 15 percent of the fee schedule amount otherwise established (without regard to this paragraph).

"(ii) LIMIT IN REDUCTION.—In the case of a service in a fee schedule area for which the adjusted historical payment basis exceeds 115 percent of the fee schedule amount for services furnished in 1992, there shall be substituted for the fee schedule amount an amount equal to the adjusted historical payment basis minus 15 percent of the fee schedule amount otherwise established (without regard to this paragraph).

"(B) SPECIAL RULE FOR 1993, 1994, AND 1995.—If a physicians' service in a fee schedule area is subject to the provisions of subparagraph (A) in 1992, for physicians' services furnished in the area—

"(i) during 1993, there shall be substituted for the fee schedule amount an amount equal to the sum of—

"(I) 75 percent of the fee schedule amount determined under subparagraph (A), adjusted by the update established under subsection (d)(3) for 1993, and

"(II) 25 percent of the fee schedule amount determined under paragraph (1) for 1993 without regard to this paragraph;

"(ii) during 1994, there shall be substituted for the fee schedule amount an amount equal to the sum of—

"(I) 67 percent of the fee schedule amount determined under clause (i), adjusted by the update established under subsection (d)(3) for 1994, and

"(II) 33 percent of the fee schedule amount determined under paragraph (1) for 1994 without regard to this paragraph; and

"(iii) during 1995, there shall be substituted for the fee schedule amount an amount equal to the sum of—

"(I) 50 percent of the fee schedule amount determined under clause (ii) adjusted by the update established under subsection (d)(3) for 1995, and

"(II) 50 percent of the fee schedule amount determined under paragraph (1) for 1995 without regard to this paragraph.

"(C) SPECIAL RULE FOR ANESTHESIA SERVICES.—With respect to physicians' services which are anesthesia services, the Secretary shall provide for a transition in the same manner as a transition is provided for other services under subparagraph (B).

"(D) ADJUSTED HISTORICAL PAYMENT BASIS DEFINED.—

"(i) IN GENERAL.—In this paragraph, the term 'adjusted historical payment basis' means, with respect to a physicians' service furnished in a fee schedule area, the weighted average prevailing charge applied in the area for the service in 1991 (as determined by the Secretary without regard to physician specialty and as adjusted to reflect payments for services with customary charges below the prevailing charge or other payment limitations imposed by law or regulation) adjusted by the update established under subsection (d)(3) for 1992.

"(ii) APPLICATION TO RADIOLOGY SERVICES.—In applying clause (i) in the case of physicians' services which are radiology services (including radiologist services, as defined in section 1834(b)(6)), there shall be substituted for the weighted average prevailing charge the amount provided under the fee schedule established for the service for the fee schedule area under section 1834(b).

"(3) INCENTIVES FOR PARTICIPATING PHYSICIANS.—In applying paragraph (1)(B) in the case of a nonparticipating physician, the fee schedule amount shall be 95 percent of such amount otherwise applied under this subsection (without regard to this paragraph).

Regulations.

"(b) ESTABLISHMENT OF FEE SCHEDULES.—

"(1) IN GENERAL.—Before January 1 of each year beginning with 1992, the Secretary shall establish, by regulation, fee schedules that establish payment amounts for all physicians' services furnished in all fee schedule areas (as defined in subsection (j)(2)) for the year. Except as provided in paragraph (2), each such payment amount for a service shall be equal to the product of—

"(A) the relative value for the service (as determined in subsection (c)(2)),

"(B) the conversion factor (established under subsection (d)) for the year, and

"(C) the geographic adjustment factor (established under subsection (e)(2)) for the service for the fee schedule area.

"(2) TREATMENT OF RADIOLOGY SERVICES AND ANESTHESIA SERVICES.—

"(A) RADIOLOGY SERVICES.—With respect to radiology services (including radiologist services, as defined in section 1834(b)(6)), the Secretary shall base the relative values on the relative value scale developed under section 1834(b)(1)(A), with appropriate modifications of the relative values to assure that the relative values established for radiology services which are similar or related to other physicians' services are consistent with the relative values established for those similar or related services.

"(B) ANESTHESIA SERVICES.—In establishing the fee schedule for anesthesia services for which a relative value guide has been established under section 4048(b) of the Omnibus Budget Reconciliation Act of 1987, the Secretary shall use, to the extent practicable, such relative value guide, with appropriate adjustment of the conversion factor, in a manner to assure that the fee schedule amounts for anesthesia services are consistent with the fee schedule amounts for other services determined by the Secretary to be of comparable value. In applying the previous sentence, the Secretary shall adjust the conversion factor by geographic adjustment factors in the same manner as such adjustment is made under paragraph (1)(C).

"(C) CONSULTATION.—The Secretary shall consult with the Physician Payment Review Commission and organizations representing physicians or suppliers who furnish radiology services and anesthesia services in applying subparagraphs (A) and (B).

"(c) DETERMINATION OF RELATIVE VALUES FOR PHYSICIANS' SERVICES.—

"(1) DIVISION OF PHYSICIANS' SERVICES INTO COMPONENTS.—In this section, with respect to a physicians' service:

"(A) WORK COMPONENT DEFINED.—The term 'work component' means the portion of the resources used in furnishing the service that reflects physician time and intensity in furnishing the service. Such portion shall—

"(i) include activities before and after direct patient contact, and

"(ii) be defined, with respect to surgical procedures, to reflect a global definition including pre-operative and post-operative physicians' services.

"(B) PRACTICE EXPENSE COMPONENT DEFINED.—The term 'practice expense component' means the portion of the resources used in furnishing the service that reflects the general categories of expenses (such as office rent and wages of personnel, but excluding malpractice expenses) comprising practice expenses. In this subparagraph, the term 'practice expenses' includes all expenses for furnishing physicians' services, excluding malpractice expenses, physician compensation, and other physician fringe benefits.

"(C) MALPRACTICE COMPONENT DEFINED.—The term 'malpractice component' means the portion of the resources used in furnishing the service that reflects malpractice expenses in furnishing the service.

"(2) DETERMINATION OF RELATIVE VALUES.—

"(A) IN GENERAL.—

"(i) COMBINATION OF UNITS FOR COMPONENTS.—The Secretary shall develop a methodology for combining the work, practice expense, and malpractice relative value units, determined under subparagraph (C), for each service in a manner to produce a single relative value for that service.

"(ii) EXTRAPOLATION.—The Secretary may use extrapolation and other techniques to determine the number of relative value units for physicians' services for which specific data are not available and shall take into account recommendations of the Physician Payment Review Commission and the results of consultations with organizations representing physicians who provide such services.

"(B) PERIODIC REVIEW AND ADJUSTMENTS IN RELATIVE VALUES.—

"(i) PERIODIC REVIEW.—The Secretary, not less often than every 5 years, shall review the relative values established under this paragraph for all physicians' services.

"(ii) ADJUSTMENTS.—

"(I) IN GENERAL.—The Secretary shall, to the extent the Secretary determines to be necessary and subject to subclause (II), adjust the number of such units to take into account changes in medical practice, coding changes, new data on relative value components, or the addition of new procedures. The Secretary shall publish an explanation of the basis for such adjustments.

"(II) LIMITATION ON ANNUAL ADJUSTMENTS.—The adjustments under subclause (I) for a year may not cause the amount of expenditures under this part for the year to differ by more than $20,000,000 from the amount of expenditures under this part that would have been made if such adjustments had not been made.

"(iii) CONSULTATION.—The Secretary, in making adjustments under clause (ii), shall consult with the Physician Payment Review Commission and organizations representing physicians.

"(C) COMPUTATION OF RELATIVE VALUE UNITS FOR COMPONENTS.—For purposes of this section for each physicians' service—

"(i) WORK RELATIVE VALUE UNITS.—The Secretary shall determine a number of work relative value units for the service based on the relative resources incorporating physician time and intensity required in furnishing the service.

"(ii) PRACTICE EXPENSE RELATIVE VALUE UNITS.—The Secretary shall determine a number of practice expense relative value units equal to the product of—

"(I) the base allowed charges (as defined in subparagraph (D)) for the service, and

"(II) the practice expense percentage for the service (as determined under paragraph (3)(C)(ii)).

"(iii) MALPRACTICE RELATIVE VALUE UNITS.—The Secretary shall determine a number of malpractice relative value units equal to the product of—

"(I) the base allowed charges (as defined in subparagraph (D)) for the service, and

"(II) the malpractice percentage for the service (as determined under paragraph (3)(C)(iii)).

"(D) BASE ALLOWED CHARGES DEFINED.—In this paragraph, the term 'base allowed charges' means, with respect to a physician's service, the national average allowed charges for the service under this part for services furnished during 1991, as estimated by the Secretary using the most recent data available.

"(3) COMPONENT PERCENTAGES.—For purposes of paragraph (2), the Secretary shall determine a work percentage, a practice expense percentage, and a malpractice percentage for each physician's service as follows:

"(A) DIVISION OF SERVICES BY SPECIALTY.—For each physician's service or class of physicians' services, the Secretary shall determine the average percentage of each such service or class of services that is performed, nationwide, under this part by physicians in each of the different physician specialties (as identified by the Secretary).

"(B) DIVISION OF SPECIALTY BY COMPONENT.—The Secretary shall determine the average percentage division of resources, among the work component, the practice expense component, and the malpractice component, used by physicians in each of such specialties in furnishing physicians' services. Such percentages shall be based on national data that describe the elements of physician practice costs and revenues, by physician specialty. The Secretary may use extrapolation and other techniques to determine practice costs and revenues for specialties for which adequate data are not available.

"(C) DETERMINATION OF COMPONENT PERCENTAGES.—

"(i) WORK PERCENTAGE.—The work percentage for a service (or class of services) is equal to the sum (for all physician specialties) of—

"(I) the average percentage division for the work component for each physician specialty (determined under subparagraph (B)), multiplied by

"(II) the proportion (determined under subparagraph (A)) of such service (or services) performed by physicians in that specialty.

"(ii) PRACTICE EXPENSE PERCENTAGE.—The practice expense percentage for a service (or class of services) is equal to the sum (for all physician specialties) of—

"(I) the average percentage division for the practice expense component for each physician specialty (determined under subparagraph (B)), multiplied by

"(II) by the proportion (determined under subparagraph (A)) of such service (or services) performed by physicians in that specialty.

"(iii) MALPRACTICE PERCENTAGE.—The malpractice percentage for a service (or class of services) is equal to the sum (for all physician specialties) of—

"(I) the average percentage division for the malpractice component for each physician specialty (determined under subparagraph (B)), multiplied by

"(II) by the proportion (determined under subparagraph (A)) of such service (or services) performed by physicians in that specialty.

"(D) PERIODIC RECOMPUTATION.—The Secretary may, from time to time, provide for the recomputation of work percentages, practice expense percentages, and malpractice percentages determined under this paragraph.

"(3) ANCILLARY POLICIES.—The Secretary may establish ancillary policies (with respect to the use of modifiers, local codes, and other matters) as may be necessary to implement this subsection.

"(4) CODING.—The Secretary shall establish a uniform procedure coding system for the coding of all physicians' services. The Secretary shall provide for an appropriate coding structure for visits and consultations. The Secretary may incorporate the use of time in the coding for visits and consultations only for services furnished on or after January 1, 1993. The Secretary, in establishing such coding system, shall consult with the Physician Payment Review Commission and other organizations representing physicians.

"(5) NO VARIATION FOR SPECIALISTS.—The Secretary may not vary the conversion factor or the number of relative value units for a physicians' service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician.

"(d) CONVERSION FACTORS.—

"(1) ESTABLISHMENT.—

"(A) IN GENERAL.—The conversion factor for each year shall be the conversion factor established under this subsection for the previous year (or, in the case of 1992, specified in subparagraph (B)) adjusted by the update (established under subparagraph (C)) for the year involved.

"(B) SPECIAL PROVISION FOR 1992.—For purposes of subparagraph (A), the conversion factor specified in this subparagraph is a conversion factor (determined by the Secretary) which, if this section were to apply during 1991 using such conversion factor, would result in the same aggregate amount of payments under this part for physicians' services as the estimated aggregate amount of the payments under this part for such services in 1991.

Federal Register, publication.

"(C) PUBLICATION.—The Secretary shall cause to have published in the Federal Register, during the last 15 days of October of—

"(i) 1991, the conversion factor (or factors) which will apply to physicians' services for 1992, and the update (or updates) determined under paragraph (3) for 1992; and

"(ii) each succeeding year, the update (or updates) determined under paragraph (3) for the following year.

"(2) RECOMMENDATION OF UPDATE.—

Reports.

"(A) IN GENERAL.—Not later than April 15 of each year (beginning with 1991), the Secretary shall transmit to the Congress a report that includes a recommendation on the

appropriate update (or updates) in the conversion factor (or factors) for all physicians' services in the following year. The Secretary may recommend a uniform update or different updates for different categories or groups of services. In making the recommendation, the Secretary shall consider—

"(i) the percentage change in the medicare economic index (described in the fourth sentence of section 1842(b)(3)) for that year;

"(ii) the percentage by which actual expenditures for all physicians' services (as defined in subsection (f)(5)(A)) under this part for the fiscal year ending in the year preceding the year in which such recommendation is made were greater or less than actual expenditures for all such physicians' services in the fiscal year ending in the second preceding year;

"(iii) the relationship between the percentage determined under clause (ii) for a fiscal year and the performance standard rate of increase (established under subsection (f)(2)) for that fiscal year;

"(iv) changes in volume or intensity of services;

"(v) access to services; and

"(vi) other factors that may contribute to changes in volume or intensity of services or access to services.

For purposes of making the comparison under clause (iii), the Secretary shall adjust the performance standard rate of increase for a fiscal year to reflect changes in the actual proportion of HMO enrollees (as defined in subsection (f)(5)(B)) in that fiscal year compared with such proportion for the previous fiscal year.

"(B) ADDITIONAL CONSIDERATIONS.—In making recommendations under subparagraph (A), the Secretary may also consider—

"(i) unexpected changes by physicians in response to the implementation of the fee schedule;

"(ii) unexpected changes in outlay projections;

"(iii) changes in the quality or appropriateness of care; and

"(iv) any other relevant factors not measured in the resource-based payment methodology.

"(C) SPECIAL RULE FOR 1992 UPDATE.—In considering the update for 1992, the Secretary shall make a separate determination of the percentage and relationship described in clauses (ii) and (iii) of subparagraph (A) with respect to the category of surgical services (as defined by the Secretary pursuant to subsection (j)(1)).

"(D) EXPLANATION OF UPDATE.—The Secretary shall include in each report under subparagraph (A)—

"(i) the update recommended for each category of physicians' services (established by the Secretary under subsection (j)(1)) and for each of the following groups of physicians' services: nonsurgical services, visits, consultations, and emergency room services;

"(ii) the rationale for the recommended update (or updates) for each category and group of services described in clause (i); and

"(iii) the data and analyses underlying the update (or updates) recommended.

"(E) COMPUTATION OF BUDGET-NEUTRAL ADJUSTMENT.—

"(i) IN GENERAL.—The Secretary shall include in the report made under subparagraph (A) in a year a statement of the percentage by which (I) the actual expenditures for physicians' services under this part (during the fiscal year ending in the preceding year, as set forth in most recent annual report made pursuant to section 1841(b)(2)), exceeded, or was less than (II) the expenditures projected for the fiscal year under clause (ii).

"(ii) PROJECTED EXPENDITURES.—For purposes of clause (i), the expenditures projected under this clause for a fiscal year is the actual expenditures for physicians' services made under this part in the second preceding fiscal year—

"(I) increased by the weighted average percentage increase permitted under this part for physicians' services in the preceding fiscal year;

"(II) adjusted to reflect the percentage change in the average number of individuals enrolled under this part (who are not enrolled with a risk-sharing contract under section 1876) for the preceding fiscal year compared with the second preceding fiscal year;

"(III) adjusted to reflect the average annual percentage growth in the volume and intensity of physicians' services under this part for the five-fiscal-year period ending with the second preceding fiscal year; and

"(IV) adjusted to reflect the percentage change in expenditures for physicians' services under this part in the preceding fiscal year (compared with the second preceding fiscal year) which result from changes in law or regulations.

Reports. "(F) COMMISSION REVIEW.—The Physician Payment Review Commission shall review the report submitted under subparagraph (A) in a year and shall submit to the Congress, by not later than May 15 of the year, a report including its recommendations respecting the update (or updates) in the conversion factor (or factors) for the following year.

"(3) UPDATE.—

"(A) BASED ON INDEX.—

"(i) IN GENERAL.—Unless Congress otherwise provides, subject to subparagraph (B), for purposes of this section the update for a year is equal to the Secretary's estimate of the percentage increase in the appropriate update index (as defined in clause (ii)) for the year.

"(ii) APPROPRIATE UPDATE INDEX DEFINED.—In clause (i), the term 'appropriate update index' means—

"(I) for services for which prevailing charges in 1989 were subject to a limit under the fourth sentence of section 1842(b)(3), the medicare economic index (referred to in that sentence), and

"(II) for other services, such index (such as the consumer price index) that was applicable under this part in 1989 to increases in the payment amounts recognized under this part with respect to such services.

"(B) ADJUSTMENT IN UPDATE.—

"(i) IN GENERAL.—The update for a year provided under subparagraph (A) shall, subject to clause (ii), be increased or decreased by the same percentage by which (I) the percentage increase in the actual expenditures for physicians' services (as defined in section (f)(5)(A)) in the second previous fiscal year over the third previous fiscal year, was less or greater, respectively, than (II) the performance standard rate of increase (established under subsection (f)) for such category of services for the second previous fiscal year.

"(ii) RESTRICTIONS ON ADJUSTMENT.—The adjustment made under clause (i) for a year may not result in a decrease of—

"(I) more than 2 percentage points for the update for 1992 or 1993,

"(II) 2½ percentage points for the update for 1994 or 1995, and

"(III) 3 percentage points for the update for any succeeding year.

"(e) GEOGRAPHIC ADJUSTMENT FACTORS.—

"(1) ESTABLISHMENT OF GEOGRAPHIC INDICES.—

"(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall establish—

"(i) an index which reflects the relative costs of the mix of goods and services comprising practice expenses (other than malpractice expenses) in the different fee schedule areas compared to the national average of such costs,

"(ii) an index which reflects the relative costs of malpractice expenses in the different fee schedule areas compared to the national average of such costs, and

"(iii) an index which reflects ¼ of the difference between the relative value of physicians' work effort in each of the different fee schedule areas and the national average of such work effort.

"(B) CLASS-SPECIFIC GEOGRAPHIC COST-OF-PRACTICE INDICES.—The Secretary may establish more than one index under subparagraph (A)(i) in the case of classes of physicians' services, if, because of differences in the mix of goods and services comprising practice expenses for the different classes of services, the application of a single index under such clause to different classes of such services would be substantially inequitable.

"(2) COMPUTATION OF GEOGRAPHIC ADJUSTMENT FACTOR.—For purposes of subsection (b)(1)(C), for all physicians' services for each fee schedule area the Secretary shall establish a geographic adjustment factor equal to the sum of the geographic cost-of-practice adjustment factor (specified in paragraph (3)), the geographic malpractice adjustment factor (specified in para-

graph (4)), and the geographic physician work adjustment factor (specified in paragraph (5)) for the service and the area.

"(3) GEOGRAPHIC COST-OF-PRACTICE ADJUSTMENT FACTOR.—For purposes of paragraph (2), the 'geographic cost-of-practice adjustment factor', for a service for a fee schedule area, is the product of—

"(A) the proportion of the total relative value for the service that reflects the relative value units for the practice expense component, and

"(B) the geographic cost-of-practice index value for the area for the service, based on the index established under paragraph (1)(A)(i) or (1)(B) (as the case may be).

"(4) GEOGRAPHIC MALPRACTICE ADJUSTMENT FACTOR.—For purposes of paragraph (2), the 'geographic malpractice adjustment factor', for a service for a fee schedule area, is the product of—

"(A) the proportion of the total relative value for the service that reflects the relative value units for the malpractice component, and

"(B) the geographic malpractice index value for the area, based on the index established under paragraph (1)(A)(ii).

"(5) GEOGRAPHIC PHYSICIAN WORK ADJUSTMENT FACTOR.—For purposes of paragraph (2), the 'geographic physician work adjustment factor', for a service for a fee schedule area, is the product of—

"(A) the proportion of the total relative value for the service that reflects the relative value units for the work component, and

"(B) the geographic physician work index value for the area, based on the index established under paragraph (1)(A)(iii).

"(f) MEDICARE VOLUME PERFORMANCE STANDARD RATES OF INCREASE.—

"(1) PROCESS FOR ESTABLISHING MEDICARE VOLUME PERFORMANCE STANDARD RATES OF INCREASE.—

"(A) SECRETARY'S RECOMMENDATION.—By not later than April 15 of each year (beginning with 1990), the Secretary shall transmit to the Congress a recommendation on performance standard rates of increase for all physicians' services and for each category of such services for the fiscal year beginning in such year. In making the recommendation, the Secretary shall confer with organizations representing physicians and shall consider—

"(i) inflation,

"(ii) changes in numbers of enrollees (other than HMO enrollees) under this part,

"(iii) changes in the age composition of enrollees (other than HMO enrollees) under this part,

"(iv) changes in technology,

"(v) evidence of inappropriate utilization of services,

"(vi) evidence of lack of access to necessary physicians' services, and

"(vii) such other factors as the Secretary considers appropriate.

"(B) COMMISSION REVIEW.—The Physician Payment Review Commission shall review the recommendation transmitted during a year under subparagraph (A) and shall make its recommendation to Congress, by not later

than May 15 of the year, respecting the performance standard rates of increase for the fiscal year beginning in that year.

Federal Register, publication.

"(C) PUBLICATION OF PERFORMANCE STANDARD RATES OF INCREASE.—The Secretary shall cause to have published in the Federal Register, in the last 15 days of October of each year (beginning with 1990), the performance standard rates of increase for all physicians' services and for each category of physicians' services for the fiscal year beginning in that year. The Secretary shall cause to have published in the Federal Register, by not later than January 1, 1990, the performance standard rate of increase under subparagraph (D) for fiscal year 1990.

"(D) PERFORMANCE STANDARD RATE OF INCREASE FOR FISCAL YEAR 1990.—The performance standard rate of increase for fiscal year 1990 is equal to the sum of—

"(i) the Secretary's estimate of the weighted average percentage increase in the reasonable charges for physicians' services (as defined in subsection (f)(5)(A)) under this part for calendar years included in fiscal year 1990,

"(ii) the Secretary's estimate of the percentage increase or decrease in the average number of individuals enrolled under this part (other than HMO enrollees) from fiscal year 1989 to fiscal year 1990,

"(iii) the Secretary's estimate of the average annual percentage growth in volume and intensity of physicians' services under this part for the 5-fiscal-year period ending with fiscal year 1989 (based upon information contained in the most recent annual report made pursuant to section 1841(b)(2)), and

"(iv) the Secretary's estimate of the percentage increase or decrease in expenditures for physicians' services (as defined in subsection (f)(5)(A)) in fiscal year 1990 (compared with fiscal year 1989) which will result from changes in law or regulations and which is not taken into account in the percentage increase described in clause (i),

reduced by ½ percent.

"(2) SPECIFICATION OF PERFORMANCE STANDARD RATES OF INCREASE FOR SUBSEQUENT FISCAL YEARS.—

"(A) IN GENERAL.—Unless Congress otherwise provides, subject to paragraph (4), each performance standard rate of increase for a fiscal year (beginning with fiscal year 1991) shall be equal to the sum of—

"(i) the Secretary's estimate of the weighted average percentage increase in the fees for physicians' services (as defined in subsection (f)(5)(A)) under this part for calendar years included in the fiscal year involved,

"(ii) the Secretary's estimate of the percentage increase or decrease in the average number of individuals enrolled under this part (other than HMO enrollees) from the previous fiscal year to the fiscal year involved,

"(iii) the Secretary's estimate of the average annual percentage growth in volume and intensity of physicians' services under this part for the 5-fiscal-year

period ending with the preceding fiscal year (based upon information contained in the most recent annual report made pursuant to section 1841(b)(2)), and

"(iv) the Secretary's estimate of the percentage increase or decrease in expenditures for physicians' services (as defined in subsection (f)(5)(A)) in the fiscal year (compared with the preceding fiscal year) which will result from changes in law or regulations and which is not taken into account in the percentage increase described in clause (i),

reduced by the performance standard factor (specified in subparagraph (B)). In clause (i), the term 'fees' means, with respect to 1991, reasonable charges and, with respect to any succeeding year, fee schedule amounts.

"(B) PERFORMANCE STANDARD FACTOR.—For purposes of subparagraph (A). the performance standard factor—

"(i) for 1991 is 1 percentage point,

"(ii) for 1992 is 1½ percentage points, and

"(iii) for each succeeding year is 2 percentage points.

"(3) QUARTERLY REPORTING.—The Secretary shall establish procedures for providing, on a quarterly basis to the Physician Payment Review Commission, the Congressional Budget Office, the Congressional Research Service, the Committees on Ways and Means and Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate, information on compliance with performance standard rates of increase established under this subsection.

"(4) SEPARATE GROUP-SPECIFIC PERFORMANCE STANDARD RATES OF INCREASE.—

"(A) IMPLEMENTATION OF PLAN.—Subject to paragraph (B), the Secretary shall, after completion of the study required under section 6102(e)(3) of the Omnibus Budget Reconciliation Act of 1989, but not before October 1, 1991, implement a plan under which qualified physician groups could elect annually separate performance standard rates of increase other than the performance standard rate of increase established for the year under paragraph (2) for such physicians. The Secretary shall develop criteria to determine which physician groups are eligible to elect to have applied to such groups separate performance standard rates of increase and the methods by which such group-specific performance standard rates of increase would be accomplished. The Secretary shall report to the Congress on the criteria and methods by April 15, 1991. The Physician Payment Review Commission shall review and comment on such recommendations by May 15, 1991. Before implementing group-specific performance standard rates of increase, the Secretary shall provide for notice and comment in the Federal Register and consult with organizations representing physicians.

Reports.

Federal Register, publication.

"(B) APPROVAL.—The Secretary may not implement the plan described in subparagraph (A), unless Congress specifically approves the plan.

"(5) DEFINITIONS.—In this subsection:

"(A) SERVICES INCLUDED IN PHYSICIANS' SERVICES.—The term 'physicians' services' includes other items and services (such as clinical diagnostic laboratory tests and radiology

services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office, but does not include services furnished to an HMO enrollee under a risk-sharing contract under section 1876.

"(B) HMO ENROLLEE.—The term 'HMO enrollee' means, with respect to a fiscal year, an individual enrolled under this part who is enrolled with an entity under a risk-sharing contract under section 1876 in the fiscal year.

"(g) LIMITATION ON BENEFICIARY LIABILITY.—

"(1) LIMITATION ON ACTUAL CHARGES FOR UNASSIGNED CLAIMS.—If a nonparticipating physician knowingly and willfully bills on a repeated basis for physicians' services (furnished with respect to an individual enrolled under this part on or after January 1, 1991) an actual charge in excess of the limiting charge described in paragraph (2) and for which payment is not made on an assignment-related basis under this part, the Secretary may apply sanctions against such physician in accordance with section 1842(j)(2).

"(2) LIMITING CHARGE DEFINED.—

"(A) FOR 1991.—For physicians' services of a physician furnished during 1991, the 'limiting charge' shall be the same percentage (or, if less, 25 percent) above the recognized payment amount under this part with respect to the physician (as a nonparticipating physician) as the percentage by which—

"(i) the maximum allowable actual charge (as determined under section 1842(j)(1)(C) as of December 31, 1990, or, if less, the maximum actual charge otherwise permitted for the service under this part as of such date) for the service of the physician, exceeds

"(ii) the recognized payment amount for the service of the physician (as a nonparticipating physician) as of such date.

"(B) FOR 1992.—For physicians' services furnished during 1992, the 'limiting charge' shall be the same percentage (or, if less, 20 percent) above the recognized payment amount under this part for nonparticipating physicians as the percentage by which—

"(i) the limiting charge (as determined under subparagraph (A) as of December 31, 1991) for the service, exceeds

"(ii) the recognized payment amount for the service for nonparticipating physicians as of such date.

"(C) AFTER 1992.—For physicians' services furnished in a year after 1992, the 'limiting charge' shall be 115 percent of the recognized payment amount under this part for nonparticipating physicians.

"(D) RECOGNIZED PAYMENT AMOUNT.—In this section, the term 'recognized payment amount' means, for services furnished on or after January 1, 1992, the fee schedule amount determined under subsection (a), and, for services furnished during 1991, the applicable percentage (as defined in section 1842(b)(4)(A)(iv)) of the prevailing charge (or fee schedule amount) for nonparticipating physicians for that year.

"(3) LIMITATION ON CHARGES FOR MEDICARE BENEFICIARIES ELIGIBLE FOR MEDICAID BENEFITS.—

"(A) IN GENERAL.—Payment for physicians' services furnished on or after April 1, 1990, to an individual who is enrolled under this part and eligible for any medical assistance (including as a qualified medicare beneficiary, as defined in section 1905(p)(1)) with respect to such services under a State plan approved under title XIX may only be made on an assignment-related basis.

"(B) PENALTY.—A person may not bill for physicians' services subject to subparagraph (A) other than on an assignment-related basis. If a person knowingly and willfully bills for physicians' services in violation of the previous sentence, the Secretary may apply sanctions against the person in accordance with section 1842(j)(2).

"(4) PHYSICIAN SUBMISSION OF CLAIMS.—

"(A) IN GENERAL.—For services furnished on or after September 1, 1990, within 1 year after the date of providing a service for which payment is made under this part on a reasonable charge or fee schedule basis, a physician, supplier, or other person (or an employer or facility in the cases described in section 1842(b)(6)(A))—

Claims.

"(i) shall complete and submit a claim for such service on a standard claim form specified by the Secretary to the carrier on behalf of a beneficiary, and

"(ii) may not impose any charge relating to completing and submitting such a form.

"(B) PENALTY.—(i) With respect to an assigned claim wherever a physician, provider, supplier or other person (or an employer or facility in the cases described in section 1842(b)(6)(A)) fails to submit such a claim as required in subparagraph (A), the Secretary shall reduce by 10 percent the amount that would otherwise be paid for such claim under this part.

"(ii) If a physician, supplier, or other person (or an employer or facility in the cases described in section 1842(b)(6)(A)) fails to submit a claim required to be submitted under subparagraph (A) or imposes a charge in violation of such subparagraph, the Secretary shall apply the sanction with respect to such a violation in the same manner as a sanction may be imposed under section 1842(p)(3) for a violation of section 1842(p)(1).

"(5) ELECTRONIC BILLING; DIRECT DEPOSIT.—The Secretary shall encourage and develop a system providing for expedited payment for claims submitted electronically. The Secretary shall also encourage and provide incentives allowing for direct deposit as payments for services furnished by participating physicians. The Secretary shall provide physicians with such technical information as necessary to enable such physicians to submit claims electronically. The Secretary shall submit a plan to Congress on this paragraph by May 1, 1990.

"(6) MONITORING OF CHARGES.—

"(A) IN GENERAL.—The Secretary shall monitor—

"(i) the actual charges of nonparticipating physicians for physicians' services furnished on or after January 1, 1991, to individuals enrolled under this part, and

"(ii) changes (by specialty, type of service, and geographic area) in (I) the proportion of expenditures for physicians' services provided under this part by partici-

pating physicians, (II) the proportion of expenditures for such services for which payment is made under this part on an assignment-related basis, and (III) the amounts charged above the recognized payment amounts under this part.

"(B) REPORT.—The Secretary shall, by not later than April 15 of each year (beginning in 1992), report to the Congress regarding the changes described in subparagraph (A)(ii).

"(C) PLAN.—If the Secretary finds that there has been a significant decrease in the proportions described in subclauses (I) and (II) of subparagraph (A)(ii) or an increase in the amounts described in subclause (III) of that subparagraph, the Secretary shall develop a plan to address such a problem and transmit to Congress recommendations regarding the plan. The Physician Payment Review Commission shall review the Secretary's plan and recommendations and transmit to Congress its comments regarding such plan and recommendations.

"(7) MONITORING OF UTILIZATION AND ACCESS.—

"(A) IN GENERAL.—The Secretary shall monitor—

"(i) changes in the utilization of and access to services furnished under this part within geographic, population, and service related categories,

"(ii) possible sources of inappropriate utilization of services furnished under this part which contribute to the overall level of expenditures under this part, and

"(iii) factors underlying these changes and their interrelationships.

"(B) REPORT.—The Secretary shall by not later than April 15, of each year (beginning with 1991) report to the Congress on the changes described in subparagraph (A)(i) and shall include in the report an examination of the factors (including factors relating to different services and specific categories and groups of services and geographic and demographic variations in utilization) which may contribute to such changes.

"(C) RECOMMENDATIONS.—The Secretary shall include in each annual report under subparagraph (B) recommendations—

"(i) addressing any identified patterns of inappropriate utilization,

"(ii) on utilization review,

"(iii) on physician education or patient education,

"(iv) addressing any problems of beneficiary access to care made evident by the monitoring process, and

"(v) on such other matters as the Secretary deems appropriate.

The Physician Payment Review Commission shall comment on the Secretary's recommendations and in developing its comments, the Commission shall convene and consult a panel of physician experts to evaluate the implications of medical utilization patterns for the quality of and access to patient care.

"(h) SENDING INFORMATION TO PHYSICIANS.—Before the beginning of each year (beginning with 1992), the Secretary shall send to each physician furnishing physicians' services under this part, for serv-

ices commonly performed by the physician, information on fee schedule amounts that apply for the year in the fee schedule area for participating and non-participating physicians, and the maximum amount that may be charged consistent with subsection (g)(2). Such information shall be transmitted in conjunction with notices to physicians under section 1842(h) (relating to the participating physician program) for a year.

"(i) MISCELLANEOUS PROVISIONS.—

"(1) RESTRICTION ON ADMINISTRATIVE AND JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869 or otherwise of—

"(A) the determination of the historical payment basis (as defined in subsection (a)(2)(C)(i)),

"(B) the determination of relative values and relative value units under subsection (c),

"(C) the determination of conversion factors under subsection (d),

"(D) the establishment of geographic adjustment factors under subsection (e), and

"(E) the establishment of the system for the coding of physicians' services under this section.

"(j) DEFINITIONS.—In this section:

"(1) CATEGORY.—The term 'category' means, with respect to physicians' services, surgical services, and all physicians' services other than surgical services, and such other category or categories of physicians' services as the Secretary, from time to time, defines in regulation. The Secretary shall define surgical services and publish such definition in the Federal Register no later than May 1, 1990, after consultation with organizations representing physicians.

Federal Register, publication.

"(2) FEE SCHEDULE AREA.—The term 'fee schedule area' means a locality used under section 1842(b) for purposes of computing payment amounts for physicians' services.

"(3) PHYSICIANS' SERVICES.—The term 'physicians' services' includes items and services described in paragraphs (1), (2)(A), (2)(D), (3), and (4) of section 1861(s) (other than clinical diagnostic laboratory tests and such other items and services as the Secretary may specify).

"(4) PRACTICE EXPENSES.—The term 'practice expenses' includes all expenses for furnishing physicians' services, excluding malpractice expenses, physician compensation, and other physician fringe benefits.".

(b) REQUIREMENTS FOR CARRIERS TO PROFILE PHYSICIANS.—Section 1842(b)(3) of such Act (42 U.S.C. 1395u(b)(3)) is amended—

(1) by striking "and" at the end of subparagraph (J),

(2) by inserting "and" at the end of subparagraph (K), and

(3) by inserting after subparagraph (K) the following new subparagraph:

"(L) will monitor and profile physicians' billing patterns within each area or locality and provide comparative data to physicians whose utilization patterns vary significantly from other physicians in the same payment area or locality;".

(c) RURAL AND INNER-CITY ACCESS ADJUSTMENTS.—

(1) ADJUSTMENTS.—Section 1833(m) of such Act (42 U.S.C. 1395l(m)) is amended—

(A) by striking "class 1 or class 2", and

(B) by striking "5 percent" and inserting "10 percent"

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to services furnished on or after January 1, 1991. 42 USC 1395l note.

(d) STUDIES.— 42 USC 1395w-4 note.

(1) GAO STUDY OF ALTERNATIVE PAYMENT METHODOLOGY FOR MALPRACTICE COMPONENT.—The Comptroller General shall provide for—

(A) a study of alternative ways of paying, under section 1848 of the Social Security Act, for the malpractice component for physicians' services, in a manner that would assure, to the extent practicable, payment for medicare's share of malpractice insurance premiums, and

(B) a study to examine alternative resolution procedures for malpractice claims respecting professional services furnished under the medicare program.

The examination under subparagraph (B) shall include review of the feasibility of establishing procedures that involve no-fault payment or that involve mandatory arbitration. By not later than April 1, 1991, the Comptroller General shall submit a report to Congress on the results of the studies. Reports.

(2) STUDY OF PAYMENTS TO RISK-CONTRACTING PLANS.—The Secretary of Health and Human Services (in this subsection referred to as the "Secretary") shall conduct a study of how payments under section 1848 of the Social Security Act may affect payments to eligible organizations with risk-sharing contracts under section 1876 of such Act. By not later than April 1, 1990, the Secretary shall submit a report to Congress on such study and shall include in the report such recommendations for such changes in the methodology for payment under such risk-sharing contracts as the Secretary deems appropriate. Reports.

(3) STUDY OF VOLUME PERFORMANCE STANDARD RATES OF INCREASE BY GEOGRAPHY, SPECIALTY, AND TYPE OF SERVICE.—The Secretary shall conduct a study of the feasibility of establishing, under section 1848(f) of the Social Security Act, separate performance standard rates of increase for services furnished by or within each of the following (including combinations of the following):

(A) Geographic area (such as a region, State, or other area).

(B) Specialty or group of specialties of physicians.

(C) Type of services (such as primary care, services of hospital-based physicians, and other inpatient services).

Such study shall also include the scope of services included within, or excluded from, the rate of increase in expenditure system. By not later than July 1, 1990, the Secretary shall submit a report to Congress on such study and shall include in the report such recommendations respecting the feasibility of establishing separate performance standard rates of increase in expenditures as the Secretary deems appropriate. Reports.

(4) HHS VISIT CODE MODIFICATION STUDY.—The Secretary shall conduct a study of the desirability of including time as a factor in establishing visit codes. By not later than July 1, 1991, the Secretary shall consult with the Physician Payment Review Commission, and submit a report to Congress on such study and shall include in the report recommendations respecting the desirability of modifying the number of visit codes, whether greater coding uniformity would result from including time in visit codes when compared with clarifying the clinical descrip- Reports.

tions of existing codes, and the ability to audit physician time accurately.

(5) COMMISSION STUDY OF PAYMENT FOR PRACTICE EXPENSES.—The Physician Payment Review Commission shall conduct a study of—

(A) the extent to which practice costs and malpractice costs vary by geographic locality (including region, State, Metropolitan Statistical Areas, or other areas and by specialty),

(B) the extent to which available geographic practice-cost indices accurately reflect practice costs and malpractice costs in rural areas,

(C) which geographic units would be most appropriate to use in measuring and adjusting practice costs and malpractice costs,

(D) appropriate methods for allocating malpractice expenses to particular procedures which could be incorporated into the determination of relative values for particular procedures using a consensus panel and other appropriate methodologies,

(E) the effect of alternative methods of allocating malpractice expenses on medicare expenditures by specialty, type of service, and by geographic area, and

(F) the special circumstances of rural independent laboratories in determining the geographic cost-of-practice index.

Reports. By not later than July 1, 1991, the Commission shall submit a report to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate on the study and shall include in the report such recommendations as it deems appropriate.

(6) COMMISSION STUDY OF GEOGRAPHIC PAYMENT AREAS.—The Physician Payment Review Commission shall conduct a study of the feasibility and desirability of using Metropolitan Statistical Areas or other payment areas for purposes of payment for physicians' services under part B of title XVIII of the Social Security Act. By not later than July 1, 1991, the Commission shall submit a report to Congress on such study and shall include in the report recommendations on the desirability of retaining current carrier-wide localities, changing to a system of statewide localities, or adopting Metropolitan Statistical Areas or other payment areas for purposes of payment under such part B.

Reports.

(7) COMMISSION STUDY OF PAYMENT FOR NON-PHYSICIAN PROVIDERS OF MEDICARE SERVICES.—The Physician Payment Review Commission shall conduct a study of the implications of a resource-based fee schedule for physicians' services for non-physician practitioners, such as physician assistants, clinical psychologists, nurse midwives, and other health practitioners whose services can be billed under the medicare program on a fee-for-service basis. The study shall address (A) what the proper level of payment should be for these practitioners, (B) whether or not adjustments to their payments should be subject to the medicare volume performance standard process, and (C) what update to use for services outside the medicare volume performance standard process. The Commission shall submit a report to Congress on such study by not later than July 1, 1991.

Reports.

(8) COMMISSION STUDY OF PHYSICIAN FEES UNDER MEDICAID.—The Physician Payment Review Commission shall conduct a study on physician fees under State medicaid programs established under title XIX of the Social Security Act. The Commission shall specifically examine in such study the adequacy of physician reimbursement under such programs, physician participation in such programs, and access to care by medicaid beneficiaries. By no later than July 1, 1991, the Commission shall submit a report to Congress on such study and shall include such recommendations as the Commission deems appropriate. Reports.

(9) GAO STUDY ON PHYSICIAN ANTI-TRUST ISSUES.—The Comptroller General shall conduct a study of the effect of anti-trust laws on the ability of physicians to act in groups to educate and discipline peers of such physicians in order to reduce and eliminate ineffective practice patterns and inappropriate utilization. The study shall further address anti-trust issues as they relate to the adoption of practice guidelines by third-party payers and the role that practice guidelines might play as a defense in malpractice cases. By no later than July 1, 1991, the Comptroller General shall submit a report to Congress on such study and shall make such recommendations as the Comptroller General deems appropriate. Reports.

(e) MISCELLANEOUS CONFORMING AMENDMENTS.—

(1) REFERENCE TO NEW PAYMENT RULES.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)) is amended—

(A) by striking "and" before clause (M), and

(B) by inserting before the semicolon the following new clause: "and (N) with respect to expenses incurred for physicians' services (as defined in section 1848(j)(3)), the amounts paid shall be 80 percent of the payment basis determined under section 1848(a)(1)".

(2) CHANGING REFERENCE TO MAXIMUM ALLOWABLE ACTUAL CHARGES.—Section 1842(b)(3)(G) of such Act (42 U.S.C. 1395u(b)(3)(G)) is amended by striking "maximum allowable actual charges (established under subsection (j)(1)(C))" and inserting "limiting charges established under subsection (j)(1)(C)".

(3) DIFFERENTIAL FOR PARTICIPATING PHYSICIANS.—Effective for physicians' services furnished on or after January 1, 1992, the first sentence of section 1842(b)(4)(A)(iv) of such Act (42 U.S.C. 1395u(b)(4)(A)(iv)) is amended by inserting "and before January 1, 1992," after "January 1, 1987,". Effective date.

(4) PAYMENT FOR PHYSICIAN ASSISTANTS.—Section 1842(b)(12)(A)(ii)(II) of such Act (42 U.S.C. 1395u(b)(12)(A)(ii)(II)) is amended by inserting "(or, for services furnished on or after January 1, 1992, the fee schedule amount specified in section 1848, as the case may be)" after "prevailing charge rate for such services".

(5) PAYMENT FOR CERTIFIED REGISTERED NURSE ANESTHETISTS.—Section 1833(a)(1)(H) of such Act (42 U.S.C. 1395l(a)(1)(H)) is amended by inserting "(or, for services furnished on or after January 1, 1992, the fee schedule amount provided under section 1848, as the case may be)" after "prevailing charge that would be recognized".

(6) PAYMENT FOR RADIOLOGIST SERVICES.—(A) Section 1833(a)(1)(J) of such Act (42 U.S.C. 1395l(a)(1)(J)) is amended by inserting "subject to section 1848," before "the amounts".

(B) Section 4049(b)(2) of the Omnibus Budget Reconciliation Act of 1987 is amended by striking ", and until" and all that follows through "Social Security Act".

42 USC 1395m note.

(7) PAYMENT FOR NURSE MIDWIVES.—Section 1833(a)(1)(K) of the Social Security Act (42 U.S.C. 1395l(a)(1)(K)) is amended by inserting ", or, for services furnished on or after January 1, 1992, 65 percent of the fee schedule amount provided under section 1848 for the same service performed by a physician" after "for the same service performed by a physician".

(8) PHYSICIANS' SERVICES FOR INDIVIDUALS WITH END STAGE RENAL DISEASE.—Section 1881(b)(3)(A) of such Act (42 U.S.C. 1395rr(b)(3)(A)) is amended by inserting "or, for services furnished on or after January 1, 1992, on the basis described in section 1848" after "comparable services".

(9) EXTENSION OF MAXIMUM ALLOWABLE ACTUAL CHARGE LIMITS.—Subparagraphs (B)(ii) and (D)(v) of section 1842(j)(1) of such Act (42 U.S.C. 1395u(j)(1)) are each amended by striking all that follows "after" the first place it appears and inserting "December 31, 1990.".

42 USC 1395u note.

(10) TREATMENT OF CERTAIN EYE EXAMINATION VISITS AS PRIMARY CARE SERVICES.—In applying section 1842(i)(4) of the Social Security Act for services furnished on or after January 1, 1990, intermediate and comprehensive office visits for eye examinations and treatments (codes 92002 and 92004) shall be considered to be primary care services.

42 USC 1395w-4 note.

(11) DISTRIBUTION OF MODEL FEE SCHEDULE.—By September 1, 1990, the Secretary shall develop a Model Fee Schedule, using the methodology set forth in section 1848 of the Social Security Act. The Model Fee Schedule shall include as many services as the Secretary concludes can be assigned valid relative values. The Secretary shall submit the Model Fee Schedule to the appropriate committees of Congress and make it generally available to the public.

Public information.

(f) PAYMENT FOR PATHOLOGY SERVICES.—

(1) FEE SCHEDULE.—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

"(f) FEE SCHEDULE FOR PHYSICIAN PATHOLOGY SERVICES.—

"(1) APPLICATION.—Subject to section 1848, the Secretary shall provide for application of a fee schedule with respect to physician pathology services. Subject to paragraph (2), such fee schedule shall be based on relative values developed by the Secretary, in consultation with organizations representing physicians performing such services. Such fee schedule shall be designed so as to result in expenditures under this part for services covered under the schedule in an amount that would not exceed the amount of such expenditures which would otherwise occur. In developing such fee schedule the Secretary shall take into account the special circumstances of rural independent laboratories.

"(2) GEOGRAPHIC AREA ADJUSTMENT.—The Secretary shall provide for a geographic area adjustment of the conversion factors in a manner comparable to the geographic area adjustment applied to physicians' services under section 1848 during the year in which the services are furnished.".

(2) PAYMENT ON BASIS OF FEE SCHEDULE.—Section 1833(a)(1)(J) of such Act (42 U.S.C. 1395l(a)(1)(J)) is amended—

(A) by inserting "or physician pathology services" after "1834(b)(6))", and

(B) by inserting "or section 1834(f), respectively" after "1834(b)".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to services furnished on or after January 1, 1991. 42 USC 1395l note.

(g) EFFECTIVE DATE.—Except as otherwise provided in this section, this section, and the amendments made by this section, shall take effect on the date of the enactment of this Act. 42 USC 1395l note.

SEC. 6103. ESTABLISHMENT OF AGENCY FOR HEALTH CARE POLICY AND RESEARCH.

(a) IN GENERAL.—The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by inserting after title VIII the following new title:

"TITLE IX—AGENCY FOR HEALTH CARE POLICY AND RESEARCH

"PART A—ESTABLISHMENT AND GENERAL DUTIES

"SEC. 901. ESTABLISHMENT. 42 USC 299.

"(a) IN GENERAL.—There is established within the Service an agency to be known as the Agency for Health Care Policy and Research.

"(b) PURPOSE.—The purpose of the Agency is to enhance the quality, appropriateness, and effectiveness of health care services, and access to such services, through the establishment of a broad base of scientific research and through the promotion of improvements in clinical practice and in the organization, financing, and delivery of health care services.

"(c) APPOINTMENT OF ADMINISTRATOR.—There shall be at the head of the Agency an official to be known as the Administrator for Health Care Policy and Research. The Administrator shall be appointed by the Secretary. The Secretary, acting through the Administrator, shall carry out the authorities and duties established in this title.

"SEC. 902. GENERAL AUTHORITIES AND DUTIES. 42 USC 299a.

"(a) IN GENERAL.—In carrying out section 901(b), the Administrator shall conduct and support research, demonstration projects, evaluations, training, guideline development, and the dissemination of information, on health care services and on systems for the delivery of such services, including activities with respect to—

"(1) the effectiveness, efficiency, and quality of health care services;

"(2) subject to subsection (d), the outcomes of health care services and procedures;

"(3) clinical practice, including primary care and practice-oriented research;

"(4) health care technologies, facilities, and equipment;

"(5) health care costs, productivity, and market forces;

"(6) health promotion and disease prevention;

"(7) health statistics and epidemiology; and

"(8) medical liability.

"(b) REQUIREMENTS WITH RESPECT TO RURAL AREAS AND UNDERSERVED POPULATIONS.—In carrying out subsection (a), the Administrator shall undertake and support research, demonstration projects, and evaluations with respect to—

"(1) the delivery of health care services in rural areas (including frontier areas); and

"(2) the health of low-income groups, minority groups, and the elderly.

"(c) MULTIDISCIPLINARY CENTERS.—The Administrator may provide financial assistance to public or nonprofit private entities for meeting the costs of planning and establishing new centers, and operating existing and new centers, for multidisciplinary health services research, demonstration projects, evaluations, training, policy analysis, and demonstrations respecting the matters referred to in subsection (b).

"(d) RELATION TO CERTAIN AUTHORITIES REGARDING SOCIAL SECURITY.—Activities authorized in this section may include, and shall be appropriately coordinated with, experiments, demonstration projects, and other related activities authorized by the Social Security Act and the Social Security Amendments of 1967. Activities under subsection (a)(2) of this section that affect the programs under titles XVIII and XIX of the Social Security Act shall be carried out consistent with section 1142 of such Act.

42 USC 299a-1.

"SEC. 903. DISSEMINATION.

"(a) IN GENERAL.—The Administrator shall—

"(1) promptly publish, make available, and otherwise disseminate, in a form understandable and on as broad a basis as practicable so as to maximize its use, the results of research, demonstration projects, and evaluations conducted or supported under this title and the guidelines, standards, and review criteria developed under this title;

Public information.

"(2) promptly make available to the public data developed in such research, demonstration projects, and evaluations;

"(3) provide indexing, abstracting, translating, publishing, and other services leading to a more effective and timely dissemination of information on research, demonstration projects, and evaluations with respect to health care to public and private entities and individuals engaged in the improvement of health care delivery and the general public, and undertake programs to develop new or improved methods for making such information available; and

State and local governments.

"(4) as appropriate, provide technical assistance to State and local government and health agencies and conduct liaison activities to such agencies to foster dissemination.

"(b) PROHIBITION AGAINST RESTRICTIONS.—Except as provided in subsection (c), the Administrator may not restrict the publication or dissemination of data from, or the results of, projects conducted or supported under this title.

"(c) LIMITATION ON USE OF CERTAIN INFORMATION.—No information, if an establishment or person supplying the information or described in it is identifiable, obtained in the course of activities undertaken or supported under this title may be used for any purpose other than the purpose for which it was supplied unless such establishment or person has consented (as determined under regulations of the Secretary) to its use for such other purpose. Such information may not be published or released in other form if the

person who supplied the information or who is described in it is identifiable unless such person has consented (as determined under regulations of the Secretary) to its publication or release in other form.

"(d) CERTAIN INTERAGENCY AGREEMENT.—The Administrator and the Director of the National Library of Medicine shall enter into an agreement providing for the implementation of subsection (a)(3). Contracts.

"SEC. 904. HEALTH CARE TECHNOLOGY AND TECHNOLOGY ASSESSMENT. 42 USC 299a-2.

"(a) IN GENERAL.—In carrying out section 901(b), the Administrator shall promote the development and application of appropriate health care technology assessments—

"(1) by identifying needs in, and establishing priorities for, the assessment of specific health care technologies;

"(2) by developing and evaluating criteria and methodologies for health care technology assessment;

"(3) by conducting and supporting research on the development and diffusion of health care technology;

"(4) by conducting and supporting research on assessment methodologies; and

"(5) by promoting education, training, and technical assistance in the use of health care technology assessment methodologies and results.

"(b) SPECIFIC ASSESSMENTS.—

"(1) IN GENERAL.—In carrying out section 901(b), the Administrator shall conduct and support specific assessments of health care technologies.

"(2) CONSIDERATION OF CERTAIN FACTORS.—In carrying out paragraph (1), the Administrator shall consider the safety, efficacy, and effectiveness, and, as appropriate, the cost-effectiveness, legal, social, and ethical implications, and appropriate uses of such technologies, including consideration of geographic factors.

"(c) INFORMATION CENTER.—

"(1) IN GENERAL.—There shall be established at the National Library of Medicine an information center on health care technologies and health care technology assessment. Establishment.

"(2) INTERAGENCY AGREEMENT.—The Administrator and the Director of the National Library of Medicine shall enter into an agreement providing for the implementation of paragraph (1). Contracts.

"(d) RECOMMENDATIONS WITH RESPECT TO HEALTH CARE TECHNOLOGY.—

"(1) IN GENERAL.—The Administrator shall make recommendations to the Secretary with respect to whether specific health care technologies should be reimbursable under federally financed health programs, including recommendations with respect to any conditions and requirements under which any such reimbursements should be made.

"(2) CONSIDERATION OF CERTAIN FACTORS.—In making recommendations respecting health care technologies, the Administrator shall consider the safety, efficacy, and effectiveness, and, as appropriate, the cost-effectiveness and appropriate uses of such technologies.

"(3) CONSULTATIONS.—In carrying out this subsection, the Administrator shall cooperate and consult with the Director of the National Institutes of Health, the Commissioner of Food

and Drugs, and the heads of any other interested Federal department or agency.

"PART B—FORUM FOR QUALITY AND EFFECTIVENESS IN HEALTH CARE

42 USC 299b. "SEC. 911. ESTABLISHMENT OF OFFICE.

"There is established within the Agency an office to be known as the Office of the Forum for Quality and Effectiveness in Health Care. The office shall be headed by a director, who shall be appointed by the Administrator.

42 USC 299b-1. "SEC. 912. DUTIES.

"(a) ESTABLISHMENT OF FORUM PROGRAM.—The Administrator, acting through the Director, shall establish a program to be known as the Forum for Quality and Effectiveness in Health Care. For the purpose of promoting the quality, appropriateness, and effectiveness of health care, the Director, using the process set forth in section 913, shall arrange for the development and periodic review and updating of—

"(1) clinically relevant guidelines that may be used by physicians, educators, and health care practitioners to assist in determining how diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically; and

"(2) standards of quality, performance measures, and medical review criteria through which health care providers and other appropriate entities may assess or review the provision of health care and assure the quality of such care.

"(b) CERTAIN REQUIREMENTS.—Guidelines, standards, performance measures, and review criteria under subsection (a) shall—

"(1) be based on the best available research and professional judgment regarding the effectiveness and appropriateness of health care services and procedures;

"(2) be presented in formats appropriate for use by physicians, health care practitioners, providers, medical educators, and medical review organizations and in formats appropriate for use by consumers of health care; and

"(3) include treatment-specific or condition-specific practice guidelines for clinical treatments and conditions in forms appropriate for use in clinical practice, for use in educational programs, and for use in reviewing quality and appropriateness of medical care.

"(c) AUTHORITY FOR CONTRACTS.—In carrying out this part, the Director may enter into contracts with public or nonprofit private entities.

"(d) DATE CERTAIN FOR INITIAL GUIDELINES AND STANDARDS.—The Administrator, by not later than January 1, 1991, shall assure the development of an initial set of guidelines, standards, performance measures, and review criteria under subsection (a) that includes not less than 3 clinical treatments or conditions described in section 1142(a)(3) of the Social Security Act.

"(e) RELATIONSHIP WITH MEDICARE PROGRAM.—To assure an appropriate reflection of the needs and priorities of the program under title XVIII of the Social Security Act, activities under this part that affect such program shall be conducted consistent with section 1142 of such Act.

"SEC. 913. PROCESS FOR DEVELOPMENT OF GUIDELINES AND STANDARDS. 42 USC 299b-2.

"(a) DEVELOPMENT THROUGH CONTRACTS AND PANELS.—The Director shall—

"(1) enter into contracts with public and nonprofit private entities for the purpose of developing and periodically reviewing and updating the guidelines, standards, performance measures, and review criteria described in section 912(a); and

"(2) convene panels of appropriately qualified experts (including practicing physicians with appropriate expertise) and health care consumers for the purpose of—

"(A) developing and periodically reviewing and updating the guidelines, standards, performance measures, and review criteria described in section 912(a); and

"(B) reviewing the guidelines, standards, performance measures, and review criteria developed under contracts under paragraph (1).

"(b) AUTHORITY FOR ADDITIONAL PANELS.—The Director may convene panels of appropriately qualified experts (including practicing physicians with appropriate expertise) and health care consumers for the purpose of—

"(1) developing the standards and criteria described in section 914(b); and

"(2) providing advice to the Administrator and the Director with respect to any other activities carried out under this part or under section 902(a)(2).

"(c) SELECTION OF PANEL MEMBERS.—In selecting individuals to serve on panels convened under this section, the Director shall consult with a broad range of interested individuals and organizations, including organizations representing physicians in the general practice of medicine and organizations representing physicians in specialties and subspecialties pertinent to the purposes of the panel involved. The Director shall seek to appoint physicians reflecting a variety of practice settings.

"SEC. 914. ADDITIONAL REQUIREMENTS. 42 USC 299b-3.

"(a) PROGRAM AGENDA.—

"(1) IN GENERAL.—The Administrator shall provide for an agenda for the development of the guidelines, standards, performance measures, and review criteria described in section 912(a), including—

"(A) with respect to the guidelines, identifying specific diseases, disorders, and other health conditions for which the guidelines are to be developed and those that are to be given priority in the development of the guidelines; and

"(B) with respect to the standards, performance measures, and review criteria, identifying specific aspects of health care for which the standards, performance measures, and review criteria are to be developed and those that are to be given priority in the development of the standards, performance measures, and review criteria.

"(2) CONSIDERATION OF CERTAIN FACTORS IN ESTABLISHING PRIORITIES.—

"(A) Factors considered by the Administrator in establishing priorities for purposes of paragraph (1) shall include consideration of the extent to which the guidelines,

standards, performance measures, and review criteria involved can be expected—

"(i) to improve methods of prevention, diagnosis, treatment, and clinical management for the benefit of a significant number of individuals;

"(ii) to reduce clinically significant variations among physicians in the particular services and procedures utilized in making diagnoses and providing treatments; and

"(iii) to reduce clinically significant variations in the outcomes of health care services and procedures.

"(B) In providing for the agenda required in paragraph (1), including the priorities, the Administrator shall consult with the Administrator of the Health Care Financing Administration and otherwise act consistent with section 1142(b)(3) of the Social Security Act.

"(b) STANDARDS AND CRITERIA.—

"(1) PROCESS FOR DEVELOPMENT, REVIEW, AND UPDATING.—The Director shall establish standards and criteria to be utilized by the recipients of contracts under section 913, and by the expert panels convened under such section, with respect to the development and periodic review and updating of the guidelines, standards, performance measures, and review criteria described in section 912(a).

"(2) AWARD OF CONTRACTS.—The Director shall establish standards and criteria to be utilized for the purpose of ensuring that contracts entered into for the development or periodic review or updating of the guidelines, standards, performance measures, and review criteria described in section 912(a) will be entered into only with appropriately qualified entities.

"(3) CERTAIN REQUIREMENTS FOR STANDARDS AND CRITERIA.—The Director shall ensure that the standards and criteria established under paragraphs (1) and (2) specify that—

"(A) appropriate consultations with interested individuals and organizations are to be conducted in the development of the guidelines, standards, performance measures, and review criteria described in section 912(a); and

"(B) such development may be accomplished through the adoption, with or without modification, of guidelines, standards, performance measures, and review criteria that—

"(i) meet the requirements of this part; and

"(ii) are developed by entities independently of the program established in this part.

"(4) IMPROVEMENTS OF STANDARDS AND CRITERIA.—The Director shall conduct and support research with respect to improving the standards and criteria developed under this subsection.

"(c) DISSEMINATION.—The Director shall promote and support the dissemination of the guidelines, standards, performance measures, and review criteria described in section 912(a). Such dissemination shall be carried out through organizations representing health care providers, organizations representing health care consumers, peer review organizations, accrediting bodies, and other appropriate entities.

"(d) PILOT TESTING.—The Director may conduct or support pilot testing of the guidelines, standards, performance measures, and review criteria developed under section 912(a). Any such pilot test-

ing may be conducted prior to, or concurrently with, their dissemination under subsection (c).

"(e) EVALUATIONS.—The Director shall conduct and support evaluations of the extent to which the guidelines, standards, performance standards, and review criteria developed under section 912 have had an effect on the clinical practice of medicine.

"(f) RECOMMENDATIONS TO ADMINISTRATOR.—The Director shall make recommendations to the Administrator on activities that should be carried out under section 902(a)(2) and under section 1142 of the Social Security Act, including recommendations of particular research projects that should be carried out with respect to—

"(1) evaluating the outcomes of health care services and procedures;

"(2) developing the standards and criteria required in subsection (b); and

"(3) promoting the utilization of the guidelines, standards, performance standards, and review criteria developed under section 912(a).".

(b) OUTCOMES OF HEALTH CARE SERVICES AND PROCEDURES.—

(1) ESTABLISHMENT OF PROGRAM OF RESEARCH.—Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following new section:

"RESEARCH ON OUTCOMES OF HEALTH CARE SERVICES AND PROCEDURES

"SEC. 1142. (a) ESTABLISHMENT OF PROGRAM.— 42 USC 1320b-12.

"(1) IN GENERAL.—The Secretary, acting through the Administrator for Health Care Policy and Research, shall—

"(A) conduct and support research with respect to the outcomes, effectiveness, and appropriateness of health care services and procedures in order to identify the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically; and

"(B) assure that the needs and priorities of the program under title XVIII are appropriately reflected in the development and periodic review and updating (through the process set forth in section 913 of the Public Health Service Act) of treatment-specific or condition-specific practice guidelines for clinical treatments and conditions in forms appropriate for use in clinical practice, for use in educational programs, and for use in reviewing quality and appropriateness of medical care.

"(2) EVALUATIONS OF ALTERNATIVE SERVICES AND PROCEDURES.—In carrying out paragraph (1), the Secretary shall conduct or support evaluations of the comparative effects, on health and functional capacity, of alternative services and procedures utilized in preventing, diagnosing, treating, and clinically managing diseases, disorders, and other health conditions.

"(3) INITIAL GUIDELINES.—

"(A) In carrying out paragraph (1)(B) of this subsection, and section 912(d) of the Public Health Service Act, the Secretary shall, by not later than January 1, 1991, assure the development of an initial set of the guidelines specified in paragraph (1)(B) that shall include not less than 3 clinical treatments or conditions that—

"(i)(I) account for a significant portion of expenditures under title XVIII; and

"(II) have a significant variation in the frequency or the type of treatment provided; or

Reports.

"(ii) otherwise meet the needs and priorities of the program under title XVIII, as set forth under subsection (b)(3).

"(B)(i) The Secretary shall provide for the use of guidelines developed under subparagrah (A) to improve the quality, effectiveness, and appropriateness of care provided under title XVIII. The Secretary shall determine the impact of such use on the quality, appropriateness, effectiveness, and cost of medical care provided under such title and shall report to the Congress on such determination by not later than January 1, 1993.

"(ii) For the purpose of carrying out clause (i), the Secretary shall expend, from the amounts specified in clause (iii), $1,000,000 for fiscal year 1990 and $1,500,000 for each of the fiscal years 1991 and 1992.

"(iii) For each fiscal year, for purposes of expenditures required in clause (ii)—

"(I) 60 percent of an amount equal to the expenditure involved is appropriated from the Federal Hospital Insurance Trust Fund (established under section 1817); and

"(II) 40 percent of an amount equal to the expenditure involved is appropriated from the Federal Supplementary Medical Insurance Trust Fund (established under section 1841).

"(b) PRIORITIES.—

"(1) IN GENERAL.—The Secretary shall establish priorities with respect to the diseases, disorders, and other health conditions for which research and evaluations are to be conducted or supported under subsection (a). In establishing such priorities, the Secretary shall, with respect to a disease, disorder, or other health condition, consider the extent to which—

"(A) improved methods of prevention, diagnosis, treatment, and clinical management can benefit a significant number of individuals;

"(B) there is significant variation among physicians in the particular services and procedures utilized in making diagnoses and providing treatments or there is significant variation in the outcomes of health care services or procedures due to different patterns of diagnosis or treatment;

"(C) the services and procedures utilized for diagnosis and treatment result in relatively substantial expenditures; and

"(D) the data necessary for such evaluations are readily available or can readily be developed.

"(2) PRELIMINARY ASSESSMENTS.—For the purpose of establishing priorities under paragraph (1), the Secretary may, with respect to services and procedures utilized in preventing, diagnosing, treating, and clinically managing diseases, disorders, and other health conditions, conduct or support assessments of the extent to which—

"(A) rates of utilization vary among similar populations for particular diseases, disorders, and other health conditions;

"(B) uncertainties exist on the effect of utilizing a particular service or procedure; or

"(C) inappropriate services and procedures are provided.

"(3) RELATIONSHIP WITH MEDICARE PROGRAM.—In establishing priorities under paragraph (1) for research and evaluation, and under section 914(a) of the Public Health Service Act for the agenda under such section, the Secretary shall assure that such priorities appropriately reflect the needs and priorities of the program under title XVIII, as set forth by the Administrator of the Health Care Financing Administration.

"(c) METHODOLOGIES AND CRITERIA FOR EVALUATIONS.—For the purpose of facilitating research under subsection (a), the Secretary shall—

"(1) conduct and support research with respect to the improvement of methodologies and criteria utilized in conducting research with respect to outcomes of health care services and procedures;

"(2) conduct and support reviews and evaluations of existing research findings with respect to such treatment or conditions;

"(3) conduct and support reviews and evaluations of the existing methodologies that use large data bases in conducting such research and shall develop new research methodologies, including data-based methods of advancing knowledge and methodologies that measure clinical and functional status of patients, with respect to such research;

"(4) provide grants and contracts to research centers, and contracts to other entities, to conduct such research on such treatment or conditions, including research on the appropriate use of prescription drugs; Grants. Contracts.

"(5) conduct and support research and demonstrations on the use of claims data and data on clinical and functional status of patients in determining the outcomes, effectiveness, and appropriateness of such treatment; and

"(6) conduct and support supplementation of existing data bases, including the collection of new information, to enhance data bases for research purposes, and the design and development of new data bases that would be used in outcomes and effectiveness research.

"(d) STANDARDS FOR DATA BASES.—In carrying out this section, the Secretary shall develop—

"(1) uniform definitions of data to be collected and used in describing a patient's clinical and functional status;

"(2) common reporting formats and linkages for such data; and

"(3) standards to assure the security, confidentiality, accuracy, and appropriate maintenance of such data.

"(e) DISSEMINATION OF RESEARCH FINDINGS AND GUIDELINES.— Education.

"(1) IN GENERAL.—The Secretary shall provide for the dissemination of the findings of research and the guidelines described in subsection (a), and for the education of providers and others in the application of such research findings and guidelines.

"(2) COOPERATIVE EDUCATIONAL ACTIVITIES.—In disseminating findings and guidelines under paragraph (1), and in providing for education under such paragraph, the Secretary shall work with professional associations, medical specialty and subspecialty organizations, and other relevant groups to identify and implement effective means to educate physicians, other

providers, consumers, and others in using such findings and guidelines, including training for physician managers within provider organizations.

"(f) EVALUATIONS.—The Secretary shall conduct and support evaluations of the activities carried out under this section to determine the extent to which such activities have had an effect on the practices of physicians in providing medical treatment, the delivery of health care, and the outcomes of health care services and procedures.

"(g) RESEARCH WITH RESPECT TO DISSEMINATION.—The Secretary may conduct or support research with respect to improving methods of disseminating information on the effectiveness and appropriateness of health care services and procedures.

"(h) REPORT TO CONGRESS.—Not later than February 1 of each of the years 1991 and 1992, and of each second year thereafter, the Secretary shall report to the Congress on the progress of the activities under this section during the preceding fiscal year (or preceding 2 fiscal years, as appropriate), including the impact of such activities on medical care (particularly medical care for individuals receiving benefits under title XVIII).

"(i) AUTHORIZATION OF APPROPRIATIONS.—

"(1) IN GENERAL.—There are authorized to be appropriated to carry out this section—

"(A) $50,000,000 for fiscal year 1990;

"(B) $75,000,000 for fiscal year 1991;

"(C) $110,000,000 for fiscal year 1992;

"(D) $148,000,000 for fiscal year 1993; and

"(E) $185,000,000 for fiscal year 1994.

"(2) SPECIFICATIONS.—For the purpose of carrying out this section, for each of the fiscal years 1990 through 1992 an amount equal to two-thirds of the amounts authorized to be appropriated under paragraph (1), and for each of the fiscal years 1993 and 1994 an amount equal to 70 percent of such amounts, are to be appropriated in the following proportions from the following trust funds:

"(A) 60 percent from the Federal Hospital Insurance Trust Fund (established under section 1817).

"(B) 40 percent from the Federal Supplementary Medical Insurance Trust Fund (established under section 1841).

"(3) ALLOCATIONS.—

"(A) For each fiscal year, of the amounts transferred or otherwise appropriated to carry out this section, the Secretary shall reserve appropriate amounts for each of the purposes specified in clauses (i) through (iv) of subparagraph (B).

"(B) The purposes referred to in subparagraph (A) are—

"(i) the development of guidelines, standards, performance measures, and review criteria;

"(ii) research and evaluation;

"(iii) data-base standards and development; and

"(iv) education and information dissemination.".

42 USC 1320b-12 note.

(2) REPORT ON LINKAGE OF PUBLIC AND PRIVATE RESEARCH RELATED DATA.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall report to the Congress on the feasibility of linking research-related data described in section 1142(d) of the Social Security Act (as added by paragraph (1) of this subsection) with

similar data collected or maintained by non-Federal entities and by Federal agencies other than the Department of Health and Human Services (including the Departments of Defense and Veterans Affairs and the Office of Personnel Management).

(3) TECHNICAL AND CONFORMING PROVISIONS.—

(A) Effective for fiscal years beginning after fiscal year 1990, subsection (c) of section 1875 of the Social Security Act (42 U.S.C. 1395ll) is repealed.

(B) Section 1862(a)(1)(E) of the Social Security Act (42 U.S.C. 1395y(a)(1)(E)) is amended by striking "section 1875(c)" and inserting "section 1142".

(c) ADDITIONAL AUTHORITIES AND DUTIES WITH RESPECT TO AGENCY FOR HEALTH CARE POLICY AND RESEARCH.—Title IX of the Public Health Service Act, as added by subsection (a) of this section, is amended by adding at the end the following new part:

"PART C—GENERAL PROVISIONS

"SEC. 921. ADVISORY COUNCIL FOR HEALTH CARE POLICY, RESEARCH, AND EVALUATION. 42 USC 299c.

"(a) ESTABLISHMENT.—There is established an advisory council to be known as the National Advisory Council for Health Care Policy, Research, and Evaluation.

"(b) DUTIES.—

"(1) IN GENERAL.—The Council shall advise the Secretary and the Administrator with respect to activities to carry out the purpose of the Agency under section 901(b).

"(2) CERTAIN RECOMMENDATIONS.—Activities of the Council under paragraph (1) shall include making recommendations to the Administrator regarding priorities for a national agenda and strategy for—

"(A) the conduct of research, demonstration projects, and evaluations with respect to health care, including clinical practice and primary care;

"(B) the development and application of appropriate health care technology assessments;

"(C) the development and periodic review and updating of guidelines for clinical practice, standards of quality, performance measures, and medical review criteria with respect to health care; and

"(D) the conduct of research on outcomes of health care services and procedures.

"(c) MEMBERSHIP.—

"(1) IN GENERAL.—The Council shall, in accordance with this subsection, be composed of appointed members and ex officio members. All members of the Council shall be voting members, other than officials designated under paragraph (3)(B) as ex officio members of the Council.

"(2) APPOINTED MEMBERS.—The Secretary shall appoint to the Council 17 appropriately qualified representatives of the public who are not officers or employees of the United States. The Secretary shall ensure that the appointed members of the Council, as a group, are representative of professions and entities concerned with, or affected by, activities under this title and

under section 1142 of the Social Security Act. Of such members—

"(A) 8 shall be individuals distinguished in the conduct of research, demonstration projects, and evaluations with respect to health care;

"(B) 3 shall be individuals distinguished in the practice of medicine;

"(C) 2 shall be individuals distinguished in the health professions;

"(D) 2 shall be individuals distinguished in the fields of business, law, ethics, economics, and public policy; and

"(E) 2 shall be individuals representing the interests of consumers of health care.

"(3) EX OFFICIO MEMBERS.—The Secretary shall designate as ex officio members of the Council—

"(A) the Director of the National Institutes of Health, the Director of the Centers for Disease Control, the Administrator of the Health Care Financing Administration, the Assistant Secretary of Defense (Health Affairs), the Chief Medical Officer of the Department of Veterans Affairs; and

"(B) such other Federal officials as the Secretary may consider appropriate.

"(d) SUBCOUNCIL ON OUTCOMES AND GUIDELINES.—

"(1) ESTABLISHMENT.—For the purpose of carrying out the duties specified in subparagraphs (C) and (D) of subsection (b)(2), the Secretary shall establish a subcouncil of the Council and shall designate the membership of the subcouncil in accordance with paragraph (2).

"(2) MEMBERSHIP.—The subcouncil established pursuant to paragraph (1) shall consist of—

"(A) 6 individuals from among the individuals appointed to the Council under subparagraphs (A) through (C) of subsection (c)(2);

"(B) 2 individuals from among the individuals appointed to the Council under subparagraphs (D) and (E) of such subsection; and

"(C) each of the officials designated as ex officio members of the Council under subsection (c)(3)(A).

"(e) TERMS.—

"(1) IN GENERAL.—Except as provided in paragraph (2), members of the Council appointed under subsection (c)(2) shall serve for a term of 3 years.

"(2) STAGGERED ROTATION.—Of the members first appointed to the Council under subsection (c)(2), the Secretary shall appoint 6 members to serve for a term of 3 years, 6 members to serve for a term of 2 years, and 5 members to serve for a term of 1 year.

"(3) SERVICE BEYOND TERM.—A member of the Council appointed under subsection (c)(2) may continue to serve after the expiration of the term of the member until a successor is appointed.

"(f) VACANCIES.—If a member of the Council appointed under subsection (c)(2) does not serve the full term applicable under subsection (e), the individual appointed to fill the resulting vacancy shall be appointed for the remainder of the term of the predecessor of the individual.

"(g) CHAIR.—The Administrator shall, from among the members of the Council appointed under subsection (c)(2), designate an individual to serve as the chair of the Council.

"(h) MEETINGS.—The Council shall meet not less than once during each discrete 4-month period and shall otherwise meet at the call of the Administrator or the chair.

"(i) COMPENSATION AND REIMBURSEMENT OF EXPENSES.—

"(1) APPOINTED MEMBERS.—Members of the Council appointed under subsection (c)(2) shall receive compensation for each day (including traveltime) engaged in carrying out the duties of the Council. Such compensation may not be in an amount in excess of the maximum rate of basic pay payable for GS-18 of the General Schedule.

"(2) EX OFFICIO MEMBERS.—Officials designated under subsection (c)(3) as ex officio members of the Council may not receive compensation for service on the Council in addition to the compensation otherwise received for duties carried out as officers of the United States.

"(j) STAFF.—The Administrator shall provide to the Council such staff, information, and other assistance as may be necessary to carry out the duties of the Council.

"(k) DURATION.—Notwithstanding section 14(a) of the Federal Advisory Committee Act, the Council shall continue in existence until otherwise provided by law.

"SEC. 922. PEER REVIEW WITH RESPECT TO GRANTS AND CONTRACTS. 42 USC 299c-1.

"(a) REQUIREMENT OF REVIEW.—

"(1) IN GENERAL.—Appropriate technical and scientific peer review shall be conducted with respect to each application for a grant, cooperative agreement, or contract under this title.

"(2) REPORTS TO ADMINISTRATOR.—Each peer review group to which an application is submitted pursuant to paragraph (1) shall report its finding and recommendations respecting the application to the Administrator in such form and in such manner as the Administrator shall require.

"(b) APPROVAL AS PRECONDITION OF AWARDS.—The Administrator may not approve an application described in subsection (a)(1) unless the application is recommended for approval by a peer review group established under subsection (c).

"(c) ESTABLISHMENT OF PEER REVIEW GROUPS.—

"(1) IN GENERAL.—The Administrator shall establish such technical and scientific peer review groups as may be necessary to carry out this section. Such groups shall be established without regard to the provisions of title 5, United States Code, that govern appointments in the competitive service, and without regard to the provisions of chapter 51, and subchapter III of chapter 53, of such title that relate to classification and pay rates under the General Schedule.

"(2) MEMBERSHIP.—The members of any peer review group established under this section shall be appointed from among individuals who are not officers or employees of the United States and who by virtue of their training or experience are eminently qualified to carry out the duties of such peer review group.

"(3) DURATION.—Notwithstanding section 14(a) of the Federal Advisory Committee Act, peer review groups established under

this section shall continue in existence until otherwise provided by law.

"(d) CATEGORIES OF REVIEW.—

"(1) IN GENERAL.—With respect to technical and scientific peer review under this section, such review of applications with respect to research, demonstration projects, or evaluations shall be conducted by different peer review groups than the peer review groups that conduct such review of applications with respect to dissemination activities or the development of research agendas (including conferences, workshops, and meetings).

"(2) AUTHORITY FOR PROCEDURAL ADJUSTMENTS IN CERTAIN CASES.—In the case of applications described in subsection (a)(1) for financial assistance whose direct costs will not exceed $50,000, the Administrator may make appropriate adjustments in the procedures otherwise established by the Administrator for the conduct of peer review under this section. Such adjustments may be made for the purpose of encouraging the entry of individuals into the field of research, for the purpose of encouraging clinical practice-oriented research, and for such other purposes as the Administrator may determine to be appropriate.

"(e) REGULATIONS.—The Secretary shall issue regulations for the conduct of peer review under this section.

42 USC 299c-2.

"SEC. 923. CERTAIN PROVISIONS WITH RESPECT TO DEVELOPMENT, COLLECTION, AND DISSEMINATION OF DATA.

"(a) STANDARDS WITH RESPECT TO UTILITY OF DATA.—

"(1) IN GENERAL.—With respect to data developed or collected by any entity for the purpose described in section 901(b), the Administrator shall, in order to assure the utility, accuracy, and sufficiency of such data for all interested entities, establish guidelines for uniform methods of developing and collecting such data. Such guidelines shall include specifications for the development and collection of data on the outcomes of health care services and procedures.

"(2) RELATIONSHIP WITH MEDICARE PROGRAM.—In any case where guidelines under paragraph (1) may affect the administration of the program under title XVIII of the Social Security Act, the guidelines shall be in the form of recommendations to the Secretary for such program.

"(b) STATISTICS.—The Administrator shall—

"(1) take such action as may be necessary to assure that statistics developed under this title are of high quality, timely, and comprehensive, as well as specific, standardized, and adequately analyzed and indexed; and

"(2) publish, make available, and disseminate such statistics on as wide a basis as is practicable.

42 USC 299c-3.

"SEC. 924. ADDITIONAL PROVISIONS WITH RESPECT TO GRANTS AND CONTRACTS.

"(a) REQUIREMENT OF APPLICATION.—The Administrator may not, with respect to any program under this title authorizing the provision of grants, cooperative agreements, or contracts, provide any such financial assistance unless an application for the assistance is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances,

and information as the Administrator determines to be necessary to carry out the program involved.

"(b) PROVISION OF SUPPLIES AND SERVICES IN LIEU OF FUNDS.—

"(1) IN GENERAL.—Upon the request of an entity receiving a grant, cooperative agreement, or contract under this title, the Secretary may, subject to paragraph (2), provide supplies, equipment, and services for the purpose of aiding the entity in carrying out the project involved and, for such purpose, may detail to the entity any officer or employee of the Department of Health and Human Services.

"(2) CORRESPONDING REDUCTION IN FUNDS.—With respect to a request described in paragraph (1), the Secretary shall reduce the amount of the financial assistance involved by an amount equal to the costs of detailing personnel and the fair market value of any supplies, equipment, or services provided by the Administrator. The Secretary shall, for the payment of expenses incurred in complying with such request, expend the amounts withheld.

"(c) APPLICABILITY OF CERTAIN PROVISIONS WITH RESPECT TO CONTRACTS.—Contracts may be entered into under this part without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

"SEC. 925. CERTAIN ADMINISTRATIVE AUTHORITIES. 42 USC 299c-4.

"(a) DEPUTY ADMINISTRATOR AND OTHER OFFICERS AND EMPLOYEES.—

"(1) DEPUTY ADMINISTRATOR.—The Administrator may appoint a deputy administrator for the Agency.

"(2) OTHER OFFICERS AND EMPLOYEES.—The Administrator may appoint and fix the compensation of such officers and employees as may be necessary to carry out this title. Except as otherwise provided by law, such officers and employees shall be appointed in accordance with the civil service laws and their compensation fixed in accordance with title 5, United States Code.

"(b) FACILITIES.—The Secretary, in carrying out this title— District of Columbia.

"(1) may acquire, without regard to the Act of March 3, 1877 (40 U.S.C. 34), by lease or otherwise through the Administrator of General Services, buildings or portions of buildings in the District of Columbia or communities located adjacent to the District of Columbia for use for a period not to exceed 10 years; and

"(2) may acquire, construct, improve, repair, operate, and maintain laboratory, research, and other necessary facilities and equipment, and such other real or personal property (including patents) as the Secretary deems necessary.

"(c) PROVISION OF FINANCIAL ASSISTANCE.—The Administrator, in carrying out this title, may make grants to, and enter into cooperative agreements with, public and nonprofit private entities and individuals, and when appropriate, may enter into contracts with public and private entities and individuals. Grants. Contracts.

"(d) UTILIZATION OF CERTAIN PERSONNEL AND RESOURCES.—

"(1) DEPARTMENT OF HEALTH AND HUMAN SERVICES.—The Administrator, in carrying out this title, may utilize personnel and equipment, facilities, and other physical resources of the Department of Health and Human Services, permit appropriate (as determined by the Secretary) entities and individuals to

utilize the physical resources of such Department, and provide technical assistance and advice.

"(2) OTHER AGENCIES.—The Administrator, in carrying out this title, may use, with their consent, the services, equipment, personnel, information, and facilities of other Federal, State, or local public agencies, or of any foreign government, with or without reimbursement of such agencies.

"(e) CONSULTANTS.—The Secretary, in carrying out this title, may secure, from time to time and for such periods as the Administrator deems advisable but in accordance with section 3109 of title 5, United States Code, the assistance and advice of consultants from the United States or abroad.

"(f) EXPERTS.—

"(1) IN GENERAL.—The Secretary may, in carrying out this title, obtain the services of not more than 50 experts or consultants who have appropriate scientific or professional qualifications. Such experts or consultants shall be obtained in accordance with section 3109 of title 5, United States Code, except that the limitation in such section on the duration of service shall not apply.

"(2) TRAVEL EXPENSES.—

"(A) Experts and consultants whose services are obtained under paragraph (1) shall be paid or reimbursed for their expenses associated with traveling to and from their assignment location in accordance with sections 5724, 5724a(a)(1), 5724a(a)(3), and 5726(c) of title 5, United States Code.

"(B) Expenses specified in subparagraph (A) may not be allowed in connection with the assignment of an expert or consultant whose services are obtained under paragraph (1) unless and until the expert agrees in writing to complete the entire period of assignment, or one year, whichever is shorter, unless separated or reassigned for reasons that are beyond the control of the expert or consultant and that are acceptable to the Secretary. If the expert or consultant violates the agreement, the money spent by the United States for the expenses specified in subparagraph (A) is recoverable from the expert or consultant as a debt of the United States. The Secretary may waive in whole or in part a right of recovery under this subparagraph.

"(g) VOLUNTARY AND UNCOMPENSATED SERVICES.—The Administrator, in carrying out this title, may accept voluntary and uncompensated services.

42 USC 299c-5.

"SEC. 926. FUNDING.

"(a) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this title, there are authorized to be appropriated $35,000,000 for fiscal year 1990, $50,000,000 for fiscal year 1991, and $70,000,000 for fiscal year 1992.

"(b) EVALUATIONS.—In addition to amounts available pursuant to subsection (a) for carrying out this title, there shall be made available for such purpose, from the amounts made available pursuant to section 2611 of this Act (relating to evaluations), an amount equal to 40 percent of the maximum amount authorized in such section 2611 to be made available.

42 USC 299c-6.

"SEC. 927. DEFINITIONS.

"For purposes of this title:

"(1) The term 'Administrator' means the Administrator for Health Care Policy and Research.

"(2) The term 'Agency' means the Agency for Health Care Policy and Research.

"(3) The term 'Council' means the National Advisory Council on Health Care Policy, Research, and Evaluation.

"(4) The term 'Director' means the Director of the Office of the Forum for Quality and Effectiveness in Health Care.".

(d) GENERAL PROVISIONS.—

(1) TERMINATIONS.—

(A) The National Center for Health Services Research and Health Care Technology Assessment is terminated, and part A of title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by striking section 305. 42 USC 242c note. 42 USC 242c.

(B) The council on health care technology established under section 309 of the Public Health Service Act is terminated, and part A of title III of such Act is amended by striking section 309. 42 USC 242n note. 42 USC 242n.

(2) CONTRACT FOR TEMPORARY ASSISTANCE TO SECRETARY WITH RESPECT TO HEALTH CARE TECHNOLOGY ASSESSMENT.— 42 USC 299a-2 note.

(A) The Secretary of Health and Human Services shall request the Institute of Medicine of the National Academy of Sciences to enter into a contract—

(i) to develop and recommend to the Secretary priorities for the assessment of specific health care technologies under section 904 of the Public Health Service Act (as added by subsection (a) of this section); and

(ii) to assist the Administrator for Health Care Policy and Research, and the Director of the National Library of Medicine, in establishing the information center required under subsection (c)(1) of such section 904.

(B) In carrying out section 904(c)(1) of the Public Health Service Act (as added by subsection (a) of this section), the Secretary of Health and Human Services shall, as appropriate, provide for the transfer to the Secretary of any information and materials developed by the council on health care technology under section 309(c)(1)(A) of the Public Health Service Act (as such section was in effect on the day before the effective date of this section).

(C) The Secretary of Health and Human Services shall ensure that the contract under subparagraph (A) specifies that the activities described in clauses (i) and (ii) of such subparagraph shall be completed not later than 1 year after the date on which the Secretary enters into the contract.

(D) For the purpose of carrying out the contract under subparagraph (A), there is authorized to be appropriated $300,000 for fiscal year 1990. Appropriation authorization.

(e) TECHNICAL AND CONFORMING AMENDMENTS.—

(1) SECTION 304.—Section 304 of the Public Health Service Act (42 U.S.C. 242b) is amended—

(A) in subsection (a)—

(i) by striking paragraphs (1) and (2); and

(ii) by striking the paragraph designation in paragraph (3);

(B) in subsection (a) (as amended by subparagraph (A) of this paragraph)—

(i) by striking "the National Center for Health Services Research and Health Care Technology Assessment" and inserting "the Agency for Health Care Policy and Research"; and

(ii) by striking "in sections 305, 306, and 309" and inserting "in section 306 and in title IX";

(C) in subsection (b), in the matter preceding paragraph (1), by striking "subsection (a)," and inserting "subsection (a) and section 306,"; and

(D) in subsection (c)—

(i) in paragraph (1), in the second sentence, by striking "the National Center for Health Services Research and Health Care Technology Assessment" and inserting "the Agency for Health Care Policy and Research"; and

(ii) in paragraph (2), by striking "the National Center for Health Services Research and Health Care Technology Assessment" and inserting "the Agency for Health Care Policy and Research".

(2) SECTION 306.—Section 306 of the Public Health Service Act (42 U.S.C. 242k) is amended—

(A) in subsection (a), by adding at the end the following new sentence: "The Secretary, acting through the Center, shall conduct and support statistical and epidemiological activities for the purpose of improving the effectiveness, efficiency, and quality of health services in the United States.";

(B) in subsection (b), in the matter preceding paragraph (1), by striking "section 304(a)," and inserting "subsection (a),"; and

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

Appropriation authorization.

"(m) For health statistical and epidemiological activities undertaken or supported under this section, there are authorized to be appropriated $55,000,000 for fiscal year 1988 and such sums as may be necessary for each of the fiscal years 1989 and 1990.".

(3) SECTION 307.—Section 307(a) of the Public Health Service Act (42 U.S.C. 242l(a)) is amended by striking "sections 304, 305, 306, and 309" and inserting "section 306 and by title IX".

(4) SECTION 308.—Section 308 of the Public Health Service Act (42 U.S.C. 242m) is amended—

(A) in the section heading, by striking "SECTIONS" and all that follows and inserting the following: "EFFECTIVENESS, EFFICIENCY, AND QUALITY OF HEALTH SERVICES";

(B) in subsection (a)—

(i) in paragraph (1)(A)(i), by striking "sections 304 through 307 and section 309" and inserting "sections 304, 306, and 307 and title IX"; and

(ii) in paragraph (2), by striking "the National Center for Health Services Research and Health Care Technology Assessment" and inserting "the Agency for Health Care Policy and Research";

(C) in subsection (b)—

(i) in paragraph (1), by striking "sections 304, 305, 306, 307, and 309" and inserting "section 304, 306, or 307";

(ii) in subparagraph (A) of paragraph (2)—

(I) in the first sentence, by striking "under section 304 or 305," and inserting "under section 306";

(II) by striking the second sentence; and

(III) by amending the last sentence to read as follows: "The Director of the National Center for Health Statistics shall establish such peer review groups as may be necessary to provide for such an evaluation of each such application.";

(iii) in subparagraph (B) of paragraph (2), by striking "the Director involved," and inserting "the Director of the National Center for Health Statistics,";

(iv) in subparagraph (C) of paragraph (2), by striking "the Directors," and inserting "the Director of the National Center for Health Statistics,"; and

(v) in paragraph (3), in the first sentence—

(I) by striking "section 304, 305, or 306" the first place such term appears and inserting "section 306"; and

(II) by striking "section 304, 305, or 306" the second place such term appears and inserting "any of such sections";

(D) in subsection (d)—

(i) in the matter preceding paragraph (1), by striking "section 304, 305, 306, 307, or 309" and inserting "section 304, 306, or 307";

(ii) in paragraph (1), by striking "in other form, and" and inserting "in other form." and by striking the paragraph designation; and

(iii) by striking paragraph (2);

(E) in subsection (e)—

(i) in paragraph (1), by striking "section 304, 305, 306, 307, or 309" and inserting "section 304, 306, or 307"; and

(ii) in paragraph (2), in the matter preceding subparagraph (A), by striking "section 304, 305, 306, 307, or 309" and inserting "section 304, 306, or 307";

(F) in subsection (f), by striking "section 304, 305, 306, or 309" and inserting "section 304 or 306";

(G) in subsection (g)—

(i) in paragraph (1), by striking the matter after and below subparagraph (C); and

(ii) in paragraph (2), by striking "sections 304, 305, 306, and 309" and inserting "sections 304 and 306";

(H) in subsection (h)(1)—

(i) by striking "section 304, 305, 306, or 309" the first place such term appears and inserting "section 306"; and

(ii) by striking "section 304, 305, 306, or 309" the second place such term appears and inserting "any of such sections"; and

(I) by striking subsection (i).

(5) SECTION 330.—Section 330(e)(3)(G)(i) of the Public Health Service Act (42 U.S.C. 254c(e)(3)(G)(i)) is amended by inserting after "(i)" the following: "except in the case of an entity operated by an Indian tribe or tribal or Indian organization under the Indian Self-Determination Act,". Indians.

42 USC 11137 note.

(6) SECTION 402.—Section 402 of the Public Health Service Amendments of 1987 is amended—

(A) by redesignating subsection (c) as subsection (d) and by inserting after subsection (b) the following new subsection:

State and local governments. 42 USC 11111. 42 USC 11115.

"(c) Such Act is amended in section 411(c)(2) by striking subparagraph (B), by striking 'subparagraphs (A) and (B)' in subparagraph (C), and by redesignating subparagraph (C) as subparagraph (B). Such Act is amended in section 415(a) by inserting before the period at the end the following: 'or as preempting or overriding any State law which provides incentives, immunities, or protection for those engaged in a professional review action that is in addition to or greater than that provided by this part'"; and

42 USC 11137 note.

(B) in subsection (d)(1) (as so redesignated), by striking "subsection (a)" and inserting "subsections (a) and (c)".

(7) SECTION 487.—Section 487(d)(3)(B) of the Public Health Service Act (42 U.S.C. 288(d)(3)(B)) is amended by striking "National Center" and all that follows through "Assessment" and inserting "Agency for Health Care Policy and Research".

42 USC 299 note.

(f) TRANSITIONAL AND SAVINGS PROVISIONS.—

(1) TRANSFER OF PERSONNEL, ASSETS, AND LIABILITIES.—Personnel of the Department of Health and Human Services employed on the date of the enactment of this Act in connection with the functions vested in the Administrator for Health Care Policy and Research pursuant to the amendments made by this section, and assets, property, contracts, liabilities, records, unexpended balances of appropriations, authorizations, allocations, and other funds, of such Department arising from or employed, held, used, or available on such date, or to be made available after such date, in connection with such functions shall be transferred to the Administrator for appropriate allocation. Unexpended funds transferred under this paragraph shall be used only for the purposes for which the funds were originally authorized and appropriated.

(2) SAVINGS PROVISIONS.—With respect to functions vested in the Administrator for Health Care Policy and Research pursuant to the amendments made by this section, all orders, rules, regulations, grants, contracts, certificates, licenses, privileges, and other determinations, actions, or official documents, of the Department of Health and Human Services that have been issued, made, granted, or allowed to become effective in the performance of such functions, and that are effective on the date of the enactment of this Act, shall continue in effect according to their terms unless changed pursuant to law.

SEC. 6104. REDUCTION IN PAYMENTS FOR CERTAIN PROCEDURES.

(a) IN GENERAL.—Section 1842(b) of the Social Security Act (42 U.S.C. 1395u(b)) is amended by adding at the end the following new paragraph:

"(14)(A) In determining the reasonable charge for a physicians' service specified in subparagraph (C)(i) and furnished during the 9-month period beginning on April 1, 1990, the prevailing charge for such service shall be the prevailing charge otherwise recognized for such service for 1989 reduced by 15 percent or, if less, ⅓ of the percent (if any) by which the prevailing charge otherwise applied in the locality in 1989 exceeds the locally-adjusted reduced prevailing amount (as determined under subparagraph (B)(i)) for the service.

"(B) For purposes of this paragraph:

"(i) The 'locally-adjusted reduced prevailing amount' for a locality for a physicians' service is equal to the product of—

"(I) the reduced national weighted average prevailing charge for the service (specified under clause (ii)), and

"(II) the adjustment factor (specified under clause (iii)) for the locality.

"(ii) The 'reduced national weighted average prevailing charge' for a physicians' service is equal to the national weighted average prevailing charge for the service (specified in subparagraph (C)(ii)) reduced by the percentage change (specified in subparagraph (C)(iii)) for the service.

"(iii) The 'adjustment factor', for a physicians' service for a locality, is the sum of—

"(I) the practice expense ratio for the service (specified in Table #1 in the Joint Explanatory Statement referred to in subparagraph (C)(i)), multiplied by the geographic practice cost index value (specified in subparagraph (C)(iv)) for the locality, and

"(II) 1 minus the practice expense ratio.

"(C) For purposes of this paragraph:

"(i) The physicians' services specified in this clause are the physicians' services specified in Table #2 in the Joint Explanatory Statement of the Committee of Conference submitted with the Conference Report to accompany H.R. 3299 (the 'Omnibus Budget Reconciliation Act of 1989'), 101st Congress, which specification is of physicians' services that have been identified as overvalued by at least 10 percent based on a comparison of payments for such services under a resource-based relative value scale and of the national average prevailing charges under this part.

"(ii) The 'national weighted average prevailing charge' specified in this clause, for a physicians' service specified in clause (i), is the national weighted average prevailing charge for the service in 1989 as determined by the Secretary using the best data available.

"(iii) The 'percent change' specified in this clause, for a physicians' service specified in clause (i), is the percent change specified for the service in Table #2 in the Joint Explanatory Statement referred to in clause (i).

"(iv) The geographic practice cost index value specified in this clause for a locality is such value specified for the locality in Table #3 in the Joint Explanatory Statement referred to in clause (i).

"(D) In the case of a reduction in the prevailing charge for a physicians' service under subparagraph (A), if a nonparticipating physician furnishes the service to an individual entitled to benefits under this part, after the effective date of such reduction, the physician's actual charge is subject to a limit under subsection (j)(1)(D).".

(b) SPECIAL LIMITS ON ACTUAL CHARGES.—Section 1842(j)(1)(D) of such Act is amended— 42 USC 1395u.

(1) in clause (ii)(II), by inserting "or (b)(14)(A)" after "(b)(10)(A)", and

(2) in clause (iii)(II), by striking "or (b)(11)(C)(i)" and inserting "(b)(11)(C)(i), or (b)(14)(A)".

SEC. 6105. REDUCTION IN PAYMENTS FOR RADIOLOGY SERVICES.

(a) FEE SCHEDULES FOR RADIOLOGIST SERVICES REDUCED.—Section 1834(b)(4) of the Social Security Act (42 U.S.C. 1395m(b)(4)) is amended—

(1) by redesignating subparagraphs (C) and (D) as subparagraphs (D) and (E), and

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

"(C) 1990 FEE SCHEDULES.—For radiologist services (other than portable X-ray services) furnished under this part during 1990, after March 31 of such year, the conversion factors used under this subsection shall be 96 percent of the conversion factors that applied under this subsection as of December 31, 1989.".

42 USC 1395m note.

(b) SPECIAL RULE FOR NUCLEAR MEDICINE PHYSICIANS.—In applying section 1834(b) of the Social Security Act with respect to nuclear medicine services furnished by a physician for whom nuclear medicine services account for at least 80 percent of the total amount of charges made under part B of title XVIII of the Social Security Act—

(1) during 1990, after April 1, 1990, there shall be substituted for the fee schedule otherwise applicable a fee schedule based ⅓ on the fee schedule computed under such section (without regard to this subsection) and ⅔ on 101 percent of the 1988 prevailing charge for such services; and

(2) during 1991, there shall be substituted for the fee schedule otherwise applicable a fee schedule based ⅔ on the fee schedule computed under such section (without regard to this subsection) and ⅓ on 101 percent of the 1988 prevailing charge for such services.

42 USC 1395m note.

(c) INTERVENTIONAL RADIOLOGISTS.—In applying section 1834(b) of the Social Security Act to radiologist services furnished in 1990, the exception for "split billing" set forth at section 5262J of the Medicare Carriers Manual shall apply to services furnished in 1990 in the same manner and to the same extent as the exception applied to services furnished in 1989.

SEC. 6106. ANESTHESIA SERVICES.

(a) COUNTING ACTUAL TIME UNITS FOR ANESTHESIA SERVICES AND CODIFICATION OF PREVIOUS AUTHORITY.—Section 1842 of the Social Security Act (42 U.S.C. 1395u) is amended by adding at the end the following new subsection:

Regulations.

"(q)(1) The Secretary, in consultation with groups representing physicians who furnish anesthesia services, shall establish by regulation a relative value guide for use in all carrier localities in making payment for physician anesthesia services furnished under this part. Such guide shall be designed so as to result in expenditures under this title for such services in an amount that would not exceed the amount of such expenditures which would otherwise occur.

"(2) For purposes of payment for anesthesia services (whether furnished by physicians or by certified registered nurse anesthetists) under this part, the time units shall be counted based on actual time rather than rounded to full time units.".

42 USC 1395u note.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished on or after April 1, 1990.

SEC. 6107. DELAY IN UPDATE AND REDUCTION IN PERCENTAGE INCREASE IN THE MEDICARE ECONOMIC INDEX.

(a) DELAYING UPDATES UNTIL APRIL 1.— 42 USC 1395u note.

(1) IN GENERAL.—Subject to the amendments made by this section, any increase or adjustment in customary, prevailing, or reasonable charges, fee schedule amounts, maximum allowable actual charges, and other limits on actual charges with respect to physicians' services and other items and services described in paragraph (2) under part B of title XVIII of the Social Security Act which would otherwise occur as of January 1, 1990, shall be delayed so as to occur as of April 1, 1990, and, notwithstanding any other provision of law, the amount of payment under such part for such items and services which are furnished during the period beginning on January 1, 1990, and ending on March 31, 1990, shall be determined on the same basis as the amount of payment for such services furnished on December 31, 1989.

(2) ITEMS AND SERVICES COVERED.—The items and services described in this paragraph are items and services (other than ambulance services and clinical diagnostic laboratory services) for which payment is made under part B of title XVIII of the Social Security Act on the basis of a reasonable charge or a fee schedule.

(3) EXTENSION OF PARTICIPATION AGREEMENTS AND RELATED PROVISIONS.—Notwithstanding any other provision of law—

(A) subject to the last sentence of this paragraph, each participation agreement in effect on December 31, 1989, under section 1842(h)(1) of the Social Security Act shall remain in effect for the 3-month period beginning on January 1, 1990;

(B) the effective period for such agreements under such section entered into for 1990 shall be the 9-month period beginning on April 1, 1990, and the Secretary of Health and Human Services shall provide an opportunity for physicians and suppliers to enroll as participating physicians and suppliers before April 1, 1990;

(C) instead of publishing, under section 1842(h)(4) of the Social Security Act, at the beginning of 1990, directories of participating physicians and suppliers for 1990, the Secretary shall provide for such publication, at the beginning of the 9-month period beginning on April 1, 1990, of such directories of participating physicians and suppliers for such period; and

(D) instead of providing to nonparticipating physicians under section 1842(b)(3)(G) of the Social Security Act at the beginning of 1990, a list of maximum allowable actual charges for 1990, the Secretary shall provide, at the beginning of the 9-month period beginning on April 1, 1990, such physicians such a list for such 9-month period.

An agreement with a participating physician or supplier described in subparagraph (A) in effect on December 31, 1989, under section 1842(h)(1) of the Social Security Act shall not remain in effect for the period described in subparagraph (A) if the participating physician or supplier requests on or before December 31, 1989, that the agreement be terminated.

(b) PERCENTAGE INCREASE IN MEI FOR 1990.—Section 1842(b)(4)(E) of the Social Security Act (42 U.S.C. 1395u(b)(4)(E)) is amended by adding at the end the following new clause:

"(iv) For purposes of this part for items and services furnished in 1990, after March 31, 1990, the percentage increase in the MEI is—

"(I) 0 percent for radiology services, for anesthesia services, and for other services specified in Table #2 in the Joint Explanatory Statement of the Committee of Conference submitted with the Conference Report to accompany H.R. 3299 (the 'Omnibus Budget Reconciliation Act of 1989'), 101st Congress,

"(II) 2 percent for other services (other than primary care services), and

"(III) such percentage increase in the MEI (as defined in subsection (i)(3)) as would be otherwise determined for primary care services (as defined in subsection (i)(4)).".

SEC. 6108. MISCELLANEOUS PROVISIONS RELATING TO PAYMENT FOR PHYSICIANS' SERVICES.

(a) CUSTOMARY CHARGE FOR NEW PHYSICIANS.—

(1) PHASE-IN TO PREVAILING CHARGE LEVEL.—Section 1842(b)(4)(F) of the Social Security Act (42 U.S.C. 1395u(b)(4)(F)) is amended—

(A) by inserting "furnished during a calendar year" after "physicians' services", and

(B) by adding at the end the following: "For the first calendar year during which the preceding sentence no longer applies, the Secretary shall set the customary charge at a level no higher than 85 percent of the prevailing charge for the service.".

42 USC 1395u note.

(2) EFFECTIVE DATE.—(A) Subject to subparagraph (B), the amendments made by paragraph (1) apply to services furnished in 1990 which were subject to the first sentence of section 1842(b)(4)(F) of the Social Security Act in 1989.

(B) The amendments made by paragraph (1) shall not apply to services furnished in 1990 before April 1, 1990. With respect to physicians' services furnished during 1990 on and after April 1, such amendments shall be applied as though any reference, in the matter inserted by such amendments, to the "first calendar year during which the preceding sentence no longer applies" were deemed a reference to the remainder of 1990.

(b) LIMITATION ON AMOUNTS FOR CERTAIN SERVICES FURNISHED BY MORE THAN ONE SPECIALTY.—

(1) IN GENERAL.—Section 1842(b) of such Act (42 U.S.C. 1395u(b)), as amended by section 6104(a) of this subtitle, is amended by adding at the end the following:

"(15)(A) In determining the reasonable charge for surgery, radiology, and diagnostic physicians' services which the Secretary shall designate (based on their high volume of expenditures under this part) and for which the prevailing charge (but for this paragraph) differs by physician specialty, the prevailing charge for such a service may not exceed the prevailing charge or fee schedule amount for that specialty of physicians that furnish the service most frequently nationally.

"(B) In the case of a reduction in the prevailing charge for a physician's service under subparagraph (A), if a nonparticipating physician furnishes the service to an individual entitled to benefits

under this part, after the effective date of the reduction, the physician's actual charge is subject to a limit under subsection (j)(1)(D).".

(2) SPECIAL LIMITS ON ACTUAL CHARGES.—Section 1842(j)(1)(D) of such Act (42 U.S.C. 1395u(j)(1)(D)) is amended—

(A) in clause (ii)(IV), by inserting "or (b)(15)(A)" before the comma at the end, and

(B) in clause (iii)(II), by striking "or (b)(14)(A)" and inserting "(b)(14)(A), or (b)(15)(A)".

(3) EFFECTIVE DATE.—The amendments made by this subsection apply to procedures performed after March 31, 1990. 42 USC 1395u note.

SEC. 6109. WAIVER OF LIABILITY LIMITING RECOUPMENT IN CERTAIN CASES. 42 USC 1395gg note.

In the case where more than the correct amount may have been paid to a physician or individual under part B of title XVIII of the Social Security Act with respect to services furnished during the period beginning on July 1, 1985, and ending on March 31, 1986, as a result of a carrier's establishing statewide fees for certain procedure codes while the carrier was in the process of implementing the national common procedure coding system of the Health Care Financing Administration, the provisions of section 1870(c) of the Social Security Act shall apply, without the need for affirmative action by such a physician or individual, so as to prevent any recoupment, or other decrease in subsequent payments, to the physician or individual. The previous sentence shall apply to claims for items and services which were reopened by carriers on or after July 31, 1987.

SEC. 6110. REDUCTION IN CAPITAL PAYMENTS FOR OUTPATIENT HOSPITAL SERVICES.

Section 1861(v)(1)(S) of the Social Security Act (42 U.S.C. 1395x(v)(1)(S)) is amended—

(1) by inserting "(i)" after "(S)", and

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

"(ii)(I) 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 outpatient hospital services, 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 year 1990.

"(II) Subclause (I) shall not apply to payments with respect to the capital-related costs of any hospital that is a sole community hospital (as defined in section 1886(d)(5)(D)(iii)).

"(III) In applying subclause (I) to services for which payment is made on the basis of a blend amount under section 1833(i)(3)(A)(ii) or 1833(n)(1)(A)(ii), capital-related costs reflected in the amounts described in sections 1833(i)(3)(B)(i)(I) and 1833(n)(1)(B)(i)(I), respectively, shall be reduced in accordance with such subclause.".

SEC. 6111. CLINICAL DIAGNOSTIC LABORATORY TESTS.

(a) REDUCTION OF LIMITATION AMOUNT ON PAYMENT AMOUNT.—Section 1833(h) of the Social Security Act (42 U.S.C. 1395l(h)) is amended—

(1) in subparagraphs (B) and (C) of paragraph (1), by striking "during the period" and all that follows through "established on a nationwide basis" and inserting "on or after July 1, 1984";

(2) in paragraph (4)(B)(i), by striking "or" at the end;
(3) in paragraph (4)(B)(ii)—
(A) by striking "and so long as a fee schedule for the test has not been established on a nationwide basis,",
(B) by inserting "and before January 1, 1990," after "March 31, 1988,", and
(C) by striking the period at the end and inserting ", and"; and
(4) by adding at the end of paragraph (4)(B) the following new clause:
"(iii) after December 31, 1989, is equal to 93 percent of the median of all the fee schedules established for that test for that laboratory setting under paragraph (1).".

(b) RESTRICTION ON PAYMENT TO REFERRING LABORATORY.—
(1) IN GENERAL.—Section 1833(h)(5)(A)(ii) of such Act (42 U.S.C. 1395l(h)(5)(A)(ii)) is amended by striking "referring laboratory, and" and inserting "referring laboratory but only if—
Rural areas.
"(I) the referring laboratory is located in, or is part of, a rural hospital,
"(II) the referring laboratory is a wholly-owned subsidiary of the entity performing such test, the referring laboratory wholly owns the entity performing such test, or both the referring laboratory and the entity performing such test are wholly-owned by a third entity, or
"(III) not more than 30 percent of the clinical diagnostic laboratory tests for which such referring laboratory submits bills or requests for payment in any year are performed by another laboratory, and".

42 USC 1395l note.
(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to clinical diagnostic laboratory tests performed on or after January 1, 1990.

SEC. 6112. DURABLE MEDICAL EQUIPMENT.

(a) DELAY IN AND REDUCTION OF UPDATE FOR 1990.—
(1) INEXPENSIVE AND ROUTINELY PURCHASED DURABLE MEDICAL EQUIPMENT AND ITEMS REQUIRING FREQUENT AND SUBSTANTIAL SERVICING.—Paragraphs (2)(B)(i) and (3)(B)(i) of section 1834(a) of the Social Security Act (42 U.S.C. 1395m(a)) are each amended by striking "in 1989" and inserting "in 1989 and in 1990".
(2) MISCELLANEOUS DEVICES AND ITEMS AND OTHER COVERED ITEMS.—Paragraph (8)(A)(ii) of such section is amended—
(A) in subclause (I), by striking "1989" and inserting "1989 and 1990", and
(B) in subclause (II), by striking "1990, 1991," and inserting "1991".
(3) OXYGEN AND OXYGEN EQUIPMENT.—Paragraph (9)(A)(ii) of such section is amended—
(A) in subclause (I), by striking "1989" and inserting "1989 and 1990", and
(B) in subclause (II), by striking "1990, 1991," and inserting "1991".
(4) CONFORMING AMENDMENTS.—Such section is further amended—
(A) in paragraph (7)(A)(i), by striking "this subparagraph" and inserting "this clause";
(B) in paragraph (7)(B)(i), by inserting "in" after "rental of the item"; and

(C) in paragraph (7)(B)(ii), by striking "the payment amount" and all that follows and inserting "clause (i) shall apply in the same manner as it applies to items furnished during 1989.".

(b) RENTAL PAYMENTS FOR ENTERAL AND PARENTERAL PUMPS.— 42 USC 1395m note.

(1) IN GENERAL.—Except as provided in paragraph (2), the amount of any monthly rental payment under part B of title XVIII of the Social Security Act for an enteral or parenteral pump furnished on or after April 1, 1990, shall be determined in accordance with the methodology under which monthly rental payments for such pumps were determined during 1989.

(2) CAP ON RENTAL PAYMENTS, SERVICING, AND REPAIRS.—In the case of an enteral or parenteral pump described in paragraph (1) that is furnished on a rental basis during a period of medical need—

(A) monthly rental payments shall not be made under part B of title XVIII of the Social Security Act for more than 15 months during such period, and

(B) after monthly rental payments have been made for 15 months during such period, payment under such part shall be made for maintenance and servicing of the pump in such amounts as the Secretary of Health and Human Services determines to be reasonable and necessary to ensure the proper operation of the pump.

(c) REDUCTION IN FEE SCHEDULES FOR SEAT-LIFT CHAIRS AND TRANSCUTANEOUS ELECTRICAL NERVE STIMULATORS.—Paragraph (1) of such section 1834(a) is amended by adding at the end the following new subparagraph: 42 USC 1395m.

"(D) REDUCTION IN FEE SCHEDULES FOR CERTAIN ITEMS.—With respect to a seat-lift chair or transcutaneous electrical nerve stimulator furnished on or after April 1, 1990, the Secretary shall reduce the payment amount applied under subparagraph (B)(ii) for such an item by 15 percent.".

(d) TREATMENT OF POWER DRIVEN WHEELCHAIRS.—

(1) AS ROUTINELY PURCHASED.—Section 1834(a)(2)(A) of the Social Security Act (42 U.S.C. 1395m(a)(2)(A)) is amended—

(A) by striking "or" at the end of clause (i),

(B) by adding "or" at the end of clause (ii), and

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

"(iii) which is a power-driven wheelchair (other than a customized wheelchair that is classified as a customized item under paragraph (4) pursuant to criteria specified by the Secretary),".

(2) AS CUSTOMIZED ITEM.—The Secretary of Health and Human Services shall by regulation specify criteria to be used by carriers in making determinations on a case-by-case basis as whether to classify power-driven wheelchairs as a customized item (as described in section 1834(a)(4) of the Social Security Act) for purposes of reimbursement under title XVIII of such Act. Regulations. 42 USC 1395m note.

(e) OSTOMY SUPPLIES AS PART OF HOME HEALTH SERVICES.—

(1) SPECIFIC INCLUSION IN HOME HEALTH SERVICES.—Section 1861(m)(5) of the Social Security Act (42 U.S.C. 1395x(m)(5)) is amended to read as follows:

"(5) medical supplies (including catheters, catheter supplies, ostomy bags, and supplies related to ostomy care, but excluding

drugs and biologicals) and durable medical equipment while under such a plan;".

(2) EXCLUSION FROM COVERED ITEMS.—Section 1834(a)(13) of such Act (42 U.S.C. 1395m(a)(13)) is amended by inserting after "intraocular lenses" the following: "or medical supplies (including catheters, catheter supplies, ostomy bags, and supplies related to ostomy care) furnished by a home health agency under section 1861(m)(5)".

(3) REQUIRING PROVISION AS PART OF HOME HEALTH SERVICES.—Section 1866(a)(1) of such Act (42 U.S.C. 1395cc(a)(1)) is amended—

(A) by striking "and" at the end of subparagraph (N),

(B) by striking the period at the end of subparagraph (O) and inserting "; and",

(C) and by inserting after subparagraph (O) the following new subparagraph:

"(P) in the case of home health agencies which provide home health services to individuals entitled to benefits under this title who require ostomy supplies (described in section 1861(m)(5)), to offer to furnish such supplies to such an individual as part of their furnishing of home health services.".

42 USC 1395m note.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to items furnished on or after January 1, 1990.

SEC. 6113. MENTAL HEALTH SERVICES.

(a) ELIMINATING RESTRICTION ON PSYCHOLOGISTS' SERVICES TO SERVICES FURNISHED AT COMMUNITY MENTAL HEALTH CENTERS.—Section 1861(ii) of the Social Security Act (42 U.S.C. 1395x(ii)) is amended by striking "on-site at a community mental health center" and all that follows through "because of similar circumstances of the individual,".

(b) CLINICAL SOCIAL WORKERS.—

(1) COVERAGE OF SERVICES.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(A) by striking "and" at the end of subparagraph (L);

(B) by adding "and" at the end of subparagraph (M); and

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

"(N) clinical social worker services (as defined in subsection (hh)(2));".

(2) DEFINITIONS.—Section 1861 of such Act (42 U.S.C. 1395x) is amended—

(A) in subsection (s)(2)(H)(ii), by striking "(hh)" and inserting "(hh)(2)", and

(B) in subsection (hh)—

(i) by amending the heading to read as follows:

"Clinical Social Worker; Clinical Social Worker Services",

(ii) by redesignating clauses (i) and (ii) of paragraph (3)(B) as subclauses (I) and (II), respectively,

(iii) by redesignating subparagraphs (A) and (B) of paragraph (3) as clauses (i) and (ii), respectively,

(iv) by redesignating paragraphs (1), (2), and (3) as subparagraphs (A), (B), and (C), respectively,

(v) by striking "(hh)" and inserting "(hh)(1)", and

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

"(2) The term 'clinical social worker services' means services performed by a clinical social worker (as defined in paragraph (1)) for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital and other than services furnished to an inpatient of a skilled nursing facility which the facility is required to provide as a requirement for participation) which the clinical social worker is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service.".

(3) PAYMENT BASIS.—Section 1833 of such Act (42 U.S.C. 1395l) is amended—

(A) by inserting after clause (E) of subsection (a)(1) the following new clause: "(F) with respect to clinical social worker services under section 1861(s)(2)(N), the amounts paid shall be 80 percent of the lesser of (i) the actual charge for the services or (ii) 75 percent of the amount determined for payment of a psychologist under clause (L),"; and

(B) in subsection (p)—

(i) by striking "1861(s)(2)(L) and" and by inserting "1861(s)(2)(L),", and

(ii) by inserting "and in the case of clinical social worker services for which payment may be made under this part only pursuant to section 1861(s)(2)(N)," after "1861(s)(2)(M),".

(c) DEVELOPMENT OF CRITERIA REGARDING CONSULTATION WITH A PHYSICIAN.—The Secretary of Health and Human Services shall, taking into consideration concerns for patient confidentiality, develop criteria with respect to payment for qualified psychologist services for which payment may be made directly to the psychologist under part B of title XVIII of the Social Security Act under which such a psychologist must agree to consult with a patient's attending physician in accordance with such criteria. 42 USC 1395l note.

(d) ELIMINATING DOLLAR LIMITATION ON MENTAL HEALTH SERVICES.—Section 1833(d)(1) of the Social Security Act (42 U.S.C. 1395l(d)(1)) is amended by striking "whichever" and all that follows in the first sentence and inserting "62½ percent of such expenses.".

(e) EFFECTIVE DATE.—The amendments made by this section, and the provisions of subsection (c), shall apply to services furnished on or after July 1, 1990, and the amendments made by subsection (d) shall apply to expenses incurred in a year beginning with 1990. 42 USC 1395l note.

SEC. 6114. COVERAGE OF NURSE PRACTITIONER SERVICES IN NURSING FACILITIES.

(a) SERVICES COVERED.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(1) by striking "and" at the end of subparagraph (J), and

(2) in subparagraph (K)—

(A) in clause (i), by striking "and" at the end,

(B) in clause (ii), by striking "to such services" and inserting "to services described in clause (i) or (ii)",

(C) by redesignating clause (ii) as clause (iii), and

(D) by inserting after clause (i) the following new clause:

"(ii) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a nurse practitioner (as defined in subsection (aa)(3)) working in collaboration (as defined in subsection (aa)(4)) with a physician (as defined in subsection (r)(1)) in a skilled nursing facility or nursing facility (as defined in section 1919(a)) which the nurse practitioner is legally authorized to perform by the State in which the services are performed, and".

(b) DETERMINATION OF PAYMENT AMOUNT.—Section 1842(b)(12)(A) of such Act (42 U.S.C. 1395u(b)(12)(A)) is amended by striking "physician assistant acting under the supervision of a physician" and inserting "physician assistants and nurse practitioners".

(c) PAYMENT TO EMPLOYER; PAYMENT FOR ROUTINE VISITS BY MEMBERS OF A TEAM.—Section 1842(b) of such Act (42 U.S.C. 1395u(b)) is amended—

(1) in clause (C) of the first sentence of paragraph (6), by inserting "or nurse practitioner" after "physician assistant", and

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

"(C) In the case of residents of nursing facilities who receive services described in clause (i) or (ii) of section 1861(s)(2)(K) performed by a member of a team, the Secretary shall instruct carriers to develop mechanisms which permit routine payment under this part for up to 1.5 visits per month per resident. In the previous sentence, the term 'team' refers to a physician and includes a physician assistant acting under the supervision of the physician or a nurse practitioner working in collaboration with that physician, or both.".

(d) DEFINITION OF COLLABORATION.—Section 1861(aa) of such Act (42 U.S.C. 1395x(aa)) is amended by adding at the end the following new paragraph:

"(4) The term 'collaboration' means a process in which a nurse practitioner works with a physician to deliver health care services within the scope of the practitioner's professional expertise, with medical direction and appropriate supervision as provided for in jointly developed guidelines or other mechanisms as defined by the law of the State in which the services are performed.".

42 USC 1395u note.

(e) STATE DEMONSTRATION PROJECTS ON APPLICATION OF LIMITATION ON VISITS PER MONTH PER RESIDENT ON AGGREGATE BASIS FOR A TEAM.—The Secretary of Health and Human Services shall provide for at least 1 demonstration project under which, in the application of section 1842(b)(2)(C) of the Social Security Act (as added by subsection (c)(2) of this section) in one or more States, the limitation on the number of visits per month per resident would be applied on an average basis over the aggregate total of residents receiving services from members of the team.

42 USC 1395u note.

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after April 1, 1990.

SEC. 6115. COVERAGE OF SCREENING PAP SMEARS.

(a) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by section 6003(g)(3)(A) of this subtitle, is amended—

(1) in subsection (s)—

(A) by striking "and" at the end of paragraph (12),

(B) by striking the period at the end of paragraph (13) and inserting "; and",

(C) by redesignating paragraphs (14) and (15) as paragraphs (15) and (16), respectively, and

(D) by inserting after paragraph (13) the following new paragraph;

"(14) screening pap smear."; and

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

"Screening Pap Smear

"(nn) The term 'screening pap smear' means a diagnostic laboratory test consisting of a routine exfoliative cytology test (Papanicolaou test) provided to a woman for the purpose of early detection of cervical cancer and includes a physician's interpretation of the results of the test, if the individual involved has not had such a test during the preceding 3 years (or such shorter period as the Secretary may specify in the case of a woman who is at high risk of developing cervical cancer (as determined pursuant to factors identified by the Secretary))."

(b) REVISION OF EXCLUSION GROUNDS.—Section 1862(a)(1)(F) of such Act (42 U.S.C. 1395y(a)(1)(F)) is amended by inserting before the semicolon at the end the following: ", and, in the case of screening pap smear, which is performed more frequently than is provided under 1861(nn)".

(c) CONFORMING AMENDMENTS.—Sections 1864(a), 1865(a), 1902(a)(9)(C), and 1915(a)(1)(B)(ii)(I) of such Act (42 U.S.C. 1395aa(a), 1395bb(a), 1396(a)(9)(C), 1396n(a)(1)(B)(ii)(I)) are each amended by striking "paragraphs (14) and (15)" and inserting "paragraphs (15) and (16)". 42 USC 1396a.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to screening pap smears performed on or after July 1, 1990. 42 USC 1395x note.

SEC. 6116. COVERAGE UNDER, AND PAYMENT FOR, OUTPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES UNDER PART B.

(a) COVERAGE.—

(1) Section 1861(mm) of the Social Security Act (42 U.S.C. 1395x(mm)), as added by section 6003(g)(3)(A) of this subtitle, is amended by adding at the end the following:

"(3) The term 'outpatient rural primary care hospital services' means medical and other health services furnished by a rural primary care hospital."

(2) Section 1832(a)(2) of such Act (42 U.S.C. 1395k(a)(2)) is amended—

(A) in subparagraph (F), by striking "and" at the end,

(B) in subparagraph (G) by striking the period at the end and inserting "; and", and

(C) by inserting after subparagraph (G) the following new subparagraph:

"(H) outpatient rural primary care hospital services (as defined in section 1861(mm)(3))."

(b) PAYMENT.—

(1) Section 1833(a) of such Act (42 U.S.C. 1395l(a)) is amended—

(A) in paragraph (2), in the matter before subparagraph (A), by striking "and (G)" and inserting "(G), and (H)",

(B) in paragraph (4), by striking "and" at the end,

(C) in paragraph (5), by striking the period at the end and inserting "; and", and

(D) by inserting after paragraph (5) the following new paragraph:

"(6) in the case of outpatient rural primary care hospital services, the amounts described in section 1834(g).".

(2) Section 1834 of such Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

"(g) PAYMENT FOR OUTPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—

"(1) IN GENERAL.—The amount of payment for outpatient rural primary care hospital services provided during a year before 1993 in a rural primary care hospital under this part shall be determined by one of the 2 following methods, as elected by the rural primary care hospital:

"(A) COST-BASED FACILITY FEE PLUS PROFESSIONAL CHARGES.—

"(i) FACILITY FEE.—With respect to facility services, not including any services for which payment may be made under clause (ii), there shall be paid amounts equal to the amounts described in section 1833(a)(2)(B) (describing amounts paid for hospital outpatient services).

"(ii) REASONABLE CHARGES FOR PROFESSIONAL SERVICES.—In electing treatment under this subparagraph, payment for professional medical services otherwise included within outpatient rural primary care hospital services shall be made under such other provisions of this part as would apply to payment for such services if they were not included in outpatient rural primary care hospital services.

"(B) ALL-INCLUSIVE RATE.—With respect to both facility services and professional medical services, there shall be paid amounts equal to the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, less the amount the hospital may charge as described in clause (i) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items and services described in section 1861(s)(10)(A) and for items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2), or a third opinion, if the second opinion was in disagreement with the first opinion) exceed 80 percent of such costs.

"(2) DEVELOPMENT AND IMPLEMENTATION OF ALL INCLUSIVE, PROSPECTIVE PAYMENT SYSTEM.— Not later than January 1, 1993, the Secretary shall develop and implement a prospective payment system for determining payments under this part for outpatient rural primary care hospital services using a methodology that includes all costs in providing all such services (including related professional medical services) and that determines the payment amount for such services on a prospective basis.".

Subpart B—Technical and Miscellaneous Provisions

SEC. 6131. MODIFICATION OF PAYMENT FOR THERAPEUTIC SHOES FOR INDIVIDUALS WITH SEVERE DIABETIC FOOT DISEASE.

(a) PERMITTING ADDITIONAL INSERTS.—

(1) IN GENERAL.—Section 1833(o) of the Social Security Act (42 U.S.C. 1395l(o)) is amended—

(A) by amending subparagraph (A) of paragraph (1) to read as follows:

"(A) no payment may be made under this part, with respect to any individual for any year, for the furnishing of—

"(i) more than one pair of custom molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts for such shoes, or

"(ii) more than one pair of extra-depth shoes (not including inserts provided with such shoes) and 3 pairs of inserts for such shoes, and";

(B) in paragraphs (1)(B) and (2)(A), by striking "limit" and inserting "limits";

(C) in the second sentence of paragraph (1), by inserting "(or inserts)" after "shoes" each place it appears;

(D) by amending clause (i) of paragraph (2)(A) to read as follows:

"(i) for the furnishing of—

"(I) one pair of custom molded shoes (including any inserts that are provided initially with the shoes) is $300, and

"(II) any additional pair of inserts with respect to such shoes is $50; and"; and

(E) in paragraph (2)(A)(ii)(II), by inserting "any pairs of" after "$50 for".

(2) CONFORMING AMENDMENT.—Section 1861(s)(12) of such Act (42 U.S.C. 1395x(s)(12)) is amended by inserting "with inserts" after "custom molded shoes".

(b) PERMITTING SUBSTITUTION OF SHOE MODIFICATIONS FOR INSERTS.—Section 1833(o)(2) of such Act is amended by adding at the end the following new subparagraph:

"(D) In accordance with procedures established by the Secretary, an individual entitled to benefits with respect to shoes described in section 1861(s)(12) may substitute modification of such shoes instead of obtaining one (or more, as specified by the Secretary) pairs of inserts (other than the original pair of inserts with respect to such shoes). In such case, the Secretary shall substitute, for the limits established under subparagraph (A), such limits as the Secretary estimates will assure that there is no net increase in expenditures under this subsection as a result of this subparagraph.".

(c) EFFECTIVE DATE.— 42 USC 1395l note.

(1) The amendments made by this section shall apply with respect to therapeutic shoes and inserts furnished on or after July 1, 1989.

(2) In applying the amendments made by this section, the increase under subparagraph (C) of section 1833(o)(2) of the Social Security Act shall apply to the dollar amounts specified under subparagraph (A) of such section (as amended by this section) in the same manner as the increase would have applied to the dollar amounts specified under subparagraph (A) of such section (as in effect before the date of the enactment of this Act).

SEC. 6132. PAYMENTS TO CERTIFIED REGISTERED ANESTHETISTS.

(a) EXTENSION AND EXPANSION OF CRNA PASS-THROUGH.—Section 9320(k) of the Omnibus Budget Reconciliation Act of 1986, as added by section 608(c)(2) of the Family Support Act of 1988, is amended— 42 USC 1395k note.

(1) by striking "250" each place it appears and inserting "500";

(2) in paragraph (1)—

(A) by striking "1989, 1990, and 1991" and inserting "a year (beginning with 1989)", and

(B) by striking "before April 1, 1989," and inserting "at any time before the year";

(3) in paragraph (2)—

(A) by striking "1990 or 1991" and inserting "in a year (after 1989)", and

(B) by striking "each respective year" and inserting "the year"; and

(4) by striking paragraph (3).

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 1990. 42 USC 1395k note.

SEC. 6133. INCREASE IN PAYMENT LIMIT FOR PHYSICAL AND OCCUPATIONAL THERAPY SERVICES.

(a) IN GENERAL.—Section 1833(g) of the Social Security Act (42 U.S.C. 1395l(g)) is amended by striking "$500" each place it appears and inserting "$750".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished on or after January 1, 1990. 42 USC 1395l note.

SEC. 6134. STUDY OF PAYMENT FOR PORTABLE X-RAY SERVICES. 42 USC 1395m note.

The Secretary of Health and Human Services shall conduct a study of the costs of furnishing, and payments for, portable x-ray services under part B of title XVIII of the Social Security Act. Not later than 1 year after the date of the enactment of this Act, the Secretary shall report to Congress on the results of such study and shall include a recommendation respecting whether payment for such services should be made in the same manner as for radiologists' services or on the basis of a separate fee schedule. Reports.

SEC. 6135. EXTENSION OF MUNICIPAL HEALTH SERVICE DEMONSTRATION PROJECTS.

Section 9215 of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended— 42 USC 1395b-1 note.

(1) by striking ", for a period of three additional years," and inserting "through December 31, 1993,"; and

(2) by adding at the end the following: "The Secretary shall submit a report to Congress on the waiver program with respect to the quality of health care, beneficiary costs, and such other factors as may be appropriate.". Reports.

SEC. 6136. STUDY OF REIMBURSEMENT FOR AMBULANCE SERVICES. 42 USC 1395l note.

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study to determine the adequacy and appropriateness of payment amounts under title XVIII of the Social Security Act for ambulance services. Such study shall examine at least the following:

(1) The effect of payment amounts on the provision of ambulance services in rural areas.

(2) The relationship of such payment amounts to the direct and indirect costs of providing ambulance services. Such relationship shall be examined separately—

(A)(i) for tax-subsidized, municipally-owned and operated services, (ii) for volunteer services, (iii) for private, for-profit services, and (iv) for hospital-owned services, and

(B) for different levels (such as basic life support and advanced life support) of such services.

(3) How such payment amounts compare to the payment amounts made for ambulance services under medicaid plans under title XIX of such Act.

(b) REPORT.—By not later than one year after the date of the enactment of this Act, the Secretary shall submit a report to Congress on the results of the study conducted under subsection (a) and shall include in the report such recommendations for changes in medicare payment policy with respect to ambulance services as may be needed to ensure access by medicare beneficiaries to quality ambulance services in metropolitan and rural areas.

SEC. 6137. PROPAC STUDY OF PAYMENTS FOR SERVICES IN HOSPITAL OUTPATIENT DEPARTMENTS.

42 USC 1395*l* note.

(a) IN GENERAL.—The Prospective Payment Assessment Commission shall conduct a study on payment under title XVIII of the Social Security Act for hospital outpatient services. Such study shall include an examination of—

(1) the sources of growth in spending for hospital outpatient services;

(2) the differences between the costs of delivering services in a hospital outpatient department as opposed to providing similar services in other appropriate settings (including ambulatory surgery centers and physician offices);

(3) the effects on outpatient hospital costs of the step-down method used to allocate hospital capital between inpatient and outpatient departments and the extent to which hospital outpatient costs were affected by the implementation of the prospective payment system of payment for inpatient hospital services and by increased review of such services by peer review organizations; and

(4) alternative methods for reimbursing hospitals for services in outpatient departments under the medicare program, including prospective payment methods, fee schedules, and such other methods as the Commission may consider appropriate.

(b) REPORTS.—(1) By not later than July 1, 1990, the Commission shall submit a report to Congress on the study conducted under subsection (a) with respect to the portions of the study described in paragraphs (1), (2), and (3) of such subsection, and shall include in the report such recommendations as the Commission deems appropriate.

(2) By not later than March 1, 1991, the Commission shall submit a report to Congress on the study conducted under subsection (a) with respect to the portion of the study described in paragraph (4) of such subsection, and shall include in the report such recommendations as the Commission deems appropriate.

42 USC 1395w-1 note.

SEC. 6138. PHYSPRC STUDY OF PAYMENTS FOR ASSISTANTS AT SURGERY.

(a) STUDY; CONTENTS.—The Physician Payment Review Commission shall conduct a study of the payments made under title XVIII of the Social Security Act for assistants at surgery. Such study shall examine—

(1) the necessity and appropriateness of using an assistant at surgery;

(2) the use of physician and non-physician assistants at surgery;

(3) the appropriateness of providing for payments, and the appropriate level of payment, under title XVIII of the Social Security Act for assistants at surgery; and

(4) the effect of the amendments made by section 9338 of the Omnibus Budget Reconciliation Act of 1986 on the employment of registered nurses as assistants at surgery, and whether or not the reductions described in subsection (d) of such section have been implemented.

(b) REPORT.—By not later than April 1, 1991, the Commission shall submit a report to Congress on the study conducted under subsection (a), and shall include in the report such recommendations as it deems appropriate.

42 USC 1395m note.

SEC. 6139. GAO STUDY OF STANDARDS FOR USE OF AND PAYMENT FOR ITEMS OF DURABLE MEDICAL EQUIPMENT.

(a) STUDY.—The Comptroller General shall conduct a study of the appropriate uses of items of durable medical equipment and of the appropriate criteria for making determinations of medical necessity under title XVIII of the Social Security Act for such items, with particular emphasis on items (including seat-lift chairs) that may be subject to abusive billing practices. Such study shall include an analysis of—

(1) the appropriate use of forms in making medical necessity determinations for items of durable medical equipment under such title; and

(2) procedures for identifying items of durable medical equipment that should no longer be covered under such title.

(b) USE OF PANEL IN CONDUCTING STUDY.—The Comptroller General shall conduct such study with a panel convened by the Comptroller General consisting of—

(1) specialists in the disciplines of orthopedic medicine, rehabilitation, arthritis, and geriatric medicine;

(2) representatives of consumer organizations; and

(3) representatives of carriers under the medicare program.

(c) REPORT.—Not later than April 1, 1991, the Comptroller General shall submit a report to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate on the study conducted under subsection (a), and shall include in such report such recommendations as the Comptroller General deems appropriate.

SEC. 6140. NARROWING OF RANGE OF AMOUNTS RECOGNIZED FOR ITEMS OF DURABLE MEDICAL EQUIPMENT.

Paragraphs (8) and (9) of section 1834(a) of the Social Security Act (42 U.S.C. 1395m(a)) are each amended in subparagraph (D)—

(1) in clause (i), by striking "1991" and all that follows through "80 percent" and inserting "1991, may not exceed 125 percent, and may not be lower than 85 percent"; and

(2) in clause (ii), by striking "125 percent" and all that follows through "85 percent" and inserting "120 percent, and may not be lower than 90 percent".

SEC. 6141. PHYSICIAN OFFICE LABS.

(a) IN GENERAL.—Section 1861(s) of the Social Security Act (42 U.S.C. 1395x(s)) is amended—

(1) in the matter following paragraph (14), by striking "which is independent" and all that follows through "per year," and inserting the following: ", including a laboratory that is part of";

(2) by redesignating paragraph (16) as subparagraph (B); and

(3) by inserting immediately after paragraph (15) the following:

"(16)(A) meets the certification requirements under section 353 of the Public Health Service Act; and".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on the date of the enactment of this Act. 42 USC 1395x note.

SEC. 6142. STUDY OF REIMBURSEMENT FOR BLOOD CLOTTING FACTOR FOR HEMOPHILIA PATIENTS.

The Secretary of Health and Human Services shall review the current methodology for reimbursing for blood clotting factor for hemophilia patients under part B of title XVIII of the Social Security Act and shall evaluate the effect of such methodology on the accessibility and affordability of such factor to medicare beneficiaries. By not later than 6 months after the date of the enactment of this Act, the Secretary shall report to the Committees on Energy and Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate on such review and shall include in such report such recommendations as the Secretary deems appropriate. Reports.

PART 3—PROVISIONS RELATING TO PARTS A AND B

Subpart A—General Provisions

SEC. 6201. REDUCTIONS UNDER ORIGINAL SEQUESTER ORDER AND APPLICABILITY OF NEW SEQUESTER ORDER FOR HEALTH MAINTENANCE ORGANIZATIONS. 2 USC 902 note.

Notwithstanding any other provision of law (including section 11002 or any other provision of this Act), the reductions in the amount of payments required under title XVIII of the Social Security Act made by the final sequester order issued by the President on October 16, 1989, pursuant to section 252(b) of the Balanced Budget and Emergency Deficit Control Act of 1985 shall continue to be effective (as provided by sections 252(a)(4)(B) and 256(d)(2) of such Act) through December 31, 1989, with respect to payments under section 1833(a)(1)(A) or 1876 of the Social Security Act, section 402 of the Social Security Amendments of 1967, or section 222 of the Social Security Amendments of 1972. Each such payment made during fiscal year 1990 after such date shall be increased by 1.42 percent above what it would otherwise be under this Act.

SEC. 6202. MEDICARE AS SECONDARY PAYER.

(a) IDENTIFICATION OF MEDICARE SECONDARY PAYER SITUATIONS.—

(1) DISCLOSURE OF CERTAIN TAXPAYER IDENTITY INFORMATION FOR VERIFICATION OF EMPLOYMENT STATUS OF MEDICARE BENEFICIARY AND SPOUSE OF MEDICARE BENEFICIARY.—

26 USC 6103.

(A) IN GENERAL.—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 (relating to disclosure of returns and return information for purposes other than tax administration) is amended by adding at the end thereof the following new paragraph:

"(12) DISCLOSURE OF CERTAIN TAXPAYER IDENTITY INFORMATION FOR VERIFICATION OF EMPLOYMENT STATUS OF MEDICARE BENEFICIARY AND SPOUSE OF MEDICARE BENEFICIARY.—

"(A) RETURN INFORMATION FROM INTERNAL REVENUE SERVICE.—The Secretary shall, upon written request from the Commissioner of Social Security, disclose to the Commissioner available filing status and taxpayer identity information from the individual master files of the Internal Revenue Service relating to whether any medicare beneficiary identified by the Commissioner was a married individual (as defined in section 7703) for any specified year after 1986, and, if so, the name of the spouse of such individual and such spouse's TIN.

"(B) RETURN INFORMATION FROM SOCIAL SECURITY ADMINISTRATION.—The Commissioner of Social Security shall, upon written request from the Administrator of the Health Care Financing Administration, disclose to the Administrator the following information:

"(i) The name and TIN of each medicare beneficiary who is identified as having received wages (as defined in section 3401(a)) from a qualified employer in a previous year.

"(ii) For each medicare beneficiary who was identified as married under subparagraph (A) and whose spouse is identified as having received wages from a qualified employer in a previous year—

"(I) the name and TIN of the medicare beneficiary, and

"(II) the name and TIN of the spouse.

"(iii) With respect to each such qualified employer, the name, address, and TIN of the employer and the number of individuals with respect to whom written statements were furnished under section 6051 by the employer with respect to such previous year.

"(C) DISCLOSURE BY HEALTH CARE FINANCING ADMINISTRATION.—With respect to the information disclosed under subparagraph (B), the Administrator of the Health Care Financing Administration may disclose—

"(i) to the qualified employer referred to in such subparagraph the name and TIN of each individual identified under such subparagraph as having received wages from the employer (hereinafter in this subparagraph referred to as the 'employee') for purposes of determining during what period such employee or the employee's spouse may be (or have been) covered under a group health plan of the employer and what benefits are or were covered under the plan (including the name, address, and identifying number of the plan),

"(ii) to any group health plan which provides or provided coverage to such an employee or spouse, the name of such employee and the employee's spouse (if the spouse is a medicare beneficiary) and the name and address of the employer, and, for the purpose of presenting a claim to the plan—

"(I) the TIN of such employee if benefits were paid under title XVIII of the Social Security Act with respect to the employee during a period in which the plan was a primary plan (as defined in section 1862(b)(2)(A) of the Social Security Act), and

"(II) the TIN of such spouse if benefits were paid under such title with respect to the spouse during such period, and

"(iii) to any agent of such Administrator the information referred to in subparagraph (B) for purposes of carrying out clauses (i) and (ii) on behalf of such Administrator.

"(D) SPECIAL RULES.—

"(i) RESTRICTIONS ON DISCLOSURE.—Information may be disclosed under this paragraph only for purposes of, and to the extent necessary in, determining the extent to which any medicare beneficiary is covered under any group health plan.

"(ii) TIMELY RESPONSE TO REQUESTS.—Any request made under subparagraph (A) or (B) shall be complied with as soon as possible but in no event later than 120 days after the date the request was made.

"(E) DEFINITIONS.—For purposes of this paragraph—

"(i) MEDICARE BENEFICIARY.—The term 'medicare beneficiary' means an individual entitled to benefits under part A, or enrolled under part B, of title XVIII of the Social Security Act, but does not include such an individual enrolled in part A under section 1818.

"(ii) GROUP HEALTH PLAN.—The term 'group health plan' means—

"(I) any group health plan (as defined in section 5000(b)(1)), and

"(II) any large group health plan (as defined in section 5000(b)(2)).

"(iii) QUALIFIED EMPLOYER.—The term 'qualified employer' means, for a calendar year, an employer which has furnished written statements under section 6051 with respect to at least 20 individuals for wages paid in the year.

"(F) TERMINATION.—Subparagraphs (A) and (B) shall not apply to—

"(i) any request made after September 30, 1991, and

"(ii) any request made before such date for information relating to—

"(I) 1990 or thereafter in the case of subparagraph (A), or

"(II) 1991 or thereafter in the case of subparagraph (B)."

(B) SAFEGUARDS.—

(i) Paragraph (3) of section 6103(a) of such Code is amended by inserting "(l)(12)," after "(e)(1)(D)(iii),". 26 USC 6103.

26 USC 6103.

(ii) Subparagraph (A) of section 6103(p)(3) of such Code is amended by striking "or (11)" and inserting "(11), or (12)".

(iii) Paragraph (4) of section 6103(p) of such Code is amended in the material preceding subparagraph (A) by striking "or (9) shall" and inserting "(9), or (12) shall".

(iv) Clause (ii) of section 6103(p)(4)(F) of such Code is amended by striking "or (11)" and inserting "(11), or (12)".

(v) The next to the last sentence of paragraph (4) of section 6103(p) of such Code is amended by inserting "or which receives any information under subsection (l)(12)(B) and which discloses any such information to any agent" before ", this paragraph".

(C) PENALTY.—Paragraph (2) of section 7213(a) of such Code is amended by striking "or (10)" and inserting "(10), or (12)".

26 USC 6103 note.

(D) EFFECTIVE DATE.—The amendments made by this paragraph shall take effect on the date of the enactment of this Act.

(2) RESPONSIBILITIES OF HCFA.—

(A) IN GENERAL.—Section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)), as amended by subsection (b)(1) of this section, is amended by inserting after paragraph (4) the following new paragraph:

"(5) IDENTIFICATION OF SECONDARY PAYER SITUATIONS.—

"(A) REQUESTING MATCHING INFORMATION.—

"(i) COMMISSIONER OF SOCIAL SECURITY.—The Commissioner of Social Security shall, not less often than annually, transmit to the Secretary of the Treasury a list of the names and TINs of medicare beneficiaries (as defined in section 6103(l)(12) of the Internal Revenue Code of 1986) and request that the Secretary disclose to the Commissioner the information described in subparagraph (A) of such section.

"(ii) ADMINISTRATOR.—The Administrator of the Health Care Financing Administration shall request, not less often than annually, the Commissioner of the Social Security Administration to disclose to the Administrator the information described in subparagraph (B) of section 6103(l)(12) of the Internal Revenue Code of 1986.

"(B) DISCLOSURE TO FISCAL INTERMEDIARIES AND CARRIERS.—In addition to any other information provided under this title to fiscal intermediaries and carriers, the Administrator shall disclose to such intermediaries and carriers (or to such a single intermediary or carrier as the Secretary may designate) the information received under subparagraph (A) for the purposes of carrying out this subsection.

"(C) CONTACTING EMPLOYERS.—

"(i) IN GENERAL.—With respect to each individual (in this subparagraph referred to as an 'employee') who was furnished a written statement under section 6051 of the Internal Revenue Code of 1986 by a qualified employer (as defined in section 6103(l)(12)(D)(iii) of such

Code), as disclosed under subparagraph (B), the appropriate fiscal intermediary or carrier shall contact the employer in order to determine during what period the employee or employee's spouse may be (or have been) covered under a group health plan of the employer and the nature of the coverage that is or was provided under the plan (including the name, address, and identifying number of the plan).

"(ii) EMPLOYER RESPONSE.—Within 30 days of the date of receipt of the inquiry, the employer shall notify the intermediary or carrier making the inquiry as to the determinations described in clause (i). An employer (other than a Federal or other governmental entity) who willfully or repeatedly fails to provide timely and accurate notice in accordance with the previous sentence shall be subject to a civil money penalty of not to exceed $1,000 for each individual with respect to which such an inquiry is made. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

"(iii) SUNSET ON REQUIREMENT.—Clause (ii) shall not apply to inquiries made after September 30, 1991.".

(B) DEADLINE FOR FIRST REQUEST.—The Commissioner of Social Security shall first— 42 USC 1395y note.

(i) transmit to the Secretary of the Treasury information under paragraph (5)(A)(i) of section 1862(b) of the Social Security Act (as inserted by subparagraph (A)), and

(ii) request from the Secretary disclosure of information described in section 6013(l)(12)(A) of the Internal Revenue Code of 1986,

by not later than 14 days after the date of the enactment of this Act.

(b) UNIFORM ENFORCEMENT AND COORDINATION OF BENEFITS.—

(1) IN GENERAL.—Section 1862 of the Social Security Act (42 U.S.C. 1395y) is amended—

(A) in the heading, by adding at the end the following: "AND MEDICARE AS SECONDARY PAYER"; and

(B) by amending subsection (b) to read as follows:

"(b) MEDICARE AS SECONDARY PAYER.—

"(1) REQUIREMENTS OF GROUP HEALTH PLANS.—

"(A) WORKING AGED UNDER GROUP HEALTH PLANS.—

"(i) IN GENERAL.—A group health plan—

"(I) may not take into account, for any item or service furnished to an individual 65 years of age or older at the time the individual is covered under the plan by reason of the current employment of the individual (or the individual's spouse), that the individual is entitled to benefits under this title under section 226(a), and

"(II) shall provide that any employee age 65 or older, and any employee's spouse age 65 or older, shall be entitled to the same benefits under the plan under the same conditions as any employee, and the spouse of such employee, under age 65.

"(ii) EXCLUSION OF GROUP HEALTH PLAN OF A SMALL EMPLOYER.—Clause (i) shall not apply to a group health plan unless the plan is sponsored by or contributed to by an employer that has 20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.

"(iii) EXCEPTION FOR SMALL EMPLOYERS IN MULTIEMPLOYER OR MULTIPLE EMPLOYER GROUP HEALTH PLANS.—Clause (i) also shall not apply with respect to individuals enrolled in a multiemployer or multiple employer group health plan if the coverage of the individuals under the plan is by virtue of employment with an employer that does not have 20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year; except that the exception provided in this clause shall only apply if the plan elects treatment under this clause.

"(iv) EXCEPTION FOR INDIVIDUALS WITH END STAGE RENAL DISEASE.—Clause (i) shall not apply to an item or service furnished in a month to an individual if for the month the individual is, or would upon application be, entitled to benefits under section 226A.

"(v) GROUP HEALTH PLAN DEFINED.—In this subparagraph, and subparagraph (C), the term 'group health plan' has the meaning given such term in section 5000(b)(1) of the Internal Revenue Code of 1986.

"(B) DISABLED ACTIVE INDIVIDUALS IN LARGE GROUP HEALTH PLANS.—

"(i) IN GENERAL.—A large group health plan (as defined in clause (iv)(II)) may not take into account that an active individual (as defined in clause (iv)(I)) is entitled to benefits under this title under section 226(b).

"(ii) EXCEPTION FOR INDIVIDUALS WITH END STAGE RENAL DISEASE.—Clause (i) shall not apply to an item or service furnished in a month to an individual if for the month the individual is, or would upon application be, entitled to benefits under section 226A.

"(iii) SUNSET.—Clause (i) shall only apply to items and services furnished on or after January 1, 1987, and before January 1, 1992.

"(iv) DEFINITIONS.—In this subparagraph:

"(I) ACTIVE INDIVIDUAL.—The term 'active individual' means an employee (as may be defined in regulations), the employer, self-employed individual (such as the employer), an individual associated with the employer in a business relationship, or a member of the family of any of such persons.

"(II) LARGE GROUP HEALTH PLAN.—The term 'large group health plan' has the meaning given such term in section 5000(b)(2) of the Internal Revenue Code of 1986.

"(C) INDIVIDUALS WITH END STAGE RENAL DISEASE.—A group health plan (as defined in subparagraph (A)(v))—

"(i) may not take into account that an individual is entitled to benefits under this title solely by reason of section 226A during the 12-month period which begins with the earlier of—

"(I) the month in which a regular course of renal dialysis is initiated, or

"(II) in the case of an individual who receives a kidney transplant, the first month in which he would be eligible for benefits under part A (if he had filed an application for such benefits) under the provisions of section 226A(b)(1)(B); and

"(ii) may not differentiate in the benefits it provides between individuals having end stage renal disease and other individuals covered by such plan on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner;

except that clause (ii) shall not prohibit a plan from taking into account that an individual is entitled to benefits under this title solely by reason of section 226A after the end of the 12-month period described in clause (i).

"(2) MEDICARE SECONDARY PAYER.—

"(A) IN GENERAL.—Payment under this title may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that—

"(i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1), or

"(ii) payment has been made or can reasonably be expected to be made promptly (as determined in accordance with regulations) under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.

In this subsection, the term 'primary plan' means a group health plan or large group health plan, to the extent that clause (i) applies, and a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies.

"(B) CONDITIONAL PAYMENT.—

"(i) PRIMARY PLANS.—Any payment under this title with respect to any item or service to which subparagraph (A) applies shall be conditioned on reimbursement to the appropriate Trust Fund established by this title when notice or other information is received that payment for such item or service has been or could be made under such subparagraph.

"(ii) ACTION BY UNITED STATES.—In order to recover payment under this title for such an item or service, the United States may bring an action against any entity which is required or responsible under this subsection to pay with respect to such item or service (or any portion thereof) under a primary plan (and may, in accordance with paragraph (3)(A) collect double

damages against that entity), or against any other entity (including any physician or provider) that has received payment from that entity with respect to the item or service, and may join or intervene in any action related to the events that gave rise to the need for the item or service.

"(iii) SUBROGATION RIGHTS.—The United States shall be subrogated (to the extent of payment made under this title for such an item or service) to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan.

"(iv) WAIVER OF RIGHTS.—The Secretary may waive (in whole or in part) the provisions of this subparagraph in the case of an individual claim if the Secretary determines that the waiver is in the best interests of the program established under this title.

"(3) ENFORCEMENT.—

"(A) PRIVATE CAUSE OF ACTION.—There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with such paragraphs (1) and (2)(A).

"(B) REFERENCE TO EXCISE TAX WITH RESPECT TO NONCONFORMING GROUP HEALTH PLANS.—For provision imposing an excise tax with respect to nonconforming group health plans, see section 5000 of the Internal Revenue Code of 1986.

"(4) COORDINATION OF BENEFITS.—Where payment for an item or service by a primary plan is less than the amount of the charge for such item or service and is not payment in full, payment may be made under this title (without regard to deductibles and coinsurance under this title) for the remainder of such charge, but—

"(A) payment under this title may not exceed an amount which would be payable under this title for such item or service if paragraph (2)(A) did not apply; and

"(B) payment under this title, when combined with the amount payable under the primary plan, may not exceed—

"(i) in the case of an item or service payment for which is determined under this title on the basis of reasonable cost (or other cost-related basis) or under section 1886, the amount which would be payable under this title on such basis, and

"(ii) in the case of an item or service for which payment is authorized under this title on another basis—

"(I) the amount which would be payable under the primary plan (without regard to deductibles and coinsurance under such plan), or

"(II) the reasonable charge or other amount which would be payable under this title (without regard to deductibles and coinsurance under this title),

whichever is greater.".

(2) ENFORCEMENT THROUGH EXCISE TAX.—Section 5000 of the Internal Revenue Code of 1986 is amended— 26 USC 5000.

(A) by striking "LARGE" in the heading;

(B) in subsection (a), by striking "large" each place it appears; and

(C) by amending subsections (b) and (c) to read as follows:

"(b) GROUP HEALTH PLAN AND LARGE GROUP HEALTH PLAN.—For purposes of this section—

"(1) GROUP HEALTH PLAN.—The term 'group health plan' means any plan of, or contributed to by, an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer's employees, former employees, or the families of such employees or former employees.

"(2) LARGE GROUP HEALTH PLAN.—The term 'large group health plan' means a plan of, or contributed to by, an employer or employee organization (including a self-insured plan) to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families, that covers employees of at least one employer that normally employed at least 100 employees on a typical business day during the previous calendar year.

"(c) NONCONFORMING GROUP HEALTH PLAN.—For purposes of this section, the term 'nonconforming group health plan' means a group health plan or large group health plan that at any time during a calendar year does not comply with the requirements of subparagraphs (A) and (C) or subparagraph (B), respectively, of section 1862(b)(1) of the Social Security Act.".

(3) REPEAL OF CERTAIN ALTERNATIVE ENFORCEMENT PROVISIONS.—

(A) DENIAL OF DEDUCTION FOR GROUP HEALTH PLANS.—Subsection (i) of section 162 of such Code (relating to group health plans) is repealed.

(B) CONFORMING AMENDMENT.—Section 4980B(g)(2) of such Code is amended by striking "162(i)" and inserting "5000(b)(1)".

(C) AGE DISCRIMINATION IN EMPLOYMENT ACT.—The Age Discrimination in Employment Act of 1967 is amended—

(i) by striking subsection (g) of section 4, and 29 USC 623.

(ii) in section 12(a), by striking "(except the provisions of section 4(g))". 29 USC 631.

(4) CLERICAL AND CONFORMING AMENDMENTS.—

(A) Chapter 47 of the Internal Revenue Code of 1986 is amended—

(i) in the heading, by striking "LARGE", and

(ii) in the table of sections, by striking "large".

(B) The item in the table of chapters of subtitle D of such Code relating to chapter 47 is amended by striking "large".

(C) Sections 1837(i) and 1839(b) of the Social Security Act (42 U.S.C. 1395p(i), 1395r(b)) are each amended by striking "1862(b)(3)(A)(iv)" and "1862(b)(4)(B)" each place each appears and inserting "1862(b)(1)(A)(v)" and "1862(b)(1)(B)(iv)", respectively.

(5) EFFECTIVE DATE.—The amendments made by this subsection shall apply to items and services furnished after the date of the enactment of this Act. 42 USC 162 note.

(c) SPECIAL ENROLLMENT PERIOD FOR DISABLED EMPLOYEES.—

(1) IN GENERAL.—Section 1837(i) of the Social Security Act (42 U.S.C. 1395p(i)) is amended—

(A) in paragraph (1)—

(i) by striking subparagraph (A),

(ii) by redesignating subparagraphs (B) and (C) as subparagraphs (A) and (B), respectively, and

(iii) in the second sentence, by inserting "not described in the previous sentence" after "In the case of an individual"; and

(B) in paragraph (2)—

(i) in subparagraph (B)(i), by striking "(1)(B)" and inserting "(1)(A)",

(ii) by striking subparagraph (A),

(iii) by redesignating subparagraphs (B) through (D) as subparagraphs (A) through (C), respectively, and

(iv) in the second sentence, by inserting "not described in the previous sentence" after "In the case of an individual".

(2) CONFORMING AMENDMENT.—The second sentence of section 1839(b) of such Act (42 U.S.C. 1395r(b)) is amended by striking "during which the individual has attained the age of 65 and".

42 USC 1395p note.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to enrollments occurring after, and premiums for months after, the second calendar quarter beginning after the date of the enactment of this Act.

(d) NO MATCHING BASED ON PRIVATE ACTIVITIES REQUIRED IN FISCAL INTERMEDIARY AGREEMENTS AND CARRIER CONTRACTS.—

(1) FISCAL INTERMEDIARY AGREEMENTS.—Section 1816(c)(1) of the Social Security Act (42 U.S.C. 1395h(c)(1)) is amended by adding at the end the following: "The Secretary may not require, as a condition of entering into or renewing an agreement under this section or under section 1871, that a fiscal intermediary match data obtained other than in its activities under this part with data used in the administration of this part for purposes of identifying situations in which the provisions of section 1862(b) may apply.".

(2) CARRIER CONTRACTS.—Section 1842(b)(2)(A) of such Act (42 U.S.C. 1395u(b)(2)(A)) is amended by adding at the end the following: "The Secretary may not require, as a condition of entering into or renewing a contract under this section or under section 1871, that a carrier match data obtained other than in its activities under this part with data used in the administration of this part for purposes of identifying situations in which section 1862(b) may apply.".

42 USC 1395h note.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to agreements and contracts entered into or renewed on or after the date of the enactment of this Act.

(e) TREATMENT OF EMPLOYMENT AS A MEMBER OF A RELIGIOUS ORDER.—

(1) IN GENERAL.—Section 1862(b)(1) of the Social Security Act (42 U.S.C. 1395y(b)(1)), as amended by subsection (b)(1) of this section, is amended by adding at the end the following new subparagraph:

"(D) TREATMENT OF CERTAIN MEMBERS OF RELIGIOUS ORDERS.—In this subsection, an individual shall not be considered to be employed, or an employee, with respect to the performance of services as a member of a religious

order which are considered employment only by virtue of an election made by the religious order under section 3121(r) of the Internal Revenue Code of 1986.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to items and services furnished on or after October 1, 1989. 42 USC 1395y note.

SEC. 6203. PAYMENT FOR END STAGE RENAL DISEASE SERVICES.

(a) MAINTENANCE OF CURRENT COMPOSITE RATE.—

(1) IN GENERAL.—Section 9335(a)(1) of the Omnibus Budget Reconciliation Act of 1986 is amended— 42 USC 1395rr note.

(A) by striking "and before October 1, 1988" and inserting "and before October 1, 1990", and

(B) by adding at the end the following: "No change may be made in the base rate in effect as of September 30, 1990, unless the Secretary makes such change in accordance with notice and comment requirements set forth in section 1871(b)(1) of such Act.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1986. 42 USC 1395rr note.

(b) REQUIREMENTS FOR PATIENTS DEALING DIRECTLY WITH MEDICARE.—

(1) LIMITATION ON AMOUNT OF PAYMENT GENERALLY.—Section 1881(b)(7) of the Social Security Act (42 U.S.C. 1395rr(b)(7)) is amended by inserting after the second sentence the following new sentence: "The amount of a payment made under any method other than a method based on a single composite weighted formula may not exceed the amount (or, in the case of continuous cycling peritoneal dialysis, 130 percent of the amount) of the median payment that would have been made under the formula for hospital-based facilities.".

(2) AGREEMENTS WITH PROVIDERS OF SERVICES.—Section 1881(b)(4) of such Act (42 U.S.C. 1395rr(b)(4)) is amended—

(A) by striking "(4)" and inserting "(4)(A)", and

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

"(B) The Secretary shall make payments to a supplier of home dialysis supplies and equipment furnished to a patient whose self-care home dialysis is not under the direct supervision of an approved provider of services or renal dialysis facility only in accordance with a written agreement under which—

"(i) the patient certifies that the supplier is the sole provider of such supplies and equipment to the patient,

"(ii) the supplier agrees to receive payment for the cost of such supplies and equipment only on an assignment-related basis, and

"(iii) the supplier certifies that it has entered into a written agreement with an approved provider of services or renal dialysis facility under which such provider or facility agrees to furnish to such patient all self-care home dialysis support services and all other necessary dialysis services and supplies, including institutional dialysis services and supplies and emergency services.".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to dialysis services, supplies, and equipment furnished on or after February 1, 1990. 42 USC 1395rr note.

SEC. 6204. PHYSICIAN OWNERSHIP OF, AND REFERRAL TO, HEALTH CARE ENTITIES.

(a) PROHIBITION OF CERTAIN FINANCIAL ARRANGEMENTS BETWEEN REFERRING PHYSICIANS AND CLINICAL LABORATORIES.—Title XVIII of the Social Security Act is amended by inserting after section 1876 the following new section:

"LIMITATION ON CERTAIN PHYSICIAN REFERRALS

42 USC 1395nn.

"SEC. 1877. (a) PROHIBITION OF CERTAIN REFERRALS.—

"(1) IN GENERAL.—Except as provided in subsection (b), if a physician (or immediate family member of such physician) has a financial relationship with an entity specified in paragraph (2), then—

"(A) the physician may not make a referral to the entity for the furnishing of clinical laboratory services for which payment otherwise may be made under this title, and

"(B) the entity may not present or cause to be presented a claim under this title or bill to any individual, third party payor, or other entity for clinical laboratory services furnished pursuant to a referral prohibited under subparagraph (A).

"(2) FINANCIAL RELATIONSHIP SPECIFIED.—For purposes of this section, a financial relationship of a physician (or immediate family member) with an entity specified in this paragraph is—

"(A) except as provided in subsections (c) and (d), an ownership or investment interest in the entity; or

"(B) except as provided in subsection (e), a compensation arrangement (as defined in subsection (h)(1)(A)) between the physician (or immediate family member) and the entity.

An ownership or investment interest described in subparagraph (A) may be through equity, debt, or other means.

"(b) GENERAL EXCEPTIONS TO BOTH OWNERSHIP AND COMPENSATION ARRANGEMENT PROHIBITIONS.—Subsection (a)(1) shall not apply in the following cases:

"(1) PHYSICIANS' SERVICES.—In the case of physicians' services (as defined in section 1861(q)) provided personally by (or under the personal supervision of) another physician in the same group practice (as defined in subsection (h)(4)) as the referring physician.

"(2) IN-OFFICE ANCILLARY SERVICES.—In the case of services—

"(A) that are furnished—

"(i) personally by the referring physician, personally by a physician who is a member of the same group practice as the referring physician, or personally by individuals who are employed by such physician or group practice and who are personally supervised by the physician or by another physician in the group practice, and

"(ii)(I) in a building in which the referring physician (or another physician who is a member of the same group practice) furnishes physicians' services unrelated to the furnishing of clinical laboratory services, or

"(II) in the case of a referring physician who is a member of a group practice, in another building which is used by the group practice for the centralized provision of the group's clinical laboratory services, and

"(B) that are billed by the physician performing or supervising the services, by a group practice of which such physician is a member, or by an entity that is wholly owned by such physician or such group practice,

if the ownership or investment interest in such services meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

"(3) PREPAID PLANS.—In the case of services furnished—

"(A) by an organization with a contract under section 1876 to an individual enrolled with the organization,

"(B) by an organization described in section 1833(a)(1)(A) to an individual enrolled with the organization, or

"(C) by an organization receiving payments on a prepaid basis, under a demonstration project under section 402(a) of the Social Security Amendments of 1967 or under section 222(a) of the Social Security Amendments of 1972, to an individual enrolled with the organization.

"(4) OTHER PERMISSIBLE EXCEPTIONS.—In the case of any other financial relationship which the Secretary determines, and specifies in regulations, does not pose a risk of program or patient abuse.

"(c) GENERAL EXCEPTION RELATED ONLY TO OWNERSHIP OR INVESTMENT PROHIBITION FOR OWNERSHIP IN PUBLICLY-TRADED SECURITIES.—Ownership of investment securities (including shares or bonds, debentures, notes, or other debt instruments) which were purchased on terms generally available to the public and which are in a corporation that—

"(1) is listed for trading on the New York Stock Exchange or on the American Stock Exchange, or is a national market system security traded under an automated interdealer quotation system operated by the National Association of Securities Dealers, and

"(2) had, at the end of the corporation's most recent fiscal year, total assets exceeding $100,000,000,

shall not be considered to be an ownership or investment interest described in subsection (a)(2)(A).

"(d) ADDITIONAL EXCEPTIONS RELATED ONLY TO OWNERSHIP OR INVESTMENT PROHIBITION.—The following, if not otherwise excepted under subsection (b), shall not be considered to be an ownership or investment interest described in subsection (a)(2)(A):

"(1) HOSPITALS IN PUERTO RICO.—In the case of clinical laboratory services provided by a hospital located in Puerto Rico.

"(2) RURAL PROVIDER.—In the case of clinical laboratory services if the laboratory furnishing the services is in a rural area (as defined in section 1886(d)(2)(D)).

"(3) HOSPITAL OWNERSHIP.—In the case of clinical laboratory services provided by a hospital (other than a hospital described in paragraph (1)) if—

"(A) the referring physician is authorized to perform services at the hospital, and

"(B) the ownership or investment interest is in the hospital itself (and not merely in a subdivision thereof).

"(e) EXCEPTIONS RELATING TO OTHER COMPENSATION ARRANGEMENTS.—The following shall not be considered to be a compensation arrangement described in subsection (a)(2)(B):

"(1) RENTAL OF OFFICE SPACE.—Payments made for the rental or lease of office space if—

"(A) there is a written agreement, signed by the parties, for the rental or lease of the space, which agreement—

"(i) specifies the space covered by the agreement and dedicated for the use of the lessee,

"(ii) provides for a term of rental or lease of at least one year;

"(iii) provides for payment on a periodic basis of an amount that is consistent with fair market value;

"(iv) provides for an amount of aggregate payments that does not vary (directly or indirectly) based on the volume or value of any referrals of business between the parties; and

"(v) would be considered to be commercially reasonable even if no referrals were made between the parties;

"(B) in the case of rental or lease of office space in which a physician who is an interested investor (or an interested investor who is an immediate family member of the physician) has an ownership or investment interest, the office space is in the same building as the building in which the physician (or group practice of which the physician is a member) has a practice; and

"(C) the arrangement meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

"(2) EMPLOYMENT AND SERVICE ARRANGEMENTS WITH HOSPITALS.—An arrangement between a hospital and a physician (or immediate family member) for the employment of the physician (or family member) or for the provision of administrative services, if—

"(A) the arrangement is for identifiable services;

"(B) the amount of the remuneration under the arrangement—

"(i) is consistent with the fair market value of the services, and

"(ii) is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician;

"(C) the remuneration is provided pursuant to an agreement which would be commercially reasonable even if no referrals were made to the hospital; and

"(D) the arrangement meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

"(3) OTHER SERVICE ARRANGEMENTS.—Remuneration from an entity (other than a hospital) under an arrangement if—

"(A) the arrangement is—

"(i) for specific identifiable services as the medical director or as a member of a medical advisory board at the entity pursuant to a requirement of this title,

"(ii) for specific identifiable physicians' services to be furnished to an individual receiving hospice care if payment for such services may only be made under this title as hospice care,

"(iii) for specific physicians' services furnished to a nonprofit blood center, or

"(iv) for specific identifiable administrative services (other than direct patient care services), but only under exceptional circumstances specified by the Secretary in regulations;

"(B) the requirements described in subparagraphs (B) and (C) of paragraph (2) are met with respect to the entity in the same manner as they apply to a hospital; and

"(C) the arrangement meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

"(4) PHYSICIAN RECRUITMENT.—In the case of remuneration which is provided by a hospital to a physician to induce the physician to relocate to the geographic area served by the hospital in order to be a member of the medical staff of the hospital, if—

"(A) the physician is not required to refer patients to the hospital,

"(B) the amount of the remuneration under the arrangement is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician, and

"(C) the arrangement meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

"(5) ISOLATED TRANSACTIONS.—In the case of an isolated financial transaction, such as a one-time sale of property, if—

"(A) the requirements described in subparagraphs (B) and (C) of paragraph (2) are met with respect to the entity in the same manner as they apply to a hospital, and

"(B) the transaction meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

"(6) SALARIED PHYSICIANS IN A GROUP PRACTICE.—A compensation arrangement involving payment by a group practice of the salary of a physician member of the group practice.

"(f) REPORTING REQUIREMENTS.—Each entity providing covered items or services for which payment may be made under this title shall provide the Secretary with the information concerning the entity's ownership arrangements, including—

"(1) the covered items and services provided by the entity, and

"(2) the names and all of the medicare provider numbers of the physicians who are interested investors or who are immediate relatives of interested investors.

Such information shall be provided in such form, manner, and at such times as the Secretary shall specify. Such information shall first be provided not later than 1 year after the date of the enactment of this section.

"(g) SANCTIONS.—

"(1) DENIAL OF PAYMENT.—No payment may be made under this title for a clinical laboratory service which is provided in violation of subsection (a)(1).

"(2) REQUIRING REFUNDS FOR CERTAIN CLAIMS.—If a person collects any amounts that were billed in violation of subsection (a)(1), the person shall be liable to the individual for, and shall refund on a timely basis to the individual, any amounts so collected.

"(3) CIVIL MONEY PENALTY AND EXCLUSION FOR IMPROPER CLAIMS.—Any person that presents or causes to be presented a bill or a claim for a service that such person knows or should know is for a service for which payment may not be made under paragraph (1) or for which a refund has not been made under paragraph (2) shall be subject to a civil money penalty of not more than $15,000 for each such service. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

"(4) CIVIL MONEY PENALTY AND EXCLUSION FOR CIRCUMVENTION SCHEMES.—Any physician or other entity that enters into an arrangement or scheme (such as a cross-referral arrangement) which the physician or entity knows or should know has a principal purpose of assuring referrals by the physician to a particular entity which, if the physician directly made referrals to such entity, would be in violation of this section, shall be subject to a civil money penalty of not more than $100,000 for each such arrangement or scheme. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

"(5) FAILURE TO REPORT INFORMATION.—Any person who is required, but fails, to meet a reporting requirement of subsection (f) is subject to a civil money penalty of not more than $10,000 for each day for which reporting is required to have been made.

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

"(1) COMPENSATION ARRANGEMENT; REMUNERATION.—(A) The term 'compensation arrangement' means any arrangement involving any remuneration between a physician (or immediate family member) and an entity.

"(B) The term 'remuneration' includes any remuneration, directly or indirectly, overtly or covertly, in cash or in kind.

"(2) EMPLOYEE.—An individual is considered to be 'employed by' or an 'employee' of an entity if the individual would be considered to be an employee of the entity under the usual common law rules applicable in determining the employer-employee relationship (as applied for purposes of section 3121(d)(2) of the Internal Revenue Code of 1986).

"(3) FAIR MARKET VALUE.—The term 'fair market value means the value in arms length transactions, consistent with the general market value, and, with respect to rentals or leases, the value of rental property for general commercial purposes (not taking into account its intended use) and, in the case of a lease of space, not adjusted to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor where the lessor is a potential source of patient referrals to the lessee.

"(4) GROUP PRACTICE.—The term 'group practice' means a group of two or more physicians legally organized as a partnership, professional corporation, foundation, not-for-profit corporation, faculty practice plan, or similar association—

"(A) in which each physician who is a member of the group provides substantially the full range of services

which the physician routinely provides (including medical care, consultation, diagnosis, or treatment) through the joint use of shared office space, facilities, equipment, and personnel;

"(B) for which substantially all of the services of the physicians who are members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group;

"(C) in which the overhead expenses of and the income from the practice are distributed in accordance with methods previously determined by members of the group; and

"(D) which meets such other standards as the Secretary may impose by regulation.

In the case of a faculty practice plan associated with a hospital with an approved medical residency training program in which physician members may provide a variety of different specialty services and provide professional services both within and outside the group (as well as perform other tasks such as research), the previous sentence shall be applied only with respect to the services provided within the faculty practice plan.

"(5) INTERESTED INVESTOR; DISINTERESTED INVESTOR.—The term 'interested investor' means, with respect to an entity, an investor who is a physician in a position to make or to influence referrals or business to the entity (or who is an immediate family member of such an investor), and the term 'disinterested investor' means an investor other than an interested investor.

"(6) REFERRAL; REFERRING PHYSICIAN.—

"(A) PHYSICIANS' SERVICES.—Except as provided in subparagraph (C), in the case of a clinical laboratory service which under law is required to be provided by (or under the supervision of) a physician, the request by a physician for the service, including the request by a physician for a consultation with another physician (and any test or procedure ordered by, or to be performed by (or under the supervision of) that other physician), constitutes a 'referral' by a 'referring physician'.

"(B) OTHER ITEMS.—Except as provided in subparagraph (C), in the case of another clinical laboratory service, the request or establishment of a plan of care by a physician which includes the provision of the clinical laboratory service constitutes a 'referral' by a 'referring physician'.

"(C) CLARIFICATION RESPECTING CERTAIN SERVICES INTEGRAL TO A CONSULTATION BY CERTAIN SPECIALISTS.—A request by a pathologist for clinical diagnostic laboratory tests and pathological examination services, if such services are furnished by (or under the supervision of) such pathologist pursuant to a consultation requested by another physician does not constitute a 'referral' by a 'referring physician'.".

(b) REQUIRING REQUESTS FOR PAYMENT TO INCLUDE INFORMATION ON REFERRING PHYSICIAN.—Section 1833 of such Act (42 U.S.C. 1395l) is amended by adding at the end the following new subsection:

"(q)(1) Each request for payment, or bill submitted, for an item or service furnished by an entity for which payment may be made under this part and for which the entity knows or has reason to believe there has been a referral by a referring physician (within the

meaning of section 1877) shall include the name and provider number for the referring physician and indicate whether or not the referring physician is an interested investor (within the meaning of section 1877(h)(5)).

"(2)(A) In the case of a request for payment for an item or service furnished by an entity under this part on an assignment-related basis and for which information is required to be provided under paragraph (1) but not included, payment may be denied under this part.

"(B) In the case of a request for payment for an item or service furnished by an entity under this part not submitted on an assignment-related basis and for which information is required to be provided under paragraph (1) but not included—

"(i) if the entity knowingly and willfully fails to provide such information promptly upon request of the Secretary or a carrier, the entity may be subject to a civil money penalty in an amount not to exceed $2,000, and

"(ii) if the entity knowingly, willfully, and in repeated cases fails, after being notified by the Secretary of the obligations and requirements of this subsection to provide the information required under paragraph (1), the entity may be subject to exclusion from participation in the programs under this Act for a period not to exceed 5 years, in accordance with the procedures of subsections (c), (f), and (g) of section 1128.

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under clause (i) in the same manner as they apply to a penalty or proceeding under section 1128A(a).".

42 USC 1395nn note.

(c) EFFECTIVE DATES.—

(1) Except as provided in paragraph (2), the amendments made by this section shall become effective with respect to referrals made on or after January 1, 1992.

(2) The reporting requirement of section 1877(f) of the Social Security Act shall take effect on October 1, 1990.

42 USC 1395nn note.

(d) DEADLINE FOR CERTAIN REGULATIONS.—The Secretary of Health and Human Services shall publish final regulations to carry out section 1877 of the Social Security Act by not later than October 1, 1990.

42 USC 1395nn note.

(e) GAO STUDY OF OWNERSHIP BY REFERRING PHYSICIANS.—The Comptroller General shall conduct a study of the ownership of hospitals and other providers of medicare services by referring physicians. Such study shall investigate—

(1) the types of such ownership arrangements and types of services offered under such arrangements,

(2) the returns generally earned by physician investors in such arrangements,

(3) the effect of such arrangements on (A) the utilization of items and services by medicare beneficiaries, (B) medicare expenditures, and (C) other entities providing items and services in the communities served,

(4) the effect of such arrangements on independent providers of similar services, and

(5) the effect on the provision of in-office clinical laboratory services of the limitation on payment for certain referrals contained in section 1877 of the Social Security Act.

Reports.

By not later than February 1, 1991, the Comptroller General shall report to Congress on the results of such study.

(f) QUARTERLY REPORTS TO CONGRESS ON COMPARATIVE UTILIZATION.—The Secretary of Health and Human Services shall submit to the Congress and the Comptroller General, not later than 90 days after the end of each calendar quarter, a report which provides a statistical profile (by State and type of item or service) comparing utilization of items and services by medicare beneficiaries served by entities in which the referring physician has a direct or indirect financial interest and by medicare beneficiaries served by other entities. 42 USC 1395nn note.

SEC. 6205. COSTS OF NURSING AND ALLIED HEALTH EDUCATION.

(a) RECOGNITION OF COSTS OF CERTAIN HOSPITAL-BASED NURSING SCHOOLS.—

(1) IN GENERAL.—(A) The reasonable costs incurred by a hospital in training students of a hospital-based nursing school shall be allowable as reasonable costs under title XVIII of the Social Security Act and reimbursed under such title on the same basis as if they were allowable direct costs of a hospital-operated educational program (other than an approved graduate medical education program) if, before June 15, 1989, and thereafter, the hospital demonstrates that for each year, it incurs at least 50 percent of the costs of training nursing students at such school, the nursing school and the hospital share some common board members, and all instruction is provided at the hospital or, if in another building, a building on the immediate grounds of the hospital. 42 USC 1395x note.

(B) Section 8411(b) of the Technical and Miscellaneous Revenue Act of 1988 is amended by striking "1989, 1990, and" and inserting "1986 through". 42 USC 1395b-1 note.

(2) EFFECTIVE DATE.—Paragraph (1)(A) shall apply with respect to cost reporting periods beginning on or after the date of the enactment of this Act and on or before the date on which the Secretary issues regulations pursuant to subsection (b)(2)(A). 42 USC 1395x note.

(b) DELAY IN RECOUPMENT OF CERTAIN NURSING AND ALLIED EDUCATION COSTS.— 42 USC 1395ww note.

(1) The Secretary of Health and Human Services (in this subsection referred to as the "Secretary") shall not, before October 1, 1990, recoup from, or otherwise reduce or adjust payments under title XVIII of the Social Security Act to, hospitals because of alleged overpayments to such hospitals under such title due to a determination that costs which were reported by a hospital on its medicare cost reports relating to approved nursing and allied health education programs were allowable costs and are included in the definition of "operating costs of inpatient hospital services" pursuant to section 1886(a)(4) of such Act, so that no pass-through of such costs was permitted under that section.

(2)(A) Before July 1, 1990, the Secretary shall issue regulations respecting payment of costs described in paragraph (1). Regulations.

(B) In issuing such regulations—

(i) the Secretary shall allow a comment period of not less than 60 days,

(ii) the Secretary shall consult with the Prospective Payment Assessment Commission, and

Federal Register, publication.

(iii) any final rule shall not be effective prior to October 1, 1990, or 30 days after publication of the final rule in the Federal Register, whichever is later.

(C) Such regulations shall specify—

(i) the relationship required between an approved nursing or allied health education program and a hospital for the program's costs to be attributed to the hospital;

(ii) the types of costs related to nursing or allied health education programs that are allowable by medicare;

(iii) the distinction between costs of approved educational activities as recognized under section 1886(a)(3) of the Social Security Act and educational costs treated as operating costs of inpatient hospital services; and

(iv) the treatment of other funding sources for the program.

SEC. 6206. DISCLOSURE OF ASSUMPTIONS IN ESTABLISHING AAPCC; ELIMINATION OF COORDINATED OPEN ENROLLMENT REQUIREMENT.

(a) DISCLOSURE OF ASSUMPTIONS IN ESTABLISHING AAPCC.—

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

"(F)(i) At least 45 days before making the announcement under subparagraph (A) for a year (beginning with the announcement for 1991), the Secretary shall provide for notice to eligible organizations of proposed changes to be made in the methodology or benefit coverage assumptions from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity to comment on such proposed changes.

"(ii) In each announcement made under subparagraph (A) for a year (beginning with the announcement for 1991), the Secretary shall include an explanation of the assumptions (including any benefit coverage assumptions) and changes in methodology used in the announcement in sufficient detail so that eligible organizations can compute per capita rates of payment for classes of individuals located in each county (or equivalent area) which is in whole or in part within the service area of such an organization.".

42 USC 1395mm note.

(2) NOTICE.—Before July 1, 1990, the Secretary of Health and Human Services shall provide for notice to eligible organizations of the methodology used in making the announcement under section 1876(a)(1)(A) of the Social Security Act for 1990.

(b) ELIMINATION OF COORDINATED OPEN ENROLLMENT REQUIREMENT.—

(1) IN GENERAL.—Section 1876(c)(3)(A) of such Act (42 U.S.C. 1395mm(c)(3)(A)) is amended—

(A) in clause (i), by striking "30-day period" and inserting "period or periods", and

(B) by striking clause (ii) and inserting the following:

Contracts.

"(ii)(I) If a risk-sharing contract under this section is not renewed or is otherwise terminated, eligible organizations with risk-sharing contracts under this section and serving a part of the same service area as under the terminated contract are required to have an open enrollment period for individuals who were enrolled under the terminated contract as of the date of notice of such termination. If a risk-sharing contract under this section is renewed in a manner that discontinues coverage for individuals residing in part of the service

area, eligible organizations with risk-sharing contracts under this section and enrolling individuals residing in that part of the service area are required to have an open enrollment period for individuals residing in the part of the service area who were enrolled under the contract as of the date of notice of such discontinued coverage.

"(II) The open enrollment periods required under subclause (I) shall be for 30 days and shall begin 30 days after the date that the Secretary provides notice of such requirement.

"(III) Enrollment under this clause shall be effective 30 days after the end of the open enrollment period, or, if the Secretary determines that such date is not feasible, such other date as the Secretary specifies.".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect 60 days after the date of the enactment of this Act. 42 USC 1395mm note.

SEC. 6207. EXTENSION OF EXPIRING AUTHORITIES.

(a) DELAY IN EFFECTIVE DATE IN PHYSICIAN INCENTIVE RULES.—Section 9313(c)(2)(B) of the Omnibus Budget Reconciliation Act of 1986, as amended by section 4016 of the Omnibus Budget Reconciliation Act of 1987, is amended by striking "April 1, 1990" and inserting "April 1, 1991". 42 USC 1320a-7a note.

(b) EXTENSION OF PROHIBITION ON COST SAVINGS POLICIES BEFORE BEGINNING OF FISCAL YEAR.—Section 4039(d) of the Omnibus Budget Reconciliation Act of 1987, as amended by section 426(e) of the Medicare Catastrophic Coverage Act of 1988, is amended— 42 USC 1395ww note.

(1) by striking "October 15, 1989" and inserting "October 15, 1990", and

(2) by inserting "or in fiscal year 1991" after "fiscal year 1990".

Subpart B—Technical and Miscellaneous Provisions

SEC. 6211. MEDICARE HOSPITAL PATIENT PROTECTION AMENDMENTS.

(a) SCOPE OF HOSPITAL RESPONSIBILITY FOR SCREENING.—Subsection (a) of section 1867 of the Social Security Act (42 U.S.C. 1395dd) is amended by striking "department" the third place it appears and inserting the following: "department, including ancillary services routinely available to the emergency department,".

(b) INFORMED REFUSALS OF TREATMENT OR TRANSFERS.—Subsection (b) of such section is amended—

(1) in paragraph (2)—

(A) by inserting "and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment," after "in that paragraph",

(B) by striking "or treatment" and inserting "and treatment", and

(C) by adding at the end the following new sentence: "The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment."; and

(2) in paragraph (3)—

(A) by inserting "and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer," after "with subsection (c)", and

(B) by adding at the end the following new sentence: "The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.".

(c) AUTHORIZATION FOR TRANSFERS.—

(1) INFORMED CONSENT FOR TRANSFERS AT INDIVIDUAL REQUEST.—Subsection (c)(1)(A)(i) of such section is amended by striking "requests that the transfer be effected" and inserting "after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility".

(2) CLARIFYING PHYSICIAN AUTHORIZATION FOR TRANSFERS.—Subsection (c)(1)(A) of such section is amended—

(A) by striking "or" at the end of clause (i);

(B) in clause (ii)—

(i) by striking ", or other qualified medical personnel when a physician is not readily available in the emergency department,", and

(ii) by inserting "of transfer" after "information available at the time";

(C) by striking "; and" at the end of clause (ii) and inserting ", or", and

(D) by adding at the end the following new clause:

"(iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1861(r)(1)), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and".

(3) STANDARD FOR AUTHORIZING TRANSFER.—Subsection (c)(1)(A)(ii) of such section is amended—

(A) by striking ", based upon the reasonable risks and benefits to the patient, and", and

(B) by striking "individual's medical condition" and inserting "individual and, in the case of labor, to the unborn child".

(4) INCLUSION OF SUMMARY OF RISKS AND BENEFITS IN CERTIFICATE OF TRANSFER.—Subsection (c)(1) of such section is amended by adding at the end the following:

"A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.".

(5) PROVISION OF SERVICES PENDING TRANSFER.—Subsection (c)(2) of such section is amended—

(A) by redesignating subparagraphs (A) through (D) as subparagraphs (B) through (E), respectively, and

(B) by inserting before subparagraph (B), as so redesignated, the following new subparagraph:

"(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;".

(d) REQUIRING MAINTENANCE OF RECORDS OF TRANSFERS.—Subsection (c)(2)(C) of such section, as redesignated by subsection (c)(5)(A) of this section, is amended—

(1) by striking "provides" and inserting "sends to", and

(2) by striking "with appropriate medical records" and all that follows through "transferring hospital" and inserting "all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(2)(C)) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment".

(e) PHYSICIAN LIABILITY.—Subsection (d)(2) of such subsection is amended—

(1) by amending subparagraph (B) to read as follows:

"(B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who knowingly violates a requirement of this section, including a physician who—

"(i) signs a certification under subsection (c)(1)(A) that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or

"(ii) misrepresents an individual's condition or other information, including a hospital's obligations under this section,

is subject to a civil money penalty of not more than $50,000 for each such violation and, if the violation is knowing and willful or negligent, to exclusion from participation in this title and State health care programs. The provisions of section 1128A (other than the first and second sentences of subsection (a) and subsection (b)) shall apply to a civil money penalty and exclusion under this subparagraph in the same manner as such provisions apply with respect to a penalty, exclusion, or proceeding under section 1128A(a)."; and

(2) by striking subparagraph (C) and inserting the following:

"(C) If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians (required to be maintained under section 1866(a)(1)(I)) and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph (B). However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.".

(f) ADDITIONAL OBLIGATIONS.—Such section is amended by adding at the end the following new subsections:

"(g) NONDISCRIMINATION.—A participating hospital that has specialized capabilities or facilities (such as burn units, shock-

trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

"(h) NO DELAY IN EXAMINATION OR TREATMENT.—A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) or further medical examination and treatment required under subsection (b) in order to inquire about the individual's method of payment or insurance status.

"(i) WHISTLEBLOWER PROTECTIONS.—A participating hospital may not penalize or take adverse action against a physician because the physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized.".

(g) CHANGE IN "PATIENT" TERMINOLOGY.—

(1) Subsection (c) of such section is amended—

(A) by striking "PATIENT" and inserting "INDIVIDUAL", and

(B) by striking "a patient" "the patient", "patient's", and "patients" each place each appears and inserting "an individual", "the individual", "individual's", and "individuals", respectively.

(2) Subsection (e)(5) of such section is amended by striking "a patient" each place it appears and inserting "an individual".

(h) CLARIFICATION OF "EMERGENCY MEDICAL CONDITION" DEFINITION.—

(1) IN GENERAL.—Subsection (e) of such section (as amended by section 6003(g)(3)(D)(xiv)) is amended—

(A) in paragraph (1), by striking "means" and all that follows and inserting the following:

"means—

"(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

"(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

"(ii) serious impairment to bodily functions, or

"(iii) serious dysfunction of any bodily organ or part; or

"(B) with respect to a pregnant women who is having contractions—

"(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

"(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.";

(B) by striking paragraph (2);

(C) in paragraph (4)(A)—

(i) by inserting "described in paragraph (1)(A)" after "emergency medical condition",

(ii) by inserting "or occur during" after "likely to result from",

(iii) by inserting before the period at the end the following: ", or, with respect to an emergency medical

condition described in paragraph (1)(B), to deliver (including the placenta)";

(D) in paragraph (4)(B)—

(i) by inserting "described in paragraph (1)(A)" after "emergency medical condition",

(ii) by inserting "or occur during" after "to result from", and

(iii) by inserting before the period at the end the following: ", or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta)"; and

(E) by redesignating paragraphs (3) through (6) as paragraphs (2) through (5), respectively.

(2) CONFORMING AMENDMENTS.—Such section is further amended—

(A) in the heading, by striking "ACTIVE";

(B) in subsection (a), by striking "or to determine if the individual is in active labor (within the meaning of section (e)(2))";

(C) in the heading of subsection (b), by striking "ACTIVE";

(D) in subsection (b)(1)—

(i) by striking "or is in active labor", and

(ii) in subparagraph (A), by striking "or to provide for treatment of the labor"; and

(E) in subsection (c)(1), by striking "(e)(4)(B)) or is in active labor" and inserting "(e)(3)(B))".

(i) EFFECTIVE DATE.—The amendments made by this section shall take effect on the first day of the first month that begins more than 180 days after the date of the enactment of this Act, without regard to whether regulations to carry out such amendments have been promulgated by such date. 42 USC 1395dd note.

SEC. 6212. HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS.

(a) TEMPORARY WAIVER FOR WATTS HEALTH FOUNDATION.—Section 9312(c)(3)(D) of the Omnibus Budget Reconciliation Act of 1986, as added by section 4018(d) of the Omnibus Budget Reconciliation Act of 1987, is amended— 42 USC 1395mm note. 42 USC 1320a-7a note.

(1) in clause (i), by striking "January 1, 1990" and inserting "January 1, 1994"; and

(2) by amending clauses (ii) and (iii) to read as follows:

"(ii) beginning on January 1, 1990, the Secretary of Health and Human Services shall conduct an annual review of the organization to determine the organization's compliance with the quality assurance requirements of section 1876(c)(6) of such Act; and

"(iii) after January 1, 1990, if the organization receives an unfavorable review under clause (ii), the Secretary, after notice to the organization of the unfavorable review and an opportunity to correct any deficiencies identified during the review, may provide for the sanction described in section 1876(f)(3) of such Act effective with respect to individuals enrolling with the organization after the date the Secretary notifies the organization that the organization is not in compliance with the requirements of section 1876(c)(6) of such Act.".

(b) LIMIT ON CHARGES FOR EMERGENCY SERVICES AND OUT-OF-AREA COVERAGE.—

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

"(j)(1)(A) In the case of physicians' services described in paragraph (2) which are furnished by a participating physician to an individual enrolled with an eligible organization under this section and enrolled under part B, the participation agreement under section 1842(h)(1) is deemed to provide that the physician will accept as payment in full from the eligible organization the amount that would be payable to the physician under part B and from the individual under such part, if the individual were not enrolled with an eligible organization under this section.

"(B) In the case of physicians' services described in paragraph (2) which are furnished by a nonparticipating physician, the limitations on actual charges for such services otherwise applicable under part B (to services furnished by individuals not enrolled with an eligible organization under this section) shall apply in the same manner as such limitations apply to services furnished to individuals not enrolled with such an organization.

"(2) The physicians' services described in this paragraph are physicians' services which—

"(A) are emergency services or out-of-area coverage (described in clauses (iii) and (iv) of subsection (b)(2)(A)), and

"(B) are furnished to an enrollee of an eligible organization under this section by a person who is not under a contract with the organization.".

42 USC 1395mm note.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services furnished on or after April 1, 1990.

(c) MAKING AUTHORITY FOR BENEFIT STABILIZATION FUND PERMANENT.—

(1) REPEAL ON LIMITATION ON ESTABLISHMENT OF A FUND.—Section 2350(b) of the Deficit Reduction Act of 1984 (Public Law 98-369) is amended by striking paragraphs (3) and (4).

42 USC 1395mm note.

(2) REPEAL ON LIMITING PERIOD OF USE.—Section 1876(g)(5) of the Social Security Act (42 U.S.C. 1395mm(g)(5)) is amended by striking "and during a period of not longer than four years".

42 USC 1395mm note.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date of the enactment of this Act.

SEC. 6213. RURAL HEALTH CLINIC SERVICES.

(a) STAFFING REQUIREMENTS; INCLUSION OF NURSE-MIDWIFE SERVICES.—Section 1861(aa)(2) of the Social Security Act (42 U.S.C. 1395x(aa)(2)) is amended—

(1) by striking "; and" at the end of subparagraph (I) and inserting a semicolon;

(2) by redesignating subparagraph (J) as subparagraph (K); and

(3) by inserting after subparagraph (I) the following new subparagraph:

"(J) has a nurse practitioner, a physician assistant, or a certified nurse-midwife (as defined in subsection (gg)) available to furnish patient care services not less than 50 percent of the time the clinic operates; and".

(b) COVERAGE OF SOCIAL WORKER SERVICES.—Section 1861(aa)(1)(B) of such Act (42 U.S.C. 1395x(aa)(1)(B)) is amended—

(1) by striking "or" before "by"; and

(2) by inserting "or by a clinical social worker (as defined in subsection (hh)(1))," after "Secretary)".

(c) EXPANSION OF ELIGIBLE AREAS.—The second sentence of section 1861(aa)(2) of such Act is amended— 42 USC 1395x.

(1) by striking "designated by the Secretary" and inserting "designated by the chief executive officer of the State and certified by the Secretary as an area with a shortage of personal health services, or that is designated by the Secretary";

(2) by striking "section 1302(7) of the Public Health Service Act or" and inserting "section 330(b)(3) or 1302(7) of the Public Health Service Act,"; and

(3) by striking "medical care manpower," and inserting the following: "medical care manpower, (III) as a high impact area described in section 329(a)(5) of that Act, or (IV) as an area which includes a population group which the Secretary determines has a health manpower shortage under section 332(a)(1)(B) of that Act,".

(d) EFFECTIVE DATE.—The amendments made by subsections (a) through (c) of this section shall take effect October 1, 1989. 42 USC 1395x note.

(e) DISSEMINATION OF RURAL HEALTH CLINIC INFORMATION.— State and local governments.

(1) IN GENERAL.—Not later than 60 days after the date of the enactment of this Act, the Secretary of Health and Human Services, in consultation with the Director of the Office of Rural Health Policy, shall disseminate to health care facilities and to the chief executive officer, chief health officer, and chief human services officer of each State, applications and other necessary information to enable such a facility to apply for designation as a rural health clinic for the purposes of titles XVIII and XIX of the Social Security Act. 42 USC 1395x note.

(2) DEFINITIONS.—For purposes of this subsection:

(A) The term "health care facility" means a community health center or a migrant health center, or a hospital, home health agency, or skilled nursing facility participating in a program established under title XVIII or title XIX of the Social Security Act.

(B) The term "State" includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

(f) TREATMENT OF CERTAIN FACILITIES AS RURAL HEALTH CLINICS.— The Secretary of Health and Human Services shall not deny certification of a facility as a rural health clinic under section 1861(aa)(2) of the Social Security Act if the facility is located on an island and would otherwise be qualified to be certified as such a facility but for the requirement that the services of a physician assistant or nurse practitioner be provided in the facility. 42 USC 1395x note.

(g) EXPANSION OF FUNCTIONS OF OFFICE OF RURAL HEALTH POLICY.—Section 711(b) of the Social Security Act (42 U.S.C. 912(b)) is amended—

(1) in paragraph (2)(A), by striking "health care issues" and inserting "health care issues, including rural mental health, rural infant mortality prevention, and rural occupational safety and preventive health promotion";

(2) in paragraph (2)(C), by striking "rural areas" and inserting "rural areas, including programs providing community-based mental health services, pre-natal and infant care services, and

rural occupational safety and preventive health education and promotion"; and

(3) in paragraph (4), by striking "rural health care" and inserting "rural health care, including activities relating to rural mental health, rural infant mortality, and rural occupational safety and preventive health promotion".

SEC. 6214. DETERMINING ELIGIBILITY OF HOME HEALTH AGENCIES FOR WAIVER OF LIABILITY FOR DENIED CLAIMS.

(a) SCOPE OF WAIVER AND DETERMINATION OF DENIED CLAIM.—Section 1879(f) of the Social Security Act (42 U.S.C. 1395pp(f)) is amended—

(1) in paragraph (1), by striking "with respect to" and all that follows and inserting a period; and

(2) in paragraph (4), by striking "(4) The requirement" and inserting "(4)(A) The requirement", and by adding at the end the following new subparagraph:

"(B) For purposes of determining the rate of denial of bills for a home health agency under subparagraph (A), a bill shall not be considered to be denied until the expiration of the 60-day period that begins on the date such bill is denied by the fiscal intermediary, or, with respect to such a denial for which the agency requests reconsideration, until the fiscal intermediary issues a decision denying payment for such bill.".

(b) MONITORING OF DENIED CLAIMS.—Section 1879(f) of such Act (42 U.S.C. 1395pp(f)) is amended by adding at the end the following new paragraph:

"(6) The Secretary shall monitor the proportion of denied bills submitted by home health agencies for which reconsideration is requested, and shall notify Congress if the proportion of denials reversed upon reconsideration increases significantly.".

42 USC 1395pp note.

(c) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to determinations for quarters beginning on or after the date of the enactment of this Act.

SEC. 6215. EXTENSION OF AUTHORITY TO CONTRACT WITH FISCAL INTERMEDIARIES AND CARRIERS ON OTHER THAN A COST BASIS.

42 USC 1395h note.

(a) IN GENERAL.—Section 2326(a) of the Deficit Reduction Act of 1984 is amended—

(1) in the first sentence, by striking "fiscal year 1989" and inserting "fiscal year 1993",

(2) in the second sentence, by striking "over a period of time" and inserting "over a 2-year period of time", and

(3) by inserting after the second sentence the following: "In addition, during such period the Secretary may enter into such additional agreements and contracts without regard to such cost reimbursement provisions if the fiscal intermediary or carrier involved and the Secretary agree to waive such provisions, but the Secretary may not take any action that has the effect of requiring that the intermediary or carrier agree to waive such provisions, including requiring such a waiver as a condition for entering into or renewing such an agreement or contract.".

42 USC 1395h note.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply beginning with fiscal year 1990.

SEC. 6216. EXPANSION OF RURAL HEALTH MEDICAL EDUCATION DEMONSTRATION PROJECT.

(a) NUMBER OF PROJECTS.—Section 4038(a) of the Omnibus Budget Reconciliation Act of 1987 is amended by striking "four sponsoring hospitals" and inserting "10 sponsoring hospitals". 42 USC 1395ww note.

(b) SELECTION OF NEW PROJECTS.—Section 4038(c) of such Act is amended—

(1) by striking "In selecting" and inserting "(1) In selecting";

(2) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B); and

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

"(2) The provisions of paragraph (1) shall not apply with respect to applications submitted as a result of amendments made by section 6216 of the Omnibus Budget Reconciliation Act of 1989.".

(c) COMMENCEMENT OF NEW PROJECTS.—Section 4038(e) of such Act is amended by inserting "(or the date of the enactment of the Omnibus Budget Reconciliation Act of 1989, in the case of a project conducted as a result of the amendments made by section 6216 of such Act)" after "this Act".

SEC. 6217. INNER-CITY HOSPITAL TRIAGE DEMONSTRATION PROJECT. 42 USC 1395ww note.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services shall establish a demonstration project in a public hospital that is located in a large urban area and that has established a triage system, under which the Secretary shall make payments for 3 years to reimburse the hospital for the reasonable costs of operating the system, including costs—

(1) to train hospital personnel to operate and participate in the system; and

(2) to provide services to patients who might otherwise be denied appropriate and prompt care.

(b) LIMITATIONS ON PAYMENT.—(1) The Secretary may not make payment under the demonstration project established under subsection (a) for costs that the Secretary determines are not reasonable.

(2) The amount of payment made under the demonstration project during a single year may not exceed $500,000.

SEC. 6218. GAO STUDY OF ADMINISTRATIVE COSTS OF MEDICARE PROGRAM.

(a) STUDY.—The Comptroller General shall conduct a study of the administrative burden of medicare regulations and program requirements on providers of services, fiscal intermediaries, and carriers, and shall include in such study—

(1) an assessment of current administrative costs to such entities and of trends in such administrative costs since 1982; and

(2) a comparison of the administrative burden to such entities in providing services to individuals who are not medicare beneficiaries.

For purposes of such assessment, administrative costs shall include personnel costs, training costs, the costs of data and communications systems as affected by changes in requirements of the medicare program, and costs to such entities of non-compliance with such requirements resulting from the failure of the Secretary of Health and Human Services to provide entities with adequate notice of changes in program requirements.

(b) REPORT.—Not later than March 31, 1990, the Comptroller General shall submit a report to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate on the study conducted under subsection (a).

SEC. 6219. PROVISIONS RELATING TO END STAGE RENAL DISEASE SERVICES.

(a) FLEXIBILITY IN FUNDING ESRD NETWORK ORGANIZATIONS.—The last sentence of section 1881(b)(7) of the Social Security Act (42 U.S.C. 1395rr(b)(7)) is amended by striking "network administrative" and all that follows and inserting the following: "organizations (designated under subsection (c)(1)(A)) for such organizations' necessary and proper administrative costs incurred in carrying out the responsibilities described in subsection (c)(2). The Secretary shall provide that amounts paid under the previous sentence shall be distributed to the organizations described in subsection (c)(1)(A) to ensure equitable treatment of all such network organizations. The Secretary in distributing any such payments to network organizations shall take into account—

"(A) the geographic size of the network area;

"(B) the number of providers of end stage renal disease services in the network area;

"(C) the number of individuals who are entitled to end stage renal disease services in the network area; and

"(D) the proportion of the aggregate administrative funds collected in the network area.".

(b) LIABILITY PROTECTION FOR ESRD NETWORK ORGANIZATIONS AND PROHIBITION AGAINST DISCLOSURE OF INFORMATION.—Section 1881(c) of such Act (42 U.S.C. 1395rr(c)) is amended by adding at the end the following new paragraph:

"(8) The provisions of sections 1157 and 1160 shall apply with respect to network administrative organizations (including such organizations as medical review boards) with which the Secretary has entered into agreements under this subsection.".

(c) REPORT ON PAYMENT FOR ERYTHROPOIETIN (EPO).—Not later than April 1, 1990, the Secretary of Health and Human Services shall submit a report to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate and to the Comptroller General on the methodology and rationale used to establish a payment rate for the drug erythropoietin (EPO) under title XVIII of the Social Security Act and shall include in the report (1) a summary of information provided to the Secretary by the manufacturer of EPO and used by the Secretary to establish such rate and (2) a plan for ensuring the appropriateness of such rate in the future.

SEC. 6220. AMENDMENTS RELATING TO THE UNITED STATES BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE.

42 USC 1395b note.

(a) COMMISSION NAME.—Section 401 of the Medicare Catastrophic Coverage Act of 1988 is amended by inserting before the period at the end the following: "and also to be known as the 'Claude Pepper Commission' or the 'Pepper Commission' ".

42 USC 1395b note.

(b) 4 VICE CHAIRMEN.—Section 403(b) of such Act is amended—

(1) by striking "VICE CHAIRMAN" and inserting "VICE CHAIRMEN"; and

(2) by striking "vice chairman" and inserting "4 vice chairmen".

(c) ADDITIONAL MAILING PRIVILEGE.—Section 405(f) of such Act is amended by inserting before the period at the end the following: ", and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code". 42 USC 1395b note.

(d) PRINTING OF REPORTS.—Section 405 of such Act is further amended by adding at the end the following new subsection:

"(j) PRINTING.—For purposes of costs relating to printing and binding, including the costs of personnel detailed from the Government Printing Office, the Commission shall be deemed to be a committee of the Congress.".

(e) REPORT DEADLINES.—Section 406 of such Act is amended— 42 USC 1395b note.

(1) in each of subsections (a) and (b), by striking ", not later than" and all that follows through "for the Commission,"; and

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

"(c) DEADLINES.—The two reports required under this section shall be submitted concurrently by not later than November 9, 1989.".

SEC. 6221. NATIONAL COMMISSION ON CHILDREN.

Section 1139 of the Social Security Act (42 U.S.C. 1320b-9) is amended—

(1) in subsection (d)—

(A) by striking "September 30, 1988" and inserting "March 31, 1990"; and

(B) by striking "March 31, 1990" and inserting "March 31, 1991";

(2) in subsection (e), by striking "September 30, 1990" and inserting "March 31, 1991";

(3) in subsection (j), by striking "such sums" and inserting "through fiscal year 1991, such sums"; and

(4) by adding at the end thereof the following new subsections:

"(k)(1) The Commission is authorized to accept donations of money, property, or personal services. Funds received from donations shall be deposited in the Treasury in a separate fund created for this purpose. Funds appropriated for the Commission and donated funds may be expended for such purposes as official reception and representation expenses, public surveys, public service announcements, preparation of special papers, analyses, and documentaries, and for such other purposes as determined by the Commission to be in furtherance of its mission to review national issues affecting children. Gifts and property.

"(2) For purposes of Federal income, estate, and gift taxation, money and other property accepted under paragraph (1) of this subsection shall be considered as a gift or bequest to or for the use of the United States.

"(3) Expenditure of appropriated and donated funds shall be subject to such rules and regulations as may be adopted by the Commission and shall not be subject to Federal procurement requirements.

"(l) The Commission is authorized to conduct such public surveys as it deems necessary in support of its review of national issues affecting children and, in conducting such surveys, the Commission shall not be deemed to be an 'agency' for the purpose of section 3502 of title 44, United States Code.".

42 USC 1395x note.

SEC. 6222. CONTINUED USE OF HOME HEALTH WAGE INDEX IN EFFECT PRIOR TO JULY 1, 1989, UNTIL AFTER JULY 1, 1991.

Notwithstanding the requirement of section 1861(v)(1)(L)(iii) of the Social Security Act, the Secretary of Health and Human Services shall, in determining the limits of reasonable costs under title XVIII of the Social Security Act with respect to services furnished by home health agencies, continue to utilize the wage index that was in effect for cost reporting periods beginning before July 1, 1989, until cost reporting periods beginning on or after July 1, 1991.

SEC. 6223. HCFA PERSONNEL STUDY.

(a) IN GENERAL.—The Secretary of Health and Human Services shall (subject to subsection (c)) enter into an agreement with the National Academy of Public Administration (hereafter in this section referred to as the "Academy") to—

(1) study personnel administration at the Health Care Financing Administration (hereafter in this section referred to as "HCFA");

(2) assess the adequacy of HCFA staffing; and

(3) recommend any needed changes with respect to HCFA staffing to the Secretary of Health and Human Services and the Congress.

(b) REQUIREMENTS OF STUDY.—In conducting the study, the Academy shall interview management officials at HCFA and other appropriate agencies. The study shall include consideration of—

(1) the average years in service, years to retirement and average age of various categories of HCFA personnel;

(2) the adequacy of HCFA practices to recruit personnel to replace persons who retire or resign and train new employees in the intricacies of HCFA programs;

(3) the grade structure of various categories of HCFA personnel, and the need for additional nonsupervisory positions at the GS-13, GS-14, and GS-15 levels for particularly skilled and expert personnel needed for HCFA to carry out its missions;

(4) the grade structure at HCFA with Federal agencies of similar size and responsibilities;

(5) whether bonus payments or other incentives are needed for HCFA to recruit and retain specialized personnel;

(6) particular problems in hiring personnel that may prevent recruitment and retention of qualified staff;

(7) Office of Personnel Management rules that may be burdensome to the hiring process; and

(8) how HCFA can more appropriately address the priorities of both Congress and the executive branch of Government.

(c) ARRANGEMENTS FOR STUDY.—The Secretary shall request the Academy, acting through appropriate units, to submit an application to conduct the study described in this section. If the Academy submits an acceptable application, the Secretary shall enter into an appropriate arrangement with the Academy for the conduct of the study. If the Academy does not submit an acceptable application to conduct the study, the Secretary may request one or more appropriate nonprofit private entities to submit an application to conduct the study and may enter into an appropriate arrangement for the conduct of the study by the entity which submits the best acceptable application.

(d) DATE OF REPORT.—The results of the study shall be reported to Congress and the Secretary of Health and Human Services no later than December 31, 1990.

SEC. 6224. PEER REVIEW ORGANIZATIONS.

(a) PEER REVIEW OF NON-PHYSICIAN SERVICES.—

(1) IN GENERAL.—Section 1154(a)(1) of the Social Security Act (42 U.S.C. 1320c-3(a)(1)) is amended by adding at the end the following:

"If the organization performs such reviews with respect to a type of health care practitioner other than medical doctors, the organization shall establish procedures for the involvement of health care practitioners of that type in such reviews.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to contracts entered into after the date of the enactment of this Act. 42 USC 1320c-3 note.

(b) PROVIDER AND PRACTITIONER RIGHT TO RECONSIDERATION OF PRO DETERMINATION BEFORE NOTICE TO BENEFICIARY.—

(1) IN GENERAL.—Section 1154(a)(3) of the Social Security Act (42 U.S.C. 1320c-3(a)(3)) is amended—

(A) in subparagraph (A), by striking "subparagraph (B)" and inserting "subparagraphs (B) and (D)",

(B) in subparagraph (B), by inserting "with respect to services or items disapproved by reason of subparagraph (A) or (C) of paragraph (1)" after "under subparagraph (A)", and

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

"(D) The notification under subparagraph (A) with respect to services or items disapproved by reason of paragraph (1)(B) shall not occur until after—

"(i) the organization has notified the practitioner or provider involved of the determination and of the practitioner's or provider's right to a formal reconsideration of the determination under section 1155, and

"(ii) if the provider or practitioner requests such a reconsideration, the organization has made such a reconsideration.

If a provider or practitioner is provided a reconsideration, such reconsideration shall be in lieu of any subsequent reconsideration to which the provider or practitioner may be otherwise entitled under section 1155, but shall not affect the right of a beneficiary from seeking reconsideration under such section of the organization's determination (after any reconsideration requested by the provider or physician under clause (ii)).

"(E) In the case of services and items disapproved by reason of paragraph (1)(B), the notice to the patient shall state the following: 'In the judgment of the peer review organization, the medical care received was not acceptable under the medicare program. The reasons for the denial have been discussed with your physician and hospital.'.".

(2) CONFORMING AMENDMENT.—Section 1155 of such Act (42 U.S.C. 1320c-5) is amended by inserting ", subject to section 1154(a)(3)(D)," before "any practitioner or provider". 42 USC 1320c-4.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to determinations by utilization and quality control peer review organizations with respect to which prelimi- 42 USC 1320c-3 note.

nary notifications were made under section 1154(a)(3)(B) of the Social Security Act more than 30 days after the date of the enactment of this Act.

PART 4—PART B PREMIUM

SEC. 6301. PART B PREMIUM.

Section 1839(e) of the Social Security Act (42 U.S.C. 1395r(e)) is amended by striking "1990" each place it appears and inserting "1991".

Subtitle B—Medicaid

PART 1—GENERAL PROVISIONS

SEC. 6401. MANDATORY COVERAGE OF CERTAIN LOW-INCOME PREGNANT WOMEN AND CHILDREN.

(a) IN GENERAL.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(1) in subsection (a)(10)(A)(i)—

(A) by striking "or" at the end of subclause (IV),

(B) by striking the semicolon at the end of subclause (V) and inserting ", or", and

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

"(VI) who are described in subparagraph (C) of subsection (l)(1) and whose family income does not exceed the income level the State is required to establish under subsection (l)(2)(B) for such a family;";

(2) in subsection (a)(10)(A)(ii)(IX), by inserting "or clause (i)(VI)" after "clause (i)(IV)";

(3) in subsection (l)(1)—

(A) by striking "and" at the end of subparagraph (B), and

(B) by striking subparagraph (C) and inserting the following:

"(C) children who have attained one year of age but have not attained 6 years of age, and

"(D) at the option of the State, children born after September 30, 1983, who have attained 6 years of age but have not attained 7 or 8 years of age (as selected by the State),";

(4) in subsection (l)(2)(A)—

(A) in clause (ii), by amending subclause (II) to read as follows:

"(II) April 1, 1990, 133 percent, or, if greater, the percentage provided under clause (iv).''; and

(B) by adding at the end the following new clause:

"(iv) In the case of a State which, as of the date of the enactment of this clause, has established under clause (i), or has enacted legislation authorizing, or appropriating funds, to provide for, a percentage (of the income official poverty line) that is greater than 133 percent, the percentage provided under clause (ii) for medical assistance on or after April 1, 1990, shall not be less than—

"(I) the percentage specified by the State in an amendment to its State plan (whether approved or not) as of the date of the enactment of this clause, or

"(II) if no such percentage is specified as of the date of the enactment of this clause, the percentage established under the State's authorizing legislation or provided for under the State's appropriations.";

(5) in subparagraph (B) of subsection (l)(2)—

(A) by striking ", or , if less, the percentage established under subparagraph (A)", and

(B) by redesignating such subparagraph as subparagraph (C);

(6) in subsection (l)(2), by inserting after subparagraph (A) the following new subparagraph:

"(B) For purposes of paragraph (1) with respect to individuals described in subparagraph (C) of such paragraph, the State shall establish an income level which is equal to 133 percent of the income official poverty line described in subparagraph (A) applicable to a family of the size involved.";

(6) in subsection (l)(3)—

(A) by inserting ",(a)(10)(A)(i)(VI)," after "(a)(10)(A)(i)(IV)", and

(B) in subparagraph (C), by striking "or (C)" and inserting ", (C), or (D)";

(7) in subsection (l)(4)—

(A) in subparagraph (A), by inserting "and for children described in subsection (a)(10)(A)(i)(VI)" after "(a)(10)(A)(i)(IV)", and

(B) in subparagraph (B), by inserting "or (a)(10)(A)(i)(VI)" after "(a)(10)(A)(i)(IV)";

(8) in subsection (e)(7), by striking "or (C)" and inserting ", (C), or (D)"; and

(9) in subsection (r)(2)(A), by inserting "(a)(10)(A)(i)(VI)," after "(a)(10)(A)(i)(IV),".

(b) CONFORMING AMENDMENT.—Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amended by inserting "1902(a)(10)(A)(i)(VI)," after "1902(a)(10)(A)(i)(IV),".

(c) EFFECTIVE DATE.— 42 USC 1396a note.

(1) Except as provided in paragraph (2), the amendments made by this section shall apply to payments under title XIX of the Social Security Act for calendar quarters beginning on or after April 1, 1990, with respect to eligibility for medical assistance on or after such date, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 6402. PAYMENT FOR OBSTETRICAL AND PEDIATRIC SERVICES.

(a) CODIFICATION OF ADEQUATE PAYMENT LEVEL PROVISIONS.—Section 1902(a)(30)(A) of the Social Security Act (42 U.S.C. 1396a(a)(30)(A)) is amended by inserting before the semicolon at the end the following: "and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area".

(b) ASSURING ADEQUATE PAYMENT LEVELS FOR OBSTETRICAL AND PEDIATRIC SERVICES.—Title XIX of such Act, as amended by section 303 of the Family Support Act of 1988, is amended by redesignating section 1926 as section 1927 and by inserting after section 1925 the following new section:

42 USC 1396s.

"ASSURING ADEQUATE PAYMENT LEVELS FOR OBSTETRICAL AND PEDIATRIC SERVICES

42 USC 1396r-7.

"SEC. 1926. (a)(1) A State plan under this title shall not be considered to meet the requirement of section 1902(a)(30)(A) with respect to obstetrical services (as defined in paragraph (4)(A)), as of July 1 of each year (beginning with 1990), unless, by not later than April 1 of such year, the State submits to the Secretary an amendment to the plan that specifies the payment rates to be used for such services under the plan in the succeeding period and includes in such submission such additional data as will assist the Secretary in evaluating the State's compliance with such requirement, including data relating to how rates established for payments to health maintenance organizations under section 1903(m) take into account such payment rates.

"(2) A State plan under this title shall not be considered to meet the requirement of section 1902(a)(30)(A) with respect to pediatric services (as defined in paragraph (4)(B)), as of July 1 of each year (beginning with 1990), unless, by not later than April 1 of such year, the State submits to the Secretary an amendment to the plan that specifies, by pediatric procedure, the payment rates to be used for such services under the plan in the succeeding period and includes in such submission such additional data as will assist the Secretary in evaluating the State's compliance with such requirement, including data relating to how rates established for payments to health maintenance organizations under section 1903(m) take into account such payment rates.

"(3) The Secretary, by not later than 90 days after the date of submission of a plan amendment under paragraph (1) or (2), shall—

"(A) review each such amendment for compliance with the requirement of section 1902(a)(30)(A), and

"(B) approve or disapprove each such amendment.

If the Secretary disapproves such an amendment, the State shall immediately submit a revised amendment which meets such requirement.

"(4) In this section:

"(A) The term 'obstetrical services' means services relating to pregnancy covered under the State plan provided by an obstetrician, obstetrician-gynecologist, family practitioner, certified nurse midwife, or certified family nurse practitioner and does not include inpatient or outpatient hospital services or other institutional services.

"(B) The term 'pediatric services' means services covered under the State plan provided by a pediatrician, family practitioner, or certified pediatric nurse practitioner to children under 18 years of age and does not include inpatient or outpatient hospital services or other institutional services.

"(b) For amendments submitted under subsection (a)(1) in 1992 and thereafter, the data submitted under such subsection must include, for the second previous year, at least the statewide average payment rates under the State plan for obstetrical services furnished by obstetricians, obstetrician-gynecologists, family practitioners, certified family nurse practitioners, and certified nurse midwives, by procedure. Such information shall be provided separately for providers located in each metropolitan statistical area (or similar area) in the State and in the remainder of the State.

"(c) For amendments submitted under subsection (a)(2) in 1992 and thereafter, the data submitted under such subsection must include, for the second previous year, at least the statewide average payment rates under the State plan for pediatric services furnished by pediatricians, family practitioners, and certified pediatric nurse practitioners by procedure. Such information shall be provided separately for providers located in each metropolitan statistical area (or similar area) in the State and in the remainder of the State

"(d) Nothing in this title (including section 1902(a)(30)(A)) shall be construed as preventing a State from establishing payment levels for obstetrical or pediatric services that are higher for those services furnished in rural areas than those furnished in metropolitan statistical areas.".

(c) PAYMENT FOR CERTAIN SERVICES IN CERTAIN FEDERALLY FUNDED HEALTH CENTERS.—

(1) COVERAGE.—Section 1905(a)(2) of the Social Security Act (42 U.S.C. 1396d(a)(2)) is amended by striking "and" before "(B)" and by inserting before the semicolon at the end the following: ", and (C) ambulatory services offered by a health center receiving funds under section 329, 330, or 340 of the Public Health Service Act to a pregnant woman or individual under 18 years of age".

(2) PAYMENT AMOUNTS.—Section 1902(a)(13)(E) of such Act (42 U.S.C. 1396a(a)(13)(E)) is amended by inserting ", and for payment for services described in section 1905(a)(2)(C) under the plan," after "provided by a rural health clinic under the plan".

(d) EFFECTIVE DATE.—(1) The amendments made by subsections (a) and (b) (except as otherwise provided in such amendments) shall take effect on the date of the enactment of this Act. 42 USC 1396a note.

(2)(A) The amendments made by subsection (c) apply (except as provided under subparagraph (B)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1990, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by subsection (c), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first

regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 6403. EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICES DEFINED.

(a) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended by adding at the end the following new subsection:

"(r) The term 'early and periodic screening, diagnostic, and treatment services' means the following items and services:

"(1) Screening services—

"(A) which are provided—

"(i) at intervals which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care, and

"(ii) at such other intervals, indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions; and

"(B) which shall at a minimum include—

"(i) a comprehensive health and developmental history (including assessment of both physical and mental health development),

"(ii) a comprehensive unclothed physical exam,

"(iii) appropriate immunizations according to age and health history,

"(iv) laboratory tests (including lead blood level assessment appropriate for age and risk factors), and

"(v) health education (including anticipatory guidance).

"(2) Vision services—

"(A) which are provided—

"(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and

"(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

"(B) which shall at a minimum include diagnosis and treatment for defects in vision, including eyeglasses.

"(3) Dental services—

"(A) which are provided—

"(i) at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and

"(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

"(B) which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.

"(4) Hearing services—

"(A) which are provided—

"(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and

"(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

"(B) which shall at a minimum include diagnosis and treatment for defects in hearing, including hearing aids.

"(5) Such other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.

Nothing in this title shall be construed as limiting providers of early and periodic screening, diagnostic, and treatment services to providers who are qualified to provide all of the items and services described in the previous sentence or as preventing a provider that is qualified under the plan to furnish one or more (but not all) of such items or services from being qualified to provide such items and services as part of early and periodic screening, diagnostic, and treatment services. ".

(b) REPORT ON PROVISION OF EPSDT.—Section 1902(a)(43) of such Act (42 U.S.C. 1396a(a)(43)) is amended—

(1) by striking "and" at the end of subparagraph (B),

(2) by striking the semicolon at the end of subparagraph (C) and inserting ", and", and

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

"(D) reporting to the Secretary (in a uniform form and manner established by the Secretary, by age group and by basis of eligibility for medical assistance, and by not later than April 1 after the end of each fiscal year, beginning with fiscal year 1990) the following information relating to early and periodic screening, diagnostic, and treatment services provided under the plan during each fiscal year:

"(i) the number of children provided child health screening services,

"(ii) the number of children referred for corrective treatment (the need for which is disclosed by such child health screening services),

"(iii) the number of children receiving dental services, and

"(iv) the State's results in attaining the participation goals set for the State under section 1905(r);".

(c) ANNUAL PARTICIPATION GOALS.—Section 1905(r) of such Act, as added by subsection (a), is amended by adding at the end the following: "The Secretary shall, not later than July 1, 1990, and every 12 months thereafter, develop and set annual participation goals for each State for participation of individuals who are covered under the State plan under this title in early and periodic screening, diagnostic, and treatment services.".

(d) CONFORMING AMENDMENTS.—(1) Section 1902(a)(43)(A) of such Act (42 U.S.C. 1396a(a)(43)(A)) is amended by striking "and treatment services as described in section 1905(a)(4)(B)" and inserting "and treatment services as described in section 1905(r)".

(2) Section 1905(a)(4) of such Act (42 U.S.C. 1396d(a)(4)) is amended by amending clause (B) to read as follows: "(B) early and periodic screening, diagnostic, and treatment services (as defined in subsection (r)) for individuals who are eligible under the plan and are under the age of 21; and".

42 USC 1396a note.

(e) EFFECTIVE DATE.—The amendments made by this section shall take effect on April 1, 1990, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 6404. PAYMENT FOR FEDERALLY-QUALIFIED HEALTH CENTER SERVICES.

(a) COVERAGE.—Section 1905(a)(2) of the Social Security Act (42 U.S.C. 1396d(a)(2)) is amended—

(1) by striking "and" before "(B)",

(2) by striking "subsection (l)" and inserting "subsection (l)(1)", and

(3) by inserting before the semicolon at the end the following: ", and (C) Federally-qualified health center services (as defined in subsection (l)(2)) and any other ambulatory services offered by a Federally-qualified health center and which are otherwise included in the plan".

(b) TERMS DEFINED.—Section 1905(l) of such Act is amended—

(1) by redesignating clauses (1) and (2) as clauses (A) and (B),

(2) by inserting "(1)" after "(l)", and

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

"(2)(A) The term 'Federally-qualified health center services' means services of the type described in subparagraphs (A) through (C) of section 1861(aa)(1) when furnished to an individual as an outpatient of a Federally-qualified health center and, for this purpose, any reference to a rural health clinic or a physician described in section 1861(aa)(2)(B) is deemed a reference to a Federally-qualified health center or a physician at the center, respectively.

"(B) The term 'Federally-qualified health center' means a facility which—

"(i) is receiving a grant under section 329, 330, or 340 of the Public Health Service Act, or

"(ii) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant.

In applying clause (ii), the Secretary may waive any requirement referred to in such clause for up to 2 years for good cause shown.".

(c) PAYMENT AMOUNTS.—Section 1902(a)(13)(E) of such Act (42 U.S.C. 1396a(a)(13)(E)) is amended by striking "section 1905(a)(2)(B) provided by a rural health clinic" and inserting "clause (B) or (C) of section 1905(a)(2)".

42 USC 1396a note.

(d) EFFECTIVE DATE.—(1) The amendments made by this section apply (except as provided under paragraph (2)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after April 1, 1990, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the

additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 6405. REQUIRED COVERAGE OF NURSE PRACTITIONER SERVICES.

(a) IN GENERAL.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended—

(1) in paragraph (20), by striking "and";

(2) by redesignating paragraph (21) as paragraph (22); and

(3) by inserting after paragraph (20) the following new paragraph:

"(21) services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner (as defined by the Secretary) which the certified pediatric nurse practitioner or certified family nurse practitioner is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the certified pediatric nurse practitioner or certified family nurse practitioner is under the supervision of, or associated with, a physician or other health care provider; and".

(b) CONFORMING AMENDMENT.—Section 1902(a)(10)(A) of such Act (42 U.S.C. 1396a(a)(10)(A)) is amended by striking "(1) through (5) and (17)" and by inserting "(1) through (5), (17) and (21)".

(c) EFFECTIVE DATE.—The amendments made by this section shall become effective with respect to services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner on or after July 1, 1990.

42 USC 1396a note.

SEC. 6406. REQUIRED MEDICAID NOTICE AND COORDINATION WITH SPECIAL SUPPLEMENTAL FOOD PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC).

(a) STATE PLAN REQUIREMENTS OF NOTICE AND COORDINATION.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (11), by striking "and" before "(B)" and by inserting before the semicolon at the end the following: ", and (C) provide for coordination of the operations under this title with the State's operations under the special supplemental food program for women, infants, and children under section 17 of the Child Nutrition Act of 1966";

(2) by striking "and" at the end of paragraph (51);

(3) by striking the period at the end of paragraph (52) and inserting "; and"; and

(4) by inserting after paragraph (52) the following new paragraph:

"(53) provide—

"(A) for notifying in a timely manner all individuals in the State who are determined to be eligible for medical assistance and who are pregnant women, breastfeeding or

postpartum women (as defined in section 17 of the Child Nutrition Act of 1966), or children below the age of 5, of the availability of benefits furnished by the special supplemental food program under such section, and

"(B) for referring any such individual to the State agency responsible for administering such program.".

42 USC 1396a note.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on July 1, 1990, without regard to whether regulations to carry out such amendments have been promulgated by such date.

Disadvantaged persons.
42 USC 1396r-7 note.

SEC. 6407. DEMONSTRATION PROJECTS TO STUDY THE EFFECT OF ALLOWING STATES TO EXTEND MEDICAID TO PREGNANT WOMEN AND CHILDREN NOT OTHERWISE QUALIFIED TO RECEIVE MEDICAID BENEFITS.

Contracts.

(a) IN GENERAL.—In order to allow States to develop and carry out innovative programs to extend health insurance coverage to pregnant women and children under age 20 who lack insurance and to encourage workers to obtain health insurance for themselves and their children, the Secretary of Health and Human Services (in this section referred to as the "Secretary") shall enter into agreements with several States submitting applications in accordance with subsection (b) for the purpose of conducting demonstration projects to study the effect on access to health care, private insurance coverage, and costs of health care when such States are allowed to extend benefits under title XIX of the Social Security Act, either directly, in the same manner, or otherwise as alternative assistance authorized in section 1925(b)(4)(D) of such Act, to pregnant women and children under 20 years of age who are not otherwise qualified to receive benefits under such section.

(b) PROJECT REQUIREMENTS.—(1) Each State applying to participate in the demonstration project under subsection (a) shall assure the Secretary that eligibility shall be limited to pregnant women and children who have not attained 20 years of age who are in families with income below 185 percent of the income official poverty line (referred to in subsection (c)(1)).

(2) The Secretary shall further provide in conducting demonstration projects under this section that, if one or more of such demonstration projects utilizes employer coverage as allowed under section 1925(b)(4)(D) of the Social Security Act, such project shall require an employer contribution.

(c) PREMIUMS.—In the case of pregnant women and children eligible to participate in such demonstration projects whose family income level is—

(1) below 100 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved, there shall be no premium charged; and

(2) between 100 and 185 percent of such income official poverty line, there shall be a premium equal to—

(A) an amount based on a sliding scale relating to income, or

(B) 3 percent of the family's average gross monthly earnings,

whichever is less.

(d) DURATION.—Each demonstration project under this section shall be conducted for a period not to exceed 3 years.

(e) WAIVER.—The Secretary where he deems appropriate may waive the statewideness requirement described in section 1902(a)(1) of the Social Security Act.

(f) LIMIT ON EXPENDITURES.—The Secretary in conducting the demonstration projects described in this section shall limit the amount of the Federal share of benefits paid and expenses incurred under title XIX of the Social Security Act to $10,000,000 in each of fiscal years 1990, 1991, and 1992.

(g) EVALUATION AND REPORT.—(1) For each demonstration project conducted under this section, the Secretary shall assure that an evaluation is conducted on the effect of the project with respect to—

(A) access to health care;

(B) private health care insurance coverage;

(C) costs with respect to health care; and

(D) developing feasible premium and cost-sharing policies.

(2) The Secretary shall submit to Congress an interim report containing a summary of the evaluations conducted under paragraph (1) not later than January 1, 1992, and a final report containing such summary together with such further recommendations as the Secretary may determine appropriate not later than January 1, 1994.

SEC. 6408. OTHER MEDICAID PROVISIONS.

(a) INSTITUTIONS FOR MENTAL DISEASES.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study of—

(A) the implementation, under current provisions, regulations, guidelines, and regulatory practices under title XIX of the Social Security Act, of the exclusion of coverage of services to certain individuals residing in institutions for mental diseases, and

(B) the costs and benefits of providing services under title XIX of the Social Security Act in public subacute psychiatric facilities which provide services to psychiatric patients who would otherwise require acute hospitalization.

(2) REPORT.—By not later than October 1, 1990, the Secretary shall submit a report to Congress on the study and shall include in the report recommendations respecting—

(A) modifications in such provisions, regulations, guidelines, and practices, if any, that may be appropriate to accommodate changes that may have occurred since 1972 in the delivery of psychiatric and other mental health services on an inpatient basis to such individuals, and

(B) the continued coverage of services provided in subacute psychiatric facilities under title XIX of the Social Security Act.

(3) MORATORIUM ON TREATMENT OF CERTAIN FACILITIES.—Any determination by the Secretary that Kent Community Hospital Complex in Michigan or Saginaw Community Hospital in Michigan is an institution for mental diseases, for purposes of title XIX of the Social Security Act shall not take effect until 180 days after the date the Congress receives the report required under paragraph (2). Michigan.

(b) EXTENSION OF TEXAS PERSONAL CARE SERVICES WAIVER.—Section 9523(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended by section 4115(d) of the Omnibus Budget

Reconciliation Act of 1987 (added by section 411(k)(9)(C) of the Medicare Catastrophic Coverage Act of 1988), is amended by striking "January 1, 1990" and inserting "July 1, 1990".

102 Stat. 768.

(c) HOSPICE PAYMENT FOR ROOM AND BOARD.—

(1) IN GENERAL.—Section 1902(a)(13)(D) of the Social Security Act (42 U.S.C. 1396a(a)(13)(D)) is amended—

(A) by striking "in the same amounts, and using the same methodology, as used" and inserting "in amounts no lower than the amounts, using the same methodology, used", and

(B) by striking "a separate rate may be paid for" and inserting "in the case of", and

(C) by striking "to take into account the room and board furnished by such facility" and inserting "there shall be paid an additional amount, to take into account the room and board furnished by the facility, equal to at least 95 percent of the rate that would have been paid by the State under the plan for facility services in that facility for that individual".

42 USC 1396a note.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to services furnished on or after April 1, 1990, without regard to whether or not final regulations have been promulgated by such date to implement such amendments.

(d) MEDICARE BUY-IN FOR PREMIUMS OF CERTAIN WORKING DISABLED.—

(1) IN GENERAL.—Section 1902(a)(10)(E) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)) is amended—

(A) by inserting "(i)" after "(E)",

(B) by striking the semicolon at the end and inserting ", and", and

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

"(ii) for making medical assistance available for payment of medicare cost-sharing described in section 1905(p)(3)(A)(i) for qualified disabled and working individuals described in section 1905(s);".

(2) ELIGIBILITY.—Section 1905 of such Act (42 U.S.C. 1396d), as amended by section 6403(a) of this subtitle, is amended by adding at the end the following new subsection:

"(s) The term 'qualified disabled and working individual' means an individual—

"(1) who is entitled to enroll for hospital insurance benefits under part A of title XVIII under section 1818A (as added by 6012 of the Omnibus Budget Reconciliation Act of 1989);

"(2) whose income (as determined under section 1612 for purposes of the supplemental security income program) does not exceed 200 percent of the official poverty line (as defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved;

"(3) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual or a couple (in the case of an individual with a spouse) may have and obtain benefits for supplemental security income benefits under title XVI; and

"(4) who is not otherwise eligible for medical assistance under this title.".

(3) PREMIUM PAYMENTS REQUIRED FOR CERTAIN INDIVIDUALS.—Section 1916 of such Act (42 U.S.C. 1396o) is amended—

(A) in subsection (a), by striking "(E)" and inserting "(E)(i)",

(B) by redesignating subsections (d) and (e) as subsections (e) and (f), respectively, and

(C) by inserting after subsection (c) the following new subsection:

"(d) With respect to a qualified disabled and working individual described in section 1905(s) whose income (as determined under paragraph (3) of that section) exceeds 150 percent of the official poverty line referred to in that paragraph, the State plan of a State may provide for the charging of a premium (expressed as a percentage of the medicare cost-sharing described in section 1905(p)(3)(A)(i) provided with respect to the individual) according to a sliding scale under which such percentage increases from 0 percent to 100 percent, in reasonable increments (as determined by the Secretary), as the individual's income increases from 150 percent of such poverty line to 200 percent of such poverty line.".

(4) CONFORMING AMENDMENTS.—

(A) Section 1905(p)(3) of such Act (42 U.S.C. 1396d(p)(3)) is amended—

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

"(A)(i) premiums under section 1818, and

"(ii) premiums under section 1839,", and

(ii) in subparagraph (A) as so amended, by striking "section 1818" and inserting "section 1818 or 1818A".

(B) Section 1905(p)(1)(A) of such Act is amended by inserting ", but not including an individual entitled to such benefits only pursuant to an enrollment under section 1818A" after "1818".

(C) Section 1902(f) of such Act (42 U.S.C. 1396a(f)) is amended by inserting ", except with respect to qualified disabled and working individuals (described in section 1905(s))," after "1619(b)(3)".

(5) EFFECTIVE DATE.— 42 USC 1396a note.

(A) The amendments made by this subsection apply (except as provided under subparagraph (B)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1990, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this subsection, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case

of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

PART 2—TECHNICAL AND MISCELLANEOUS PROVISIONS

SEC. 6411. MISCELLANEOUS MEDICAID TECHNICAL AMENDMENTS.

(a) TECHNICAL CORRECTION TO MEDICARE BUY-IN FOR THE ELDERLY.—

(1) CLARIFICATION WITH RESPECT TO "SECTION 209(B)" STATES.—The first sentence of section 1902(f) of the Social Security Act (42 U.S.C. 1396a(f)) is amended by inserting "and except with respect to qualified medicare beneficiaries, qualified severely impaired individuals, and individuals described in subsection (m)(1)" before ", no State".

42 USC 1396a note.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply as if it had been included in the enactment of the Medicare Catastrophic Coverage Act of 1988.

(b) EXTENSION OF DELAY IN ISSUANCE OF CERTAIN FINAL REGULATIONS.—Section 8431 of the Technical and Miscellaneous Revenue Act of 1988 is amended by striking "May 1, 1989" and inserting "December 31, 1990".

102 Stat. 3804.

(c) DISPROPORTIONATE SHARE HOSPITALS.—

(1) SPECIAL RULE FOR NEW JERSEY UNCOMPENSATED CARE TRUST FUND.—Section 1923(e)(1) of the Social Security Act (42 U.S.C. 1396r-4(e)(1)) is amended—

(A) by inserting "(A)(i)" after "without regard to the requirement of subsection (a) if", and

(B) by striking "and if" and inserting "or (ii) the plan as of January 1, 1987, provided for payment adjustments based on a statewide pooling arrangement involving all acute care hospitals and the arrangement provides for reimbursement of the total amount of uncompensated care provided by each participating hospital, and (B)".

(2) CONFORMING AMENDMENT.—Section 1915(b)(4) of such Act (42 U.S.C. 1396n(b)(4)) is amended by inserting "shall be consistent with the requirements of section 1923 and" after "which standards".

Missouri. Disadvantaged persons.

(3) TRANSITION RULE.—The State of Missouri shall be treated as having met the requirement of section 1902(a)(13)(A) of the Social Security Act (insofar as it requires payments to hospitals to take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs) for the period beginning with July 1, 1988, and ending with (and including) June 30, 1990, if the total amount of such payments for such period is not less than the total of such payments otherwise required by law for such period.

42 USC 1396n note.

(4) EFFECTIVE DATE.—The amendment made by paragraph (2) shall be effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987.

(d) FRAUD AND ABUSE TECHNICAL AMENDMENTS.—

(1) TREATMENT OF LOSS OF RIGHT TO RENEW LICENSE.—Section 1128(b)(4)(A) of the Social Security Act (42 U.S.C. 1396a-7(b)(4)(A)) is amended by inserting "or the right to apply for or renew such a license" after "lost such a license".

42 USC 1320a-7.

(2) CLARIFICATION WITH RESPECT TO EMERGENCY TREATMENT.—Sections 1862(e)(1) and 1903(i)(2) of such Act (42 U.S.C. 1395y(e)(1), 1396b(i)(2)) are each amended by inserting ", not including items or services furnished in an emergency room of a hospital" after "emergency item or service".

(3) CLARIFICATION OF EXCLUSION WITH RESPECT TO EMPLOYMENT BY HEALTH MAINTENANCE ORGANIZATIONS.—(A) Section 1876(i)(6)(A) of the Social Security Act (42 U.S.C. 1395mm(i)(6)(A)) is amended—

(i) by striking "or" at the end of clause (v),

(ii) by adding "or" at the end of clause (vi), and

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

"(vii) in the case of a risk-sharing contract, employs or contracts with any individual or entity that is excluded from participation under this title under section 1128 or 1128A for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services;".

(B) Section 1902(p)(2) of such Act (42 U.S.C. 1396a(p)(2)) is amended—

(i) by striking "or" at the end of subparagraph (A),

(ii) by striking the period at the end of subparagraph (B) and inserting ", or", and

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

"(C) employs or contracts with any individual or entity that is excluded from participation under this title under section 1128 or 1128A for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services.".

(4) EFFECTIVE DATES.—The amendments made by paragraphs (1) and (2) shall take effect on the date of the enactment of this Act. 42 USC 1320a-7 note.

(B) The amendments made by paragraph (3) shall apply to employment and contracts as of 90 days after the date of the enactment of this Act. 42 USC 1395mm note.

(e) SPOUSAL IMPOVERISHMENT.—

(1) EQUAL TREATMENT OF TRANSFERS BY COMMUNITY SPOUSE BEFORE INSTITUTIONALIZATION.—Section 1917(c) of the Social Security Act (42 U.S.C. 1396p(c)) is amended—

(A) in paragraph (1), by inserting "or whose spouse," after "an institutionalized individual (as defined in paragraph (3)) who,", and

(B) in paragraph (2)(B)—

(i) by amending clause (i) to read as follows: "(i) to or from (or to another for the sole benefit of) the individual's spouse, or", and

(ii) by striking ", or (iii)" and all that follows through "fair market value".

(2) CLARIFYING APPLICATION TO "SECTION 209(B)" STATES.—Section 1902(f) of such Act (42 U.S.C. 1396a(f)) is amended by inserting "and section 1924" after "1619(b)(3)".

(3) CLARIFICATION OF APPLICATION OF INCOME RULES TO REDETERMINATIONS.—Subsections (b)(2) and (d)(1) of section 1924

of such Act (42 U.S.C. 1396r-5) are amended by inserting "or redetermined" after "determined".

42 USC 1396a note.

(4) EFFECTIVE DATES.—

(A) SPOUSAL TRANSFERS.—The amendments made by paragraph (1) shall apply to transfers occurring after the date of the enactment of this Act.

(B) OTHER AMENDMENTS.—Except as provided in subparagraph (A), the amendments made by this subsection shall apply as if included in the enactment of section 303 of the Medicare Catastrophic Coverage Act of 1988.

(f) EXTENSION OF WAIVER FOR HEALTH INSURING ORGANIZATION.—The Secretary of Health and Human Services shall continue to waive, through June 30, 1992, the application of section 1903(m)(2)(A)(ii) of the Social Security Act to the Tennessee Primary Care Network, Inc., under the same terms and conditions as applied to such waiver as of July 1, 1989.

42 USC 1396b note.

(g) DAY HABILITATION AND RELATED SERVICES.—

(1) PROHIBITION OF DISALLOWANCE PENDING ISSUANCE OF REGULATIONS.—Except as specifically permitted under paragraph (3), the Secretary of Health and Human Services may not—

(A) withhold, suspend, disallow, or deny Federal financial participation under section 1903(a) of the Social Security Act for day habilitation and related services under paragraph (9) or (13) of section 1905(a) of such Act on behalf of persons with mental retardation or with related conditions pursuant to a provision of its State plan as approved on or before June 30, 1989, or

(B) withdraw Federal approval of any such State plan provision.

(2) REQUIREMENTS FOR REGULATION.—A final regulation described in this paragraph is a regulation, promulgated after a notice of proposed rule-making and a period of at least 60 days for public comment, that—

(A) specifies the types of day habilitation and related services that a State may cover under paragraph (9) or (13) of section 1905(a) of the Social Security Act on behalf of persons with mental retardation or with related conditions, and

(B) any requirements respecting such coverage.

(3) PROSPECTIVE APPLICATION OF REGULATION.—If the Secretary promulgates a final regulation described in paragraph (2) and the Secretary determines that a State plan under title XIX of the Social Security Act does not comply with such regulation, the Secretary shall notify the State of the determination and its basis, and such determination shall not apply to day habilitation and related services furnished before the first day of the first calendar quarter beginning after the date of the notice to the State.

(h) MORATORIUM ON ISSUANCE OF FINAL REGULATION ON MEDICALLY NEEDY INCOME LEVELS FOR CERTAIN 1-MEMBER FAMILIES.—The Secretary of Health and Human Services may not issue in final form, before December 31, 1990, any regulation implementing the proposed regulation published on September 26, 1989 (54 Federal Register 39421) insofar as such regulation changes the method for establishing the medically needy income level for single individuals in any State (including the proposed change to section 435.1007(a)(1) of title 42, Code of Federal Regulations).

(i) TECHNICAL CORRECTIONS CONCERNING TRANSITIONAL COVERAGE.—

(1) CLARIFICATION OF TERMINATION WHEN NO CHILD IN HOUSEHOLD.—Subsections (a)(3)(A) and (b)(3)(A)(i) of section 1925 of the Social Security Act (42 U.S.C. 1396r-6) are each amended by striking "who is" and inserting ", whether or not the child is".

(2) EFFECTIVE DATE FOR TERMINATION OF CURRENT 9-MONTH EXTENSION.—Section 303(f)(2)(A) of the Family Support Act of 1988 is amended by inserting before the period at the end the following: ", but such amendment shall not apply with respect to families that cease to be eligible for aid under part A of title IV of the Social Security Act before such date". 42 USC 602 note.

(3) CORRECTION OF REFERENCES.—Subsections (a)(3)(C) and (b)(3)(C)(i) of section 1925 of the Social Security Act (42 U.S.C. 1396r-6) are each amended by striking "or (v) of section 1905(a)" and inserting "of section 1905(a) or clause (i)(IV), (i)(VI), or (ii)(IX) of section 1902(a)(10)(A)".

(4) EFFECTIVE DATE.—The amendments made by this subsection shall be effective as if included in the enactment of the Family Support Act of 1988. 42 USC 1396r-6 note.

(j) MINNESOTA PREPAID MEDICAID DEMONSTRATION PROJECT EXTENSION.—Section 507 of the Family Support Act of 1988 is amended by striking "1990" and inserting "1991". 102 Stat. 2407.

Subtitle C—Maternal and Child Health Block Grant Program

SEC. 6501. INCREASE IN AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—Section 501 of the Social Security Act (42 U.S.C. 701) is amended—

(1) by amending subsection (a) to read as follows:

"(a) To improve the health of all mothers and children consistent with the applicable health status goals and national health objectives established by the Secretary under the Public Health Service Act for the year 2000, there are authorized to be appropriated $686,000,000 for fiscal year 1990 and each fiscal year thereafter—

"(1) for the purpose of enabling each State—

"(A) to provide and to assure mothers and children (in particular those with low income or with limited availability of health services) access to quality maternal and child health services;

"(B) to reduce infant mortality and the incidence of preventable diseases and handicapping conditions among children, to reduce the need for inpatient and long-term care services, to increase the number of children (especially preschool children) appropriately immunized against disease and the number of low income children receiving health assessments and follow-up diagnostic and treatment services, and otherwise to promote the health of mothers and infants by providing prenatal, delivery, and postpartum care for low income, at-risk pregnant women, and to promote the health of children by providing preventive and primary care services for low income children;

"(C) to provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits

under title XVI, to the extent medical assistance for such services is not provided under title XIX; and

"(D) to provide and to promote family-centered, community-based, coordinated care (including care coordination services, as defined in subsection (b)(3)) for children with special health care needs and to facilitate the development of community-based systems of services for such children and their families;

"(2) for the purpose of enabling the Secretary (through grants, contracts, or otherwise) to provide for special projects of regional and national significance, research, and training with respect to maternal and child health and children with special health care needs (including early intervention training and services development), for genetic disease testing, counseling, and information development and dissemination programs, for grants (including funding for comprehensive hemophilia diagnostic treatment centers) relating to hemophilia without regard to age, and for the screening of newborns for sickle cell anemia, and other genetic disorders and follow-up services; and

"(3) subject to section 502(b) for the purpose of enabling the Secretary (through grants, contracts, or otherwise) to provide for developing and expanding the following—

"(A) maternal and infant health home visiting programs in which case management services as defined in subparagraphs (A) and (B) of subsection (b)(4), health education services, and related social support services are provided in the home to pregnant women or families with an infant up to the age one by an appropriate health professional or by a qualified nonprofessional acting under the supervision of a health care professional,

"(B) projects designed to increase the participation of obstetricians and pediatricians under the program under this title and under state plans approved under title XIX,

"(C) integrated maternal and child health service delivery systems (of the type described in section 1136 and using, once developed, the model application form developed under section 6506(a) of the Omnibus Budget Reconciliation Act of 1989),

"(D) maternal and child health centers which (i) provide prenatal, delivery, and postpartum care for pregnant women and preventive and primary care services for infants up to age one, and (ii) operate under the direction of a not-for-profit hospital,

"(E) maternal and child health projects to serve rural populations, and

"(F) outpatient and community based services programs (including day care services) for children with special health care needs whose medical services are provided primarily through inpatient institutional care.", and

(2) by adding at the end of subsection (b) the following new paragraphs:

"(3) The term 'care coordination services' means services to promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families.

"(4) The term 'case management services' means—

"(A) with respect to pregnant women, services to assure access to quality prenatal, delivery, and postpartum care; and

"(B) with respect to infants up to age one, services to assure access to quality preventive and primary care services.".

(b) CONFORMING AMENDMENT.—Section 505(2)(C)(ii) of such Act (42 U.S.C. 705(2)(C)(ii)) is amended by striking "paragraphs (1) through (3) of section 501(a)" and inserting "subparagraphs (A) through (D) of section 501(a)(1)".

SEC. 6502. ALLOTMENTS TO STATE AND FEDERAL SET-ASIDES.

(a) IN GENERAL.—Section 502 of the Social Security Act (42 U.S.C. 702) is amended—

(1) by amending the first sentence of paragraph (1) of subsection (a) to read as follows: "Of the amounts appropriated under section 501(a) for a fiscal year that are not in excess of $600,000,000, the Secretary shall retain an amount equal to 15 percent for the purpose of carrying out activities described in section 501(a)(2).";

(2) in subsection (a)(3), by inserting "or subsection (b)" after "this subsection";

(3) by striking subsection (c), by redesignating subsection (b) as subsection (c), and by inserting after subsection (a) the following new subsection:

"(b)(1)(A) Of the amounts appropriated under section 501(a) for a fiscal year in excess of $600,000,000 the Secretary shall retain an amount equal to 12¾ percent thereof for the projects described in subparagraphs (A) through (F) of section 501(a)(3).

"(B) Any amount appropriated under section 501(a) for a fiscal year in excess of $600,000,000 that remains after the Secretary has retained the applicable amount (if any) under subparagraph (A) shall be retained by the Secretary in accordance with subsection (a) and allocated to the States in accordance with subsection (c).

"(2)(A) Of the amounts retained for the purpose of carrying out activities described in section 501(a)(3)(A), (B), (C), (D) and (E), the Secretary shall provide preference to qualified applicants which demonstrate that the activities to be carried out with such amounts shall be in areas with a high infant mortality rate (relative to the average infant mortality rate in the United States or in the State in which the area is located).

"(B) In carrying out activities described in section 501(a)(3)(D), the Secretary shall not provide for developing or expanding a maternal and child health center unless the Secretary has received satisfactory assurances that there will be applied, towards the costs of such development or expansion, non-Federal funds in an amount at least equal to the amount of funds provided under this title toward such development or expansion."; and

(4) in subsection (c), as redesignated by paragraph (2)—

(A) by striking "$478,000,000" and inserting "$600,000,000", and

(B) by amending paragraph (2) to read as follows:

"(2) Each such State shall be allotted for each fiscal year an amount equal to the sum of—

"(A) the amount of the allotment to the State under this subsection in fiscal year 1983, and

"(B) the State's proportion (determined under paragraph (1)(B)(ii)) of the amount by which the allotment available under this subsection for all the States for that fiscal year exceeds the amount that was available under this subsection for allotment for all the States for fiscal year 1983.".

(b) CONFORMING AMENDMENTS.—Sections 503(a) and 508(b) of such Act (42 U.S.C. 703(a), 708(b)) are amended by striking "502(b)" each place it appears and inserting "502(c)".

SEC. 6503. USE OF ALLOTMENT FUNDS AND APPLICATION FOR BLOCK GRANT FUNDS.

(a) EXPANDING USE OF FUNDS AND LIMITATION ON USE OF FUNDS FOR ADMINISTRATIVE COSTS.—Section 504 of the Social Security Act (42 U.S.C. 704) is amended—

(1) in subsection (a), by inserting "and including payment of salaries and other related expenses of National Health Service Corps personnel" after "education, and evaluation", and

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

"(d) Of the amounts paid to a State under section 503 from an allotment for a fiscal year under section 502(c), not more than 10 percent may be used for administering the funds paid under such section.".

(b) APPLICATION.—Section 505 of such Act (42 U.S.C. 705) is amended—

(1) by amending the heading to read as follows:

"APPLICATION FOR BLOCK GRANT FUNDS";

(2) by inserting "(a)" after "SEC. 505.";

(3) in the matter before paragraph (1), by inserting "an application (in a standardized form specified by the Secretary) that" after "must prepare and transmit to the Secretary";

(4) by striking paragraph (1) and redesignating paragraph (2) as paragraph (5) and by inserting before paragraph (5), as redesignated, the following new paragraphs:

"(1) contains a statewide needs assessment (to be conducted every 5 years) that shall identify (consistent with the health status goals and national health objectives referred to in section 501(a)) the need for—

"(A) preventive and primary care services for pregnant women, mothers, and infants up to age one;

"(B) preventive and primary care services for children; and

"(C) services for children with special health care needs (as specified in section 501(a)(1)(D));

"(2) includes for each fiscal year—

"(A) a plan for meeting the needs identified by the statewide needs assessment under paragraph (1); and

"(B) a description of how the funds allotted to the State under section 502(c) will be used for the provision and coordination of services to carry out such plan that shall include—

"(i) subject to paragraph (3), a statement of the goals and objectives consistent with the health status goals and national health objectives referred to in section 501(a) for meeting the needs specified in the State plan described in subparagraph (A);

"(ii) an identification of the areas and localities in the State in which services are to be provided and coordinated;

"(iii) an identification of the types of services to be provided and the categories or characteristics of individuals to be served; and

"(iv) information the State will collect in order to prepare reports required under section 506(a);

"(3) except as provided under subsection (b), provides that the State will use—

"(A) at least 30 percent of such payment amounts for preventive and primary care services for children, and

"(B) at least 30 percent of such payment amounts for services for children with special health care needs (as specified in section 501(a)(1)(D));

"(4) provides that a State receiving funds for maternal and child health services under this title shall maintain the level of funds being provided solely by such State for maternal and child health programs at a level at least equal to the level that such State provided for such programs in fiscal year 1989; and"; and

(5) in paragraph (5), as redesignated by paragraph (4) of this subsection—

(A) by striking "a statement of assurances that represents to the Secretary" and inserting "provides";

(B) in subparagraph (A), by striking "will provide" and inserting "will establish";

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

"(i) special consideration (where appropriate) for the continuation of the funding of special projects in the State previously funded under this title (as in effect before August 31, 1981), and";

(D) in subparagraph (D), by striking "and" at the end;

(E) by redesignating subparagraph (E) as subparagraph (F) and by inserting after subparagraph (D) the following new subparagraph:

"(E) the State agency (or agencies) administering the State's program under this title will provide for a toll-free telephone number (and other appropriate methods) for the use of parents to access information about health care providers and practitioners who provide health care services under this title and title XIX and about other relevant health and health-related providers and practitioners; and"; and

(F) in subparagraph (F) (as redesignated by subparagraph (E))—

(i) by striking "participate" before clause (i),

(ii) in clause (i), by striking "diagnosis" and inserting "diagnostic",

(iii) in clause (i), by striking "title XIX" and inserting "section 1905(a)(4)(B) (including the establishment of periodicity and content standards for early and periodic screening, diagnostic, and treatment services)",

(iv) by inserting "participate" after "(i)", after "(ii)", and after "(iii)",

(v) by striking "and" at the end of clause (ii),

(vi) by striking the period at the end of clause (iii) and inserting ", and", and

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

"(iv) provide, directly and through their providers and institutional contractors, for services to identify pregnant women and infants who are eligible for medical assistance under subparagraph (A) or (B) of section 1902(l)(1) and, once identified, to assist them in applying for such assistance.";

(6) by striking the last 2 sentences and inserting the following: "The application shall be developed by, or in consultation with, the State maternal and child health agency and shall be made public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during its development and after its transmittal."; and

Public information.

(7) by adding at the end the following new subsection:

"(b) The Secretary may waive the requirement under subsection (a)(3) that a State's application for a fiscal year provide for the use of funds for specific activities if for that fiscal year—

"(1) the Secretary determines—

"(A) on the basis of information provided in the State's most recent annual report submitted under section 506(a)(1), that the State has demonstrated an extraordinary unmet need for one of the activities described in subsection (a)(3), and

"(B) that the granting of the waiver is justified and will assist in carrying out the purposes of this title; and

"(2) the State provides assurances to the Secretary that the State will provide for the use of some amounts paid to it under section 503 for the activities described in subparagraphs (A) and (B) of subsection (a)(3) and specifies the percentages to be substituted in each of such subparagraphs.".

(c) CONFORMING AMENDMENTS.—(1) Section 502(c) of such Act (42 U.S.C. 702(c)), as redesignated by section 6502(a)(3) of this subtitle, is amended by striking "a description of intended activities and statement of assurances" and inserting "an application".

(2) Section 504(a) of such Act (42 U.S.C. 704(a)) is amended by striking "its description of intended expenditures and statement of assurances" and insert "its application".

(3) Section 506(a)(1)(C) of such Act (42 U.S.C. 706(a)(1)(C)) is amended by striking "description and statement" and inserting "application".

(4) Sections 502(b), 502(d)(1), 503(c), 504(a), 506(a)(1)(C), and 509(a)(6) of such Act (42 U.S.C. 702(b), 702(d)(1), 703(c), 704(a), 706(a)(1)(C), 709(a)(6)) are each amended by striking "505" each place it appears and inserting "505(a)".

SEC. 6504. REPORTS.

(a) STATE REPORTS.—Subsection (a) of section 506 of the Social Security Act (42 U.S.C. 706) is amended—

(1) in paragraph (1)—

(A) by inserting after the first sentence the following: "Each such report shall be prepared by, or in consultation with, the State maternal and child health agency.",

(B) by striking "be in such form and contain such information" and inserting "be in such standardized form and contain such information (including information described in paragraph (2))", and

(C) by striking "and of the progress made toward achieving the purposes of this title, and (C)" and inserting ", (C) to describe the extent to which the State has met the goals and objectives it set forth under section 505(a)(2)(B)(i) and the national health objectives referred to in section 501(a), and (D)";

(2) by redesignating paragraph (2) as paragraph (3); and

(3) by inserting after paragraph (1) the following new paragraph:

"(2) Each annual report under paragraph (1) shall include the following information:

"(A)(i) The number of individuals served by the State under this title (by class of individuals).

"(ii) The proportion of each class of such individuals which has health coverage.

"(iii) The types (as defined by the Secretary) of services provided under this title to individuals within each such class.

"(iv) The amounts spent under this title on each type of services, by class of individuals served.

"(B) Information on the status of maternal and child health in the State, including—

"(i) information (by county and by racial and ethnic group) on—

"(I) the rate of infant mortality, and

"(II) the rate of low-birth-weight births;

"(ii) information (on a State-wide basis) on—

"(I) the rate of maternal mortality,

"(II) the rate of neonatal death,

"(III) the rate of perinatal death,

"(IV) the number of children with chronic illness and the type of illness,

"(V) the proportion of infants born with fetal alcohol syndrome,

"(VI) the proportion of infants born with drug dependency,

"(VII) the proportion of women who deliver who do not receive prenatal care during the first trimester of pregnancy, and

"(VIII) the proportion of children, who at their second birthday, have been vaccinated against each of measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, Hib meningitis, and hepatitis B; and

"(iii) information on such other indicators of maternal, infant, and child health care status as the Secretary may specify.

"(C) Information (by racial and ethnic group) on—

"(i) the number of deliveries in the State in the year, and

"(ii) the number of such deliveries to pregnant women who were provided prenatal, delivery, or postpartum care under this title or were entitled to benefits with respect to such deliveries under the State plan under title XIX in the year.

"(D) Information (by racial and ethnic group) on—

"(i) the number of infants under one year of age who were in the State in the year, and

"(ii) the number of such infants who were provided services under this title or were entitled to benefits under the State plan under title XIX at any time during the year.

"(E) Information on the number of—
"(i) obstetricians,
"(ii) family practitioners,
"(iii) certified family nurse practitioners,
"(iv) certified nurse midwives,
"(v) pediatricians, and
"(vi) certified pediatric nurse practitioners,
who were licensed in the State in the year.

For purposes of subparagraph (A), each of the following shall be considered to be a separate class of individuals: pregnant women, infants up to age one, children with special health care needs, other children under age 22, and other individuals.".

(b) SECRETARIAL REPORT.—Paragraph (3) of subsection (a) of such section, as redesignated by subsection (a)(2) of this section, is amended to read as follows:

"(3) The Secretary shall annually transmit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report that includes—

"(A) a description of each project receiving funding under paragraph (2) or (3) of section 502(a), including the amount of Federal funds provided, the number of individuals served or trained, as appropriate, under the project, and a summary of any formal evaluation conducted with respect to the project;

"(B) a summary of the information described in paragraph (2)(A) reported by States;

"(C) based on information described in paragraph (2)(B) supplied by the States under paragraph (1), a compilation of the following measures of maternal and child health in the United States and in each State:

"(i) Information on—
"(I) the rate of infant mortality, and
"(II) the rate of low-birth-weight births.
Information under this clause shall also be compiled by racial and ethnic group.

"(ii) Information on—
"(I) the rate of maternal mortality,
"(II) the rate of neonatal death,
"(III) the rate of perinatal death,
"(IV) the proportion of infants born with fetal alcohol syndrome,
"(V) the proportion of infants born with drug dependency,
"(VI) the proportion of women who deliver who do not receive prenatal care during the first trimester of pregnancy, and
"(VII) the proportion of children, who at their second birthday, have been vaccinated against each of measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, Hib meningitis, and hepatitis B.

"(iii) Information on such other indicators of maternal, infant, and child health care status as the Secretary has specified under paragraph (2)(B)(iii).

"(iv) Information (by racial and ethnic group) on—
"(I) the number of deliveries in the State in the year, and
"(II) the number of such deliveries to pregnant women who were provided prenatal, delivery, or

postpartum care under this title or were entitled to benefits with respect to such deliveries under the State plan under title XIX in the year;

"(D) based on information described in subparagraphs (C), (D), and (E) of paragraph (2) supplied by the States under paragraph (1), a compilation of the following information in the United States and in each State:

"(i) Information on—

"(I) the number of deliveries in the year, and

"(II) the number of such deliveries to pregnant women who were provided prenatal, delivery, or postpartum care under this title or were entitled to benefits with respect to such deliveries under a State plan under title XIX in the year.

Information under this clause shall also be compiled by racial and ethnic group.

"(ii) Information on—

"(I) the number of infants under one year of age in the year, and

"(II) the number of such infants who were provided services under this title or were entitled to benefits under a State plan under title XIX at any time during the year.

Information under this clause shall also be compiled by racial and ethnic group.

"(iii) Information on the number of—

"(I) obstetricians,

"(II) family practitioners,

"(III) certified family nurse practitioners,

"(IV) certified nurse midwives,

"(V) pediatricians, and

"(VI) certified pediatric nurse practitioners,

who were licensed in a State in the year; and

"(E) an assessment of the progress being made to meet the health status goals and national health objectives referred to in section 501(a).".

SEC. 6505. FEDERAL ADMINISTRATION AND ASSISTANCE.

Section 509(a) of the Social Security Act (42 U.S.C. 709(a)) is amended—

(1) in paragraph (4) by inserting before the semicolon at the end the following: "and in developing consistent and accurate data collection mechanisms in order to report the information required under section 506(a)(2)";

(2) in paragraph (5) by striking "and" at the end thereof;

(3) in paragraph (6) by striking the period and inserting "; and"; and

(4) by adding at the end thereof the following new paragraphs:

"(7) assisting States in the development of care coordination services (as defined in section 501(b)(3)); and

"(8) developing and making available to the State agency (or agencies) administering the State's program under this title a national directory listing by State the toll-free numbers described in section 505(a)(5)(E).".

SEC. 6506. DEVELOPMENT OF MODEL APPLICATIONS.

(a) FOR MATERNAL AND CHILD ASSISTANCE PROGRAMS.— 42 USC 701 note.

(1) IN GENERAL.—The Secretary of Health and Human Services shall develop, by not later than one year after the date of the enactment of this Act and in consultation with the Secretary of Agriculture, a model application form for use in applying, simultaneously, for assistance for a pregnant woman or a child less than 6 years of age under maternal and child assistance programs (as defined in paragraph (3)). In developing such form, the Secretary is not authorized to change any requirement with respect to eligibility under any maternal and child assistance program.

Federal Register, publication.

(2) DISSEMINATION OF MODEL FORM.—The Secretary shall provide for publication in the Federal Register of the model application form developed under paragraph (1) and shall send a copy of such form to each State agency responsible for administering a maternal and child assistance program.

(3) MATERNAL AND CHILD ASSISTANCE PROGRAM DEFINED.—In this subsection, the term "maternal and child assistance program" means any of the following programs:

(A) The maternal and child health services block grant program under title V of the Social Security Act.

(B) The medicaid program under title XIX of the Social Security Act.

(C) The migrant and community health centers programs under sections 329 and 330 of the Public Health Service Act.

(D) The grant program for the homeless under section 340 of the Public Health Service Act.

(E) The "WIC" program under section 17 of the Child Nutrition Act of 1966.

(F) The head start program under the Head Start Act.

42 USC 1396a note.

(b) FOR MEDICAID PROGRAM.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall, by not later than 1 year after the date of the enactment of this Act, develop a model application form for use in applying for benefits under title XIX of the Social Security Act for individuals who are not receiving cash assistance under part A of title IV of the Social Security Act, and who are not institutionalized. In developing such model application form, the Secretary is not authorized to require that such form be adopted by States as part of their State medicaid plan.

Federal Register, publication.

(2) DISSEMINATION OF MODEL FORM.—The Secretary shall provide for publication in the Federal Register of the model application form developed under paragraph (1), and shall send a copy of such form to each State agency responsible for administering a State medicaid plan.

42 USC 701 note.

SEC. 6507. RESEARCH ON INFANT MORTALITY AND MEDICAID SERVICES.

The Secretary of Health and Human Services shall develop a national data system for linking, for any infant up to age one—

(1) the infant's birth record,

(2) any death record for the infant, and

(3) information on any claims submitted under title XIX of the Social Security Act for health care furnished to the infant or with respect to the birth of the infant.

SEC. 6508. DEMONSTRATION PROJECT ON HEALTH INSURANCE FOR MEDICALLY UNINSURABLE CHILDREN. 42 USC 701 note.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") may conduct not more than 4 demonstration projects to provide health insurance coverage (as defined by the Secretary) through an eligible plan (as defined in subsection (b)) to medically uninsurable children (as defined by the Secretary) under 19 years of age.

(b) ELIGIBILITY.—In this section, the term "eligible plan" means—

(1) a school-based plan;

(2) a plan operated under the direction of a not-for-profit entity offering health insurance; and

(3) a plan operated by a not-for-profit hospital.

(c) REQUIREMENTS.—A demonstration project conducted under subsection (a) may only be conducted under an agreement between the Secretary and an eligible plan which provides that—

(1) health insurance coverage will be made available under the project for at least 2 years, and, if the eligible plan fails to provide such coverage during such period, the Secretary will guarantee the provision of such coverage;

(2) non-Federal funds will be made available to fund the project at a level not less than—

(A) 50 percent in the first year of such agreement,

(B) 65 percent in the second year of such agreement, and

(C) 80 percent in the third or subsequent year of such agreement;

(3) the plan may not—

(A) restrict health insurance coverage on the basis of a child's medical condition, or

(B) impose waiting periods or exclusions for preexisting conditions;

(4) any premium imposed under the project shall be disclosed in advance of enrollment and shall be varied by the income of individuals; and

(5) with respect to a plan which at the time of entering into such agreement is conducting a project similar to the one described in this subsection such plan must maintain its current level of non-Federal funding at its current level unless such level is less than the applicable level described in paragraph (2).

(d) APPLICATION.—No funds may be made available by the Secretary under this section unless an application therefor has been submitted to, and approved by, the Secretary. Such application shall be in such form, be submitted in such manner, and contain and be accompanied by such information, as the Secretary may specify. No such application may be approved unless it contains assurances that the applicant will use the funds provided only for the purposes specified in the approved application and will establish such fiscal control and fund accounting procedures as may be necessary to assure proper disbursement and accounting of Federal funds paid to the applicant under this section.

(e) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall provide for an evaluation of the effects of the demonstration projects conducted under subsection (a) on—

(A) access to health services by previously medically uninsurable children,

(B) the availability of insurance coverage to participating medically uninsurable children,

(C) the demographic characteristics and health status of participating medically uninsurable children and their families, and

(D) out-of-pocket health care costs for such families.

(2) REPORT.—The Secretary shall submit a report on the demonstration projects conducted under subsection (a) to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate, and shall include in such report a summary of the evaluation described in paragraph (1).

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $5,000,000, for each of fiscal years 1991, 1992, and 1993.

42 USC 701 note.

SEC. 6509. MATERNAL AND CHILD HEALTH HANDBOOK.

(a) IN GENERAL.—

(1) DEVELOPMENT.—The Secretary of Health and Human Services shall develop a maternal and child health handbook in consultation with the National Commission to Prevent Infant Mortality and public and private organizations interested in the health and welfare of mothers and children.

(2) FIELD TESTING AND EVALUATION.—The Secretary shall complete publication of the handbook for field testing by July 1, 1990, and shall complete field testing and evaluation by June 1, 1991.

(3) AVAILABILITY AND DISTRIBUTION.—The Secretary shall make the handbook available to pregnant women and families with young children, and shall provide copies of the handbook to maternal and child health programs (including maternal and child health clinics supported through either title V or title XIX of the Social Security Act, community and migrant health centers under sections 329 and 330 of the Public Health Service Act, the grant program for the homeless under section 340 of the Public Health Service Act, the "WIC" program under section 17 of the Child Nutrition Act of 1966, and the head start program under the Head Start Act) that serve high-risk women. The Secretary shall coordinate the distribution of the handbook with State maternal and child health departments, State and local public health clinics, private providers of obstetric and pediatric care, and community groups where applicable. The Secretary shall make efforts to involve private entities in the distribution of the handbook under this paragraph.

(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $1,000,000 for each of fiscal years 1991, 1992, and 1993, for carrying out the purposes of this section.

42 USC 701 note.

SEC. 6510. EFFECTIVE DATES.

(a) IN GENERAL.—Except as provided in subsection (b), the amendments made by this subtitle shall apply to appropriations for fiscal years beginning with fiscal year 1990.

(b) APPLICATION AND REPORT.—The amendments made—

(1) by subsections (b) and (c) of section 6503 shall apply to payments for allotments for fiscal years beginning with fiscal year 1991, and

(2) by section 6504 shall apply to annual reports for fiscal years beginning with fiscal year 1991.

Subtitle D—Vaccine Compensation Technicals

SEC. 6601. VACCINE INJURY COMPENSATION TECHNICALS.

(a) REFERENCE.—Whenever in this section an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act.

(b) PUBLICATION OF PROGRAM.—Section 2110 (42 U.S.C. 300aa-10) is amended by adding at the end thereof the following:

"(c) PUBLICITY.—The Secretary shall undertake reasonable efforts to inform the public of the availability of the Program.".

(c) PETITIONS.—

(1) Section 2111(a)(1) (42 U.S.C. 300aa-11(a)(1)) is amended—

(A) by striking out "filing of a petition" and inserting in lieu thereof "filing of a petition containing the matter prescribed by subsection (c)", and

(B) by inserting at the end of paragraph (1) "The clerk of the United States Claims Court shall immediately forward the filed petition to the chief special master for assignment to a special master under section 2112(d)(1).".

(2) Section 2111(a)(2)(A)(i) (42 U.S.C. 300aa-11(a)(2)(A)(i)) is amended by striking out "under subsection (b)".

(3) Section 2111(a)(5) (42 U.S.C. 300aa-11(a)(5)) is amended—

(A) in subparagraph (A), by striking out "elect to withdraw such action" and inserting in lieu thereof "petition to have such action dismissed without prejudice or costs", and

(B) in subparagraph (B), by striking out "on the effective date of this part had pending" and inserting in lieu thereof "has pending" and by striking out "does not withdraw the action under subparagraph (A)".

(4) Section 2111(a)(6) (42 U.S.C. 300aa-11(a)(6)) is amended by striking out "the effective date of this part" each place it occurs and inserting in lieu thereof "November 15, 1988".

(5) Section 2111(a) (42 U.S.C. 300aa-11(a)) is amended by redesignating paragraph (8) as paragraph (9) and by inserting after paragraph (7) the following:

"(8) If on the effective date of this part there was pending an appeal or rehearing with respect to a civil action brought against a vaccine administrator or manufacturer and if the outcome of the last appellate review of such action or the last rehearing of such action is the denial of damages for a vaccine-related injury or death, the person who brought such action may file a petition under subsection (b) for such injury or death.".

(6) Section 2111(c) (42 U.S.C. 300aa-11(c)) is amended—

(A) in paragraph (1), by inserting "except as provided in paragraph (3)," after "(1)" and in paragraph (2), by inserting "except as provided in paragraph (3)," after "(2)",

individual for 1 or more persons maintaining the plan (including as an employee defined in section 401(c)(1) of the Internal Revenue Code of 1986)".

42 USC 300bb-8 note.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to plan years beginning after December 31, 1989.

Subtitle F—Technical and Miscellaneous Provisions Relating to Nursing Home Reform

SEC. 6901. MEDICARE AND MEDICAID TECHNICAL CORRECTIONS RELATING TO NURSING HOME REFORM.

(a) MORATORIUM ON IMPLEMENTATION OF FEBRUARY 2, 1989 REGULATION.—The regulations promulgated by the Secretary of Health and Human Services on February 2, 1989 (54 Federal Register 5315 et seq., relating to requirements for long-term care facilities) shall not be effective before October 1, 1990, insofar as such regulations apply to skilled nursing facilities and intermediate care facilities under title XVIII or XIX of the Social Security Act.

(b) NURSE AIDE TRAINING.—

(1) DELAY IN REQUIREMENT.—Sections 1819(b)(5) and 1919(b)(5) of the Social Security Act (42 U.S.C. 1395i-3(b)(5), 1396r(b)(5)) are each amended—

(A) in subparagraph (A), by striking "January 1, 1990" and inserting "October 1, 1990", and

(B) in subparagraph (B), by striking "July 1, 1989" and "January 1, 1990" and inserting "January 1, 1990" and "October 1, 1990", respectively.

42 USC 1395i-3 note.

(2) PUBLICATION OF PROPOSED REGULATIONS.—The Secretary of Health and Human Services shall issue proposed regulations to establish the requirements described in sections 1819(f)(2) and 1919(f)(2) of the Social Security Act by not later than 90 days after the date of the enactment of this Act.

(3) REQUIREMENTS FOR TRAINING AND EVALUATION PROGRAMS.—Sections 1819(f)(2)(A) and 1919(f)(2)(A) of the Social Security Act (42 U.S.C. 1395i-3(f)(2)(A), 1396r(f)(2)(A)) are each amended—

(A) in clause (i)(I), by inserting "care of cognitively impaired residents," after "social service needs,";

(B) in clause (ii), by striking "cognitive, behavioral and social care" and inserting "recognition of mental health and social service needs, care of cognitively impaired residents";

(C) by striking the period at the end of clause (iii) and inserting "; and"; and

(D) by adding at the end the following new clause:

"(iv) requirements, under both such programs, that—

"(I) provide procedures for determining competency that permit a nurse aide, at the nurse aide's option, to establish competency through procedures or methods other than the passing of a written examination and to have the competency evaluation conducted at the nursing facility at which the aide is (or will be) employed (unless the facility is described in subparagraph (B)(iii)(I)), and

"(II) prohibit the imposition on a nurse aide of any charges (including any charges for textbooks and other required course materials and any charges for the competency evaluation) for either such program.".

(4) DELAY AND TRANSITION IN 75-HOUR TRAINING PROGRAM REQUIREMENT.—

(A) Section 1919(f)(2)(B)(ii) of such Act (42 U.S.C. 1396r(f)(2)(B)(ii)) is amended by striking "January 1, 1989" and inserting "July 1, 1989".

(B) A nurse aide shall be considered to satisfy the requirement of sections 1819(b)(5)(A) and 1919(b)(5)(A) of the Social Security Act (of having completed a training and competency evaluation program approved by a State under section 1819(e)(1)(A) or 1919(e)(1)(A) of such Act), if such aide would have satisfied such requirement as of July 1, 1989, if a number of hours (not less than 60 hours) were substituted for "75 hours" in sections 1819(f)(2) and 1919(f)(2) of such Act, respectively, and if such aide had received, before July 1, 1989, at least the difference in the number of such hours in supervised practical nurse aide training or in regular in-service nurse aide education. 42 USC 1395i-3 note.

(C) A nurse aide shall be considered to satisfy the requirement of sections 1819(b)(5)(A) and 1919(b)(5)(A) of the Social Security Act (of having completed a training and competency evaluation program approved by a State under section 1819(e)(1)(A) or 1919(e)(1)(A) of such Act), if such aide was found competent (whether or not by the State), before July 1, 1989, after the completion of a course of nurse aide training of at least 100 hours duration.

(D) With respect to the nurse aide competency evaluation requirements described in sections 1819(b)(5)(A) and 1919(b)(5)(A) of the Social Security Act, a State may waive such requirements with respect to an individual who can demonstrate to the satisfaction of the State that such individual has served as a nurse aide at one or more facilities of the same employer in the State for at least 24 consecutive months before the date of the enactment of this Act.

(5) CLARIFICATION OF TEMPORARY ENHANCED FEDERAL FINANCIAL PARTICIPATION FOR NURSE AIDE TRAINING BY NURSING FACILITIES.—

(A) IN GENERAL.—Section 1903(a)(2)(B) of such Act (42 U.S.C. 1396b(a)(2)(B)) is amended—

(i) by inserting "(including the costs for nurse aides to complete such competency evaluation programs)" after "1919(e)(1)", and

(ii) by inserting "(or, for calendar quarters beginning on or after July 1, 1988, and before July 1, 1990, the lesser of 90 percent or the Federal medical assistance percentage plus 25 percentage points)" after "50 percent".

(B) NO ALLOCATION OF COSTS BEFORE OCTOBER 1, 1990.—In making payments under section 1903(a)(2)(B) of the Social Security Act for amounts expended for nurse aide training and competency evaluation programs, and competency 42 USC 1396b note.

evaluation programs, described in section 1919(e)(1) of such Act, in the case of activities conducted before October 1, 1990, the Secretary of Health and Human Services shall not take into account, or allocate amounts on the basis of, the proportion of residents of nursing facilities that is entitled to benefits under title XVIII or XIX of such Act.

42 USC 1395i-3 note.

(6) EFFECTIVE DATES.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by this subsection shall take effect as if they were included in the enactment of the Omnibus Budget Reconciliation Act of 1987.

(B) EXCEPTION.—The amendments made by paragraph (3) shall apply to nurse aide training and competency evaluation programs, and nurse aide competency evaluation programs, offered on or after the end of the 90-day period beginning on the date of the enactment of this Act, but shall not affect competency evaluations conducted under programs offered before the end of such period.

42 USC 1396r note.

(c) PUBLICATION OF PROPOSED REGULATIONS RESPECTING PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW.—The Secretary of Health and Human Services shall issue proposed regulations to establish the criteria described in section 1919(f)(8)(A) of the Social Security Act by not later than 90 days after the date of the enactment of this Act.

(d) OTHER AMENDMENTS.—

(1) CLARIFICATION OF APPLICABILITY OF ENFORCEMENT RULES TO DUALLY-CERTIFIED FACILITIES.—Section 1919(h)(8) of the Social Security Act (42 U.S.C. 1396r(h)(8)) is amended by adding at the end the following: "The provisions of this subsection shall apply to a nursing facility (or portion thereof) notwithstanding that the facility (or portion thereof) also is a skilled nursing facility for purposes of title XVIII.".

42 USC 1396b note.

(2) CLARIFICATION OF FEDERAL MATCHING RATE FOR SURVEY AND CERTIFICATION ACTIVITIES.—During the period before October 1, 1990, the Federal percentage matching payment rate under section 1903(a) of the Social Security Act for so much of the sums expended under a State plan under title XIX of such Act as are attributable to compensation or training of personnel responsible for inspecting public or private skilled nursing or intermediate care facilities to individuals receiving medical assistance to determine compliance with health or safety standards shall be 75 percent.

New York.

(3) MEDICARE WAIVER AUTHORITY FOR CERTAIN DEMONSTRATION PROJECTS.—(A) The Secretary of Health and Human Services may waive the survey and certification requirements of sections 1819(g) and 1864(a) of the Social Security Act to the extent the Secretary determines is required to carry out a demonstration project in New York (relating to testing an approved alternative survey and certification process), which has been approved as of the date of the enactment of this Act. Such waiver shall apply only during the period beginning on November 1, 1988, and ending on October 31, 1991.

Wisconsin.

(B) The Secretary also may waive the survey and certification requirements described in subparagraph (A) to the extent the Secretary determines is required to carry out a pilot demonstration project in Wisconsin (relating to testing an approved alternative survey and certification process). Such waiver shall apply

only during the one-year period beginning on the date of implementation of the project.

(4) MISCELLANEOUS TECHNICAL CORRECTIONS.—Sections 1819 and 1919 of the Social Security Act are each further amended— 42 USC 1395i-3, 1396r.

(A) in subsection (c)(1)(A)(ii)(II), by striking the closing parenthesis after "Secretary" and inserting a closing parenthesis after "obtained",

(B) in subsection (c)(1)(A)(v)(I), by striking "accommodations" and inserting "accommodation",

(C) in subsection (f)(2)(A)(i), by striking ", content of the curriculum" and inserting "and content of the curriculum", and

(D) in subsection (h)(2)(C) (of section 1819) and in subsection (h)(3)(D) (of section 1919), by inserting "after the effective date of the findings" after "6 months".

(5) ADDITIONAL MISCELLANEOUS TECHNICAL CORRECTIONS.—Section 1910 of such Act (42 U.S.C. 1396i) is amended—

(A) by inserting "AND INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED" after "RURAL HEALTH CLINICS",

(B) in subsection (b)(1), by striking "skilled nursing or intermediate care facility" and inserting "intermediate care facility for the mentally retarded",

(C) in subsection (b)(1), as amended by section 411(l)(6)(F) of the Medicare Catastrophic Coverage Act of 1988, by striking "1902(a)(28) or section 1919 or section 1905(c)" and inserting "1902(a)(31) or section 1905(d)", and

(D) in subsections (b)(1) and (b)(2), by striking "skilled nursing facility or intermediate care facility" each place it appears and inserting "intermediate care facility for the mentally retarded".

(6) EFFECTIVE DATE.— 42 USC 1395i-3.

(A) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by this subsection shall take effect as if they were included in the enactment of the Omnibus Budget Reconciliation Act of 1987.

(B) EXCEPTION.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

Subtitle G—Public Health Service Act

SEC. 6911. ESTABLISHMENT OF AGENCY FOR HEALTH CARE POLICY AND RESEARCH.

For amendments establishing the Agency for Health Care Policy and Research and creating a new title IX in the Public Health Service Act, see section 6103 of this Act.

TITLE VII—REVENUE MEASURES

Revenue Reconciliation Act of 1989. 26 USC 1 note.

SEC. 7001. SHORT TITLE; ETC.

(a) SHORT TITLE.—This title may be cited as the "Revenue Reconciliation Act of 1989".

(b) AMENDMENT OF 1986 CODE.—Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or

29 USC 1002 note.

(i) EFFECTIVE DATE.—Except as otherwise provided in this section, any amendment made by this section shall take effect as if originally included in the provision of the Employee Retirement Income Security Act of 1974 to which such amendment relates.

TITLE VIII—HUMAN RESOURCE AND INCOME SECURITY PROVISIONS

SEC. 8000. TABLE OF CONTENTS; AMENDMENT OF SOCIAL SECURITY ACT.

(a) TABLE OF CONTENTS.—

(b) AMENDMENT OF SOCIAL SECURITY ACT.—Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Social Security Act.

SEC. 8001. EXTENSION OF AUTHORITY TO TRANSFER FOSTER CARE FUNDS TO CHILD WELFARE SERVICES.

(a) 3-YEAR EXTENSION.—Subsections (b)(1), (b)(2)(B), (b)(4)(B), (b)(5)(A), (b)(5)(A)(ii), (c)(1), and (c)(2) of section 474 (42 U.S.C. 674) are each amended by striking "1989" and inserting "1992".

42 USC 674 note.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on October 1, 1989.

SEC. 8002. EXTENSION OF INDEPENDENT LIVING INITIATIVES PROGRAM.

(a) PROGRAM EXTENDED FOR 3 YEARS.—Section 477 (42 U.S.C. 677) is amended—

(1) in each of subsections (a)(1) and (e)(1), by striking ", 1988, and 1989" and inserting "through 1992"; and

(2) in subsection (c), by striking "the fiscal year 1988 or 1989" and inserting "any of the fiscal years 1988 through 1992".

(b) ENTITLEMENT INCREASED.—Section 477(e)(1) (42 U.S.C. 677(e)(1)) is amended—

(1) by inserting "(A)" after "(1)";

(2) by striking "The amount" and inserting "The basic amount";

(3) by striking "and 1989" and inserting "1989, 1990, 1991, and 1992";

(4) by striking "$45,000,000" and inserting "the basic ceiling for such fiscal year"; and

(5) by adding after and below such provision the following:

"(B) The maximum additional amount to which a State shall be entitled under section 474(a)(4) for fiscal years 1991 and 1992 shall be an amount which bears the same ratio to the additional ceiling for such fiscal year as the basic amount of such State bears to $45,000,000."; and

State and local governments.

"(C) As used in this section:

"(i) The term 'basic ceiling' means—

"(I) for fiscal year 1990, $50,000,000; and

"(II) for each fiscal year other than fiscal year 1990, $45,000,000.

"(ii) The term 'additional ceiling' means—

"(I) for fiscal year 1991, $15,000,000; and

"(II) for fiscal year 1992, $25,000,000.".

(c) MATCHING PAYMENTS TO STATES.—Section 474(a)(4) (42 U.S.C. 674(a)(4)) is amended to read as follows:

"(4) an amount equal to the sum of—

"(A) so much of the amounts expended by such State to carry out programs under section 477 as do not exceed the basic amount for such State determined under section 477(e)(1); and

"(B) the lesser of—

"(i) one-half of any additional amounts expended by such State for such programs; or

"(ii) the maximum additional amount for such State under such section 477(e)(1).".

(d) STUDY BY THE SECRETARY OF HHS; REPORT.— 42 USC 677 note.

(1) STUDY.—The Secretary of Health and Human Services shall study the programs authorized under section 477 of the Social Security Act for the purposes of evaluating the effectiveness of the programs. The study shall include a comparison of outcomes of children who participated in the programs and a comparable group of children who did not participate in the programs.

Children and youth.

(2) REPORT.—Upon completion of the study, the Secretary shall issue a report to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

(e) EFFECTIVE DATE.—The amendments made by subsections (a), (b) and (c) shall take effect October 1, 1989. 42 USC 674 note.

SEC. 8003. PERMANENT EXTENSION OF MEDICAID ELIGIBILITY EXTENSION DUE TO COLLECTION OF CHILD OR SPOUSAL SUPPORT.

(a) ELIMINATION OF SUNSET ON APPLICABILITY OF MEDICAID ELIGIBILITY EXTENSION.—Section 20(b) of the Child Support Enforcement Amendments of 1984 (Public Law 98-378) is amended by striking "and before October 1, 1989". 42 USC 606 note.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on October 1, 1989. 42 USC 606 note.

SEC. 8004. NEW AFDC QUALITY CONTROL SYSTEM.

(a) IN GENERAL.—Part A of title IV (42 U.S.C. 601 et seq.) is amended by inserting after section 407 the following:

State and local governments. 42 USC 608.

"SEC. 408. AFDC QUALITY CONTROL SYSTEM.

"(a) IN GENERAL.—In order to improve the accuracy of payments of aid to families with dependent children, the Secretary shall establish and operate a quality control system under which the Secretary shall determine, with respect to each State, the amount (if any) of the disallowance required to be repaid to the Secretary due to erroneous payments made by the State in carrying out the State plan approved under this part.

"(b) REVIEW OF CASES.—

"(1) STATE REVIEW.—

"(A) IN GENERAL.—Each State with a plan approved under this part shall for each fiscal year, in accordance with the time schedule and methodology prescribed in regulations issued under paragraphs (1) and (2) of subsection (h)—

"(i) review a sample of cases in the State with respect to which a payment has been made under such plan during the fiscal year; and

"(ii) determine the level of erroneous payments for the State for the fiscal year.

"(B) EFFECTS OF FAILURE TO COMPLETE REVIEW IN A TIMELY MANNER.—

"(i) SECRETARY CONDUCTS REVIEW.—If a State fails to conduct and complete, on a timely basis, a review required by subparagraph (A), or otherwise fails to cooperate with the Secretary in implementing this subsection, the Secretary, directly or through contractual or such other arrangements as the Secretary may find appropriate, shall conduct the review and establish the error rate for the State for the fiscal year on the basis of the best data reasonably available to the Secretary, in accordance with the statistical methods that would apply if the review were conducted by the State.

"(ii) STATE INCURS COSTS OF REVIEW.—The amount that would otherwise be payable under this part to a State for which the Secretary conducts a review under clause (i) shall be reduced by the costs incurred by the Secretary in conducting the review.

"(2) REVIEW BY THE SECRETARY.—The Secretary shall review a subsample of the cases reviewed by the State, or by the Secretary with respect to the State, under paragraph (1).

"(3) NOTIFICATION OF DIFFERENCE CASES.—Upon completion of the review under paragraph (2), the Secretary shall notify the State of any case in the subsample which the Secretary finds involves erroneous payments, and which the State's review determined to be correct (in this section referred to as a 'difference case').

Regulations.

"(4) ESTABLISHMENT OF QUALITY CONTROL REVIEW PANEL.—The Secretary shall by regulation establish a Quality Control Review Panel to review difference cases.

"(5) RESOLUTION OF DIFFERENCE CASES.—

"(A) IN GENERAL.—The State may seek review by the Panel of any difference case, within the time period prescribed in regulations issued under subsection (h)(3).

"(B) PROCEDURAL RULES.—The State and the Secretary may submit such documentation to the Panel as the State or the Secretary finds appropriate to substantiate its position. The findings of the Panel shall be made on the record, within the time period prescribed in regulations issued under subsection (h)(4). Records.

"(C) STATUS OF DECISIONS OF THE QUALITY CONTROL REVIEW PANEL.—The decisions of the Panel shall constitute the decisions of the Secretary for purposes of establishing the State's error rate for the fiscal year.

"(D) APPEALABILITY OF DECISIONS OF THE QUALITY CONTROL REVIEW PANEL.—The decisions of the Panel shall not be appealable, except as provided in subsection (k).

'(c) IDENTIFICATION OF ERRONEOUS PAYMENTS.—

"(1) APPLY PROVISIONS OF STATE PLAN.—Except as provided in paragraph (2), in determining whether a payment is an erroneous payment, the State and the Secretary shall apply all relevant provisions of the State plan approved under this part.

"(2) TREATMENT OF PROVISIONS OF STATE PLAN THAT ARE INCONSISTENT WITH FEDERAL LAW.—

"(A) IN GENERAL.—If a provision of a State plan approved under this part is inconsistent with a provision of Federal law or regulations, and the Secretary has notified the State of the inconsistency, the provision of Federal law or regulations shall control.

"(B) EXCEPTION.—Subparagraph (A) shall not apply with respect to a payment of the State if—

"(i) it is necessary for the State to enact a law in order to remove an inconsistency described in subparagraph (A), the Secretary has advised the State that the State will be allowed a reasonable period in which to enact such a law, and the payment was made during such period; or

"(ii) the State agency made the payment in compliance with a court order.

"(3) CERTAIN PAYMENTS NOT CONSIDERED ERRONEOUS.—For purposes of this section, a payment by a State shall not be considered an erroneous payment if the payment is in error solely by reason of—

"(A) the State's failure to implement properly changes in Federal statute within 6 months after the effective date of such changes or, if later, 6 months after the issuance of final regulations (including regulations in interim final form) if such regulations are reasonably necessary to construe or apply the Federal statutory change;

"(B) the State's reliance upon and correct use of erroneous information provided by the Secretary about matters of fact;

"(C) the State's reliance upon and correct use of written statements of Federal policy provided to the State by the Secretary;

"(D) the occurrence of an event in the State that—

"(i) results in the declaration by the President or the Governor of the State of a state of emergency or major disaster; and

"(ii) directly affects the State agency's ability to make correct payments under the State plan approved under this part; or

"(E) the failure of a family to submit monthly reports to the State pursuant to section 402(a)(14), if the failure did not affect the amount of the payment.

"(4) CERTAIN PAYMENTS CONSIDERED ERRONEOUS.—Notwithstanding any other provision of this section, a payment shall be considered an erroneous payment if the payment is made to a family—

"(A) which has failed without good cause to assign support rights as required by section 402(a)(26); or

"(B) any member of which is a recipient of aid under a State plan approved under this part and does not have a social security account number (unless an application for a social security account number for the family member has been filed within 30 days after the date of application for such aid).

"(d) DETERMINATION OF ERROR RATES.—

"(1) IN GENERAL.—The Secretary shall, in accordance with this subsection, determine an error rate for each State for the fiscal year involved, based on the reviews under paragraphs (1) and (2) of subsection (b) and the decisions of the Quality Control Review Panel under subsection (b)(5).

"(2) ERROR RATE FORMULA.—Except as provided in paragraph (3), the State's error rate for a fiscal year is—

"(A) the ratio of—

"(i) the erroneous payments of the State for the fiscal year; to

"(ii) the total payments of aid under the State plan approved under this part for the fiscal year; reduced by

"(B) the amount by which—

"(i) the national average underpayment rate for the fiscal year; exceeds

"(ii) the underpayment rate of the State for the fiscal year.

"(3) APPLICATION OF REDUCTION TO SUBSEQUENT FISCAL YEAR.—At the request of a State, the Secretary shall apply the reduction described in paragraph (2)(B) in determining the State's error rate for either of the 2 following fiscal years instead of in determining the State's error rate for the fiscal year to which the reduction would otherwise apply.

"(e) NOTIFICATION TO STATES OF ERROR RATES.—The Secretary shall notify each State of the error rate of the State determined under subsection (d), within the time period prescribed in regulations issued under subsection (h)(5).

"(f) IMPOSITION OF DISALLOWANCES.—If a State's error rate for a fiscal year exceeds the national average error rate for the fiscal year, the Secretary shall impose a disallowance on the State for the fiscal year in an amount equal to—

"(1) the product of—

"(A) the State's total payments of aid to families with dependent children for the fiscal year;

"(B) the Federal medical assistance percentage applicable to the State for purposes of section 1118;

"(C) the lesser of—

"(i) the ratio of—

"(I) the amount by which the State's error rate for the fiscal year exceeds the national average error rate for the fiscal year; to

"(II) the national average error rate for the fiscal year; or

"(ii) 1; and

"(D) the amount by which the State's error rate for the fiscal year exceeds the national average error rate for the fiscal year;

reduced by

"(2) the product of—

"(A) the ratio of—

"(i) the amount by which the State's error rate for the fiscal year exceeds the national average error rate for the fiscal year; and

"(ii) the State's error rate for the fiscal year;

"(B) the overpayments recovered by the State in the fiscal year; and

"(C) the Federal medical assistance percentage applicable to the State for purposes of section 1118;

and further reduced by

"(3) the product of—

"(A) the calculation described in paragraphs (1) and (2); and

"(B) the percentage by which—

"(i) the State's rate of child support collections for the fiscal year; exceeds

"(ii) the lesser of—

"(I) the national average rate of child support collections for the fiscal year; or

"(II) the average of the State's child support collection rates for each of the 3 fiscal years preceding the fiscal year.

"(g) NOTIFICATION TO STATES OF AMOUNTS OF DISALLOWANCES.—The Secretary shall notify each State on which the Secretary imposes a disallowance the amount of the disallowance, within the time period prescribed in regulations issued under subsection (h)(6).

"(h) REGULATIONS.—The Secretary, after consultation with the chief executives of the States, shall by regulation prescribe—

"(1) the periods within which—

"(A) the reviews required by paragraphs (1) and (2) of subsection (b) are to begin and be completed; and

"(B) the results of the review required by subsection (b)(1) are to be reported to the Secretary;

"(2) matters relating to the selection and size of the samples to be reviewed under paragraphs (1) and (2) of subsection (b), and the methodology for making statistically valid estimates of each State's error rate;

"(3) the period within which a State may seek review by the Quality Control Review Panel of a difference case;

"(4) the period within which a difference case appealed by a State is to be resolved by the Quality Control Review Panel;

"(5) the period, after the completion of the reviews required by paragraphs (1) and (2) of subsection (b) and the resolution by the Quality Control Review Panel of any difference cases appealed by a State, within which the Secretary is to notify the State of the error rate of the State for the fiscal year involved; and

"(6) the period within which the Secretary is to notify a State of any disallowance.

"(i) PAYMENT OF DISALLOWANCES.—

"(1) PAYMENT OPTIONS.—Within 45 days after the date a State is notified of a disallowance pursuant to subsection (g), the State shall, at the option of the State—

"(A) pay the Secretary the amount of the disallowance; or

Contracts.

"(B) enter into an agreement with the Secretary under which the State will make quarterly payments to the Secretary over a period not to exceed 30 months beginning not later than the first quarter beginning after the date the State receives the notice, in amounts sufficient to repay the disallowance with interest by the end of such period.

"(2) AUTHORITY TO ADJUST STATE MATCHING PAYMENTS.—If a State fails to pay the amount of a disallowance imposed on the State, in the manner required by the applicable subparagraph of paragraph (1), the Secretary shall reduce the amount to be paid to the State under section 403(a) by amounts sufficient to recover the amount of the disallowance with interest.

"(3) INTEREST ON UNPAID DISALLOWANCES.—

"(A) RATE OF INTEREST.—Interest on the unpaid amount of a disallowance shall accrue at the overpayment rate established under section 6621(a)(1) of the Internal Revenue Code of 1986.

"(B) ACCRUAL OF INTEREST.—

"(i) IN GENERAL.—Except as provided in clause (ii), interest on the unpaid amount of a State's disallowance shall accrue beginning 45 days after the date the State receives notice of the disallowance.

"(ii) EXCEPTION.—If the State appeals the imposition of a disallowance under this section to the Departmental Appeals Board and the Board does not decide the appeal within 90 days after the date of the State's notice of appeal, interest shall not accrue on the unpaid amount of the disallowance during the period beginning on such 90th day and ending on the date of the Board's final decision on the appeal, except to the extent that the Board finds that the State caused or requested the delay.

"(j) ADMINISTRATIVE REVIEW OF DISALLOWANCES.—

"(1) IN GENERAL.—Within 60 days after the date a State receives notice of a disallowance imposed under this section, the State may appeal the imposition of the disallowance, in whole or in part, to the Departmental Appeals Board established in the Department of Health and Human Services, by filing an appeal with the Board.

"(2) PROCEDURAL RULES.—The Board shall consider a State's appeal on the basis of such documentation as the State may submit and as the Board may require to support the final decision of the Board. In deciding whether to uphold a disallowance or any portion thereof, the Board shall conduct a thorough

review of the issues and take into account all relevant evidence. In rendering its final decision, the Board shall incorporate by reference any findings of the Quality Control Review Panel that were made in connection with the determination of the error rate and the amount of the disallowance, and such findings shall not be reviewable by the Board.

"(k) JUDICIAL REVIEW OF DISALLOWANCES.—

"(1) IN GENERAL.—Within 90 days after the date of a final decision by the Departmental Appeals Board with respect to the imposition of a disallowance on a State under this section, the State may obtain judicial review of the final decision (and the findings of the Quality Control Review Panel incorporated into the final decision) by filing an action in—

"(A) the district court of the United States for the judicial district in which the principal or headquarters office of the State agency is located; or

"(B) the United States District Court for the District of Columbia.

"(2) PROCEDURAL RULES.—The district court in which an action is filed shall review the final decision of the Board on the record established in the administrative proceeding, in accordance with the standards of review prescribed by subparagraphs (A) through (E) of section 706(2) of title 5, United States Code. The review shall be on the basis of the documents and supporting data submitted to the Board (or to the Quality Control Review Panel, in the case of any finding by the Panel which is at issue in the appeal).

"(l) REFUND OF DISALLOWANCES IMPOSED IN ERROR.—If the Secretary, directly or indirectly, receives from a State part or all of the amount of a disallowance imposed on the State under this section, and part or all of the disallowance is finally determined to have been imposed in error, the Secretary shall refund to the State the amount received by reason of the error, with interest which shall accrue from the date of receipt at the rate described in subsection (i)(3)(A).

"(m) DEFINITIONS.—As used in this section:

"(1) NATIONAL AVERAGE ERROR RATE.—The term 'national average error rate' for a fiscal year means the greater of—

"(A) the ratio of—

"(i) the total amount of erroneous payments made by all States for the fiscal year; to

"(ii) the total amount of aid paid by all the States for the fiscal year under plans approved under this part; or

"(B) 4 percent.

"(2) UNDERPAYMENT RATE.—The term 'underpayment rate', with respect to a State for a fiscal year, means the ratio of—

"(A) the total amounts of aid that should have been but were erroneously not paid for a fiscal year to recipients of aid under the State plan approved under this part; to

"(B) the total amount of aid paid under such plan for the fiscal year.

"(3) NATIONAL AVERAGE UNDERPAYMENT RATE.—The term 'national average underpayment rate' for a fiscal year means the ratio of—

"(A) the total amounts of aid that should have been but were erroneously not paid for a fiscal year to all recipients of aid under State plans approved under this part; to

"(B) the total amount of aid paid for the fiscal year under all State plans approved under this part.

"(4) CHILD SUPPORT COLLECTION RATE.—The term 'child support collection rate', with respect to a State for a fiscal year, means the ratio of—

"(A) the sum of the number of cases reported by the agency administering the State plan approved under part D for each quarter in the fiscal year for which—

"(i) an assignment was made under section 402(a)(26); and

"(ii) a collection was made under the State's plan approved under part D; to

"(B) the sum of the number of cases reported by such agency for each quarter in the fiscal year under which an assignment was made under section 402(a)(26).

"(5) NATIONAL CHILD SUPPORT COLLECTION RATE.—The term 'national child support collection rate' for a fiscal year means the ratio of—

"(A) the sum of the number of cases described in paragraph (4)(A) reported by all States for quarters in the fiscal year; to

"(B) the sum of the number of cases described in paragraph (4)(B) reported by all States for quarters in the fiscal year.

"(6) ERRONEOUS PAYMENTS.—The term 'erroneous payments' means the sum of overpayments to eligible families and payments to ineligible families made in carrying out a plan approved under this part.".

Effective date.
42 USC 603.

(b) CONFORMING REPEALS.—Effective October 1, 1990, subsections (i) and (j) of section 403 are hereby repealed.

42 USC 608 note.

(c) APPLICABILITY OF NEW QUALITY CONTROL SYSTEM.—The amendment made by subsection (a) shall apply to erroneous payments made in any fiscal year after fiscal year 1990.

State and local governments.
42 USC 603 note.

(d) NO SANCTIONS WITH RESPECT TO DISALLOWANCES BEFORE FISCAL YEAR 1991.—No disallowance or other similar sanction shall be applied to a State for any fiscal year before fiscal year 1991 under section 403(i) of the Social Security Act or any predecessor statutory or regulatory provision relating to disallowances for erroneous payments made in carrying out a State plan approved under part A of title IV of such Act.

42 USC 608 note.

(e) IMPLEMENTATION.—The Secretary of Health and Human Services shall take all actions necessary to assure that adequate numbers of staff are available to perform the functions required by the amendments made by this section.

42 USC 608 note.

(f) ANNUAL REPORTS.—The Secretary of Health and Human Services shall annually submit to the Committee on Finance of the Senate, and to the Committee on Ways and Means of the House of Representatives a report on whether the time periods contained in the regulations prescribed pursuant to section 408 of the Social Security Act (as added by subsection (a)) have been or will be met. The first such report shall be submitted not later than January 1, 1992.

Reports.
42 USC 608 note.

(g) STUDY OF NEGATIVE CASE ACTIONS.—

(1) IN GENERAL.—Not later than October 1, 1992, the Secretary of Health and Human Services shall report and make recommendations to the Congress on the results of a study of negative case actions under the program of aid to families with

dependent children under State plans approved under part A of title IV of the Social Security Act.

(2) NEGATIVE CASE ACTIONS DEFINED.—As used in paragraph (1), the term "negative case actions" means termination of assistance under part A of title IV of the Social Security Act, denial of an application for assistance under such part, or other action with respect to an application under such part without a determination of eligibility for assistance under such part.

SEC. 8005. EMERGENCY ASSISTANCE AND AFDC SPECIAL NEEDS.

42 USC 606 note.

(a) IMPLEMENTATION OF PROPOSED REGULATIONS PROHIBITED.—Except as provided in subsection (b), the Secretary of Health and Human Services (in this section referred to as the "Secretary") shall not—

(1) implement in whole or in part the proposed regulation published in the Federal Register on December 14, 1987, (52 F.R. 47420) with respect to emergency assistance and the need for and amount of assistance under the program of aid to families with dependent children; or

(2) before October 1, 1990, change any policy in effect immediately before the date of the enactment of this Act with respect to any of the matters addressed in the proposed regulation.

(b) REVISED PROPOSED REGULATION.—Notwithstanding subsection (a), the Secretary may issue a revised proposed regulation concerning the use of emergency assistance under the program of aid to families with dependent children under title IV of the Social Security Act that incorporates the recommendations included in the report entitled "Use of the Emergency Assistance and AFDC Programs to Provide Shelter to Families" that the Secretary submitted to the Congress on July 3, 1989.

(c) ESTABLISHMENT OF EFFECTIVE DATES FOR PROPOSED RULES.—Any final regulation which would change any policy in effect immediately before the date of the enactment of this Act with respect to the use of emergency assistance or special needs funds under the program of aid to families with dependent children under part A of title IV of the Social Security Act shall not take effect before October 1, 1990.

(d) REPORTING REQUIREMENTS.—With respect to any calendar quarter beginning on or after January 1, 1990, a financial report by a State submitted to the Secretary to fulfill reporting requirements under the program of aid to families with dependent children under part A of title IV of the Social Security Act shall identify any emergency assistance and special needs funds expended by the State under the program and used to pay for housing in hotels or similar temporary living arrangements (as defined by the Secretary) that house recipients of such aid.

SEC. 8006. INCREASE IN REIMBURSEMENT FOR FOSTER AND ADOPTIVE PARENT TRAINING.

State and local governments.

(a) IN GENERAL.—Section 474(a)(3) (42 U.S.C. 674(a)(3)) is amended—

(1) by striking "and" at the end of subparagraph (A);

(2) by redesignating subparagraph (B) as subparagraph (C); and

(3) by inserting after subparagraph (A) the following:

"(B) 75 percent of so much of such expenditures (including travel and per diem expenses) as are for the short-term

training of current or prospective foster or adoptive parents and the members of the staff of State-licensed or State-approved child care institutions providing care to foster and adopted children receiving assistance under this part, in ways that increase the ability of such current or prospective parents, staff members, and institutions to provide support and assistance to foster and adopted children, whether incurred directly by the State or by contract, and".

42 USC 674 note.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to expenditures made on or after October 1, 1989, and before October 1, 1992.

SEC. 8007. CASE PLANS TO INCLUDE HEALTH AND EDUCATION RECORDS AND TO BE REVIEWED AND UPDATED AT THE TIME OF EACH PLACEMENT.

(a) INCLUSION OF HEALTH AND EDUCATION RECORDS.—Section 475(1) (42 U.S.C. 675(1)) is amended—

(1) by inserting "(A)" before "A description";

(2) by striking "472(a)(1); and a" and inserting "472(a)(1). (B) A";

(3) by indenting subparagraphs (A) and (B) (as so amended by paragraphs (1) and (2) of this subsection) 4 ems to the right of the left margin;

(4) by inserting after and below subparagraph (B) (as so amended and indented) the following:

"(C) To the extent available and accessible, the health and education records of the child, including—

"(i) the names and addresses of the child's health and educational providers;

"(ii) the child's grade level performance;

"(iii) the child's school record;

"(iv) assurances that the child's placement in foster care takes into account proximity to the school in which the child is enrolled at the time of placement;

"(v) a record of the child's immunizations;

"(vi) the child's known medical problems;

"(vii) the child's medications; and

"(viii) any other relevant health and education information concerning the child determined to be appropriate by the State agency."; and

(5) by setting the last sentence flush with the left margin of the paragraph.

(b) REVIEW AND UPDATE OF HEALTH AND EDUCATION RECORD AT TIME OF PLACEMENT.—Section 475(5) (42 U.S.C. 675(5)) is amended—

(1) by striking "and" at the end of subparagraph (B);

(2) by striking the period at the end of subparagraph (C) and inserting "; and"; and

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

"(D) a child's health and education record (as described in paragraph (1)(A)) is reviewed and updated, and supplied to the foster parent or foster care provider with whom the child is placed, at the time of each placement of the child in foster care.".

42 USC 675 note.

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall take effect on April 1, 1990.

SEC. 8008. ESTABLISHMENT AND CONDUCT OF OUTREACH PROGRAM FOR CHILDREN.

(a) IN GENERAL.—Part B of title XVI (42 U.S.C. 1383 et seq.) is amended by adding at the end the following:

"SEC. 1635. OUTREACH PROGRAM FOR CHILDREN.

Blind persons. Handicapped persons. 42 USC 1383d.

"(a) ESTABLISHMENT.—The Secretary shall establish and conduct an ongoing program of outreach to children who are potentially eligible for benefits under this title by reason of disability or blindness.

"(b) REQUIREMENTS.—Under this program, the Secretary shall—

"(1) aim outreach efforts at populations for whom such efforts would be most effective; and

"(2) work in cooperation with other Federal, State, and private agencies, and nonprofit organizations, which serve blind or disabled individuals and have knowledge of potential recipients of supplemental security income benefits, and with agencies and organizations (including school systems and public and private social service agencies) which focus on the needs of children.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect 3 months after the date of the enactment of this Act. 42 USC 1383d note.

SEC. 8009. ELIGIBILITY FOR BENEFITS OF CHILDREN OF ARMED FORCES PERSONNEL RESIDING OVERSEAS.

(a) IN GENERAL.—Section 1611(f) (42 U.S.C. 1382(f)) is amended by inserting "(other than a child described in section 1614(a)(1)(B)(ii))" after "no individual".

(b) CONFORMING AMENDMENT.—Section 1614(a)(1) (42 U.S.C. 1382c(a)(1)) is amended—

(1) in subparagraph (B)—

(A) by redesignating clauses (i) and (ii) as subclauses (I) and (II), respectively;

(B) by inserting "(i)" after "(B)"; and

(C) by striking the period and inserting ", or"; and

(2) by adding after and below subparagraph (B) the following:

"(ii) is a child who is a citizen of the United States, who is living with a parent of the child who is a member of the Armed Forces of the United States assigned to permanent duty ashore outside the United States, the District of Columbia, Puerto Rico, and the territories and possessions of the United States, and who, during the month before the parent reported for such assignment, was receiving benefits under this title.".

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply with respect to benefits for months after March 1990. 42 USC 1382 note.

SEC. 8010. RULE FOR DEEMING TO CHILDREN THE INCOME AND RESOURCES OF THEIR PARENTS WAIVED FOR CERTAIN DISABLED CHILDREN.

(a) IN GENERAL.—Section 1614(f)(2) (42 U.S.C. 1382c(f)(2)) is amended—

(1) by inserting "(A)" after "(2)"; and

(2) by adding at the end the following:

"(B) Subparagraph (A) shall not apply in the case of any child who has not attained the age of 18 years who—

"(i) is disabled;

"(ii) received benefits under this title, pursuant to section 1611(e)(1)(B), while in an institution described in section 1611(e)(1)(B);

"(iii) is eligible for medical assistance under a State home care plan approved by the Secretary under the provisions of section 1915(c) relating to waivers, or authorized under section 1902(e)(3); and

"(iv) but for this subparagraph, would not be eligible for benefits under this title.".

(b) PERSONAL NEEDS ALLOWANCE.—Section 1611(e)(1)(B) (42 U.S.C. 1382(e)(1)(B)) is amended by inserting "or an eligible individual is a child described in section 1614(f)(2)(B)," before "the benefit under this title".

42 USC 1382 note.

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall take effect on the 1st day of the 6th calendar month beginning after the date of the enactment of this Act.

SEC. 8011. EXCLUSION FROM INCOME OF DOMESTIC COMMERCIAL TRANSPORTATION TICKETS RECEIVED AS GIFTS.

(a) EXCLUSION FROM INCOME.—Section 1612(b) (42 U.S.C. 1382a(b)) is amended—

(1) by striking "and" at the end of paragraph (13);

(2) by striking the period at the end of paragraph (14) and inserting "; and"; and

(3) by adding at the end the following:

"(15) the value of any commercial transportation ticket, for travel by such individual (or spouse) among the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands, which is received as a gift by such individual (or such spouse) and is not converted to cash.".

42 USC 1382a note.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on the 1st day of the 3rd calendar month beginning after the date of the enactment of this Act.

SEC. 8012. REDUCTION IN TIME DURING WHICH INCOME AND RESOURCES OF SEPARATED COUPLES MUST BE TREATED AS JOINTLY AVAILABLE.

(a) IN GENERAL.—Section 1614(b) (42 U.S.C. 1382c(b)) is amended by striking the 1st sentence and inserting "For purposes of this title, the term 'eligible spouse' means an aged, blind, or disabled individual who is the husband or wife of another aged, blind, or disabled individual, and who, in a month, is living with such aged, blind, or disabled individual on the first day of the month or, in any case in which either spouse files an application for benefits or requests restoration of eligibility under this title during the month, at the time the application or request is filed.".

42 USC 1382c note.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on October 1, 1990.

SEC. 8013. EXCLUSION OF ACCRUED INCOME WITH RESPECT TO PURCHASE OF CERTAIN BURIAL SPACES.

(a) EXCLUSION FROM INCOME.—Section 1612(b) (42 U.S.C. 1382a(b)), as amended by section 8011(a) of this Act, is amended—

(1) by striking "and" at the end of paragraph (14);

(2) by striking the period at the end of paragraph (15) and inserting "; and"; and

(3) by adding at the end the following:

"(16) interest accrued on the value of an agreement entered into by such individual (or such spouse) representing the purchase of a burial space excluded under section 1613(a)(2)(B), and left to accumulate.".

(b) EXCLUSION FROM RESOURCES.—Section 1613(a)(2)(B) (42 U.S.C. 1382b(a)(2)(B)) is amended by inserting "or agreement (including any interest accumulated thereon) representing the purchase of a burial space" after "the value of any burial space".

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall take effect on the 1st day of the 4th month beginning after the date of the enactment of this Act. 42 USC 1382a note.

SEC. 8014. EXCLUSION FROM RESOURCES OF ALL INCOME-PRODUCING PROPERTY.

(a) IN GENERAL.—Section 1613(a)(3) (42 U.S.C. 1382b(a)(3)) is amended to read as follows:

"(3) other property which is so essential to the means of self-support of such individual (and such spouse) as to warrant its exclusion, as determined in accordance with and subject to limitations prescribed by the Secretary, except that the Secretary shall not establish a limitation on property (including the tools of a tradesperson and the machinery and livestock of a farmer) that is used in a trade or business or by such individual as an employee;".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the 1st day of the 5th calendar month beginning after the date of the enactment of this Act. 42 USC 1382b note.

SEC. 8015. DEMONSTRATION OF EFFECTIVENESS OF MINNESOTA FAMILY INVESTMENT PLAN.

(a) IN GENERAL.—Upon written application of the State of Minnesota (in this section referred to as the "State") within 24 months after the date of the enactment of this Act, and after the Secretary of Health and Human Services approves the application as meeting the requirements set forth in subsection (b), the State may conduct a demonstration project to determine whether the State family investment plan helps families to become self-supporting and enhances the ability of families to care for their children more effectively than does the State program of aid to families with dependent children under part A of title IV of the Social Security Act. 42 USC 602 note

(b) PROJECT REQUIREMENTS.—In an application submitted under subsection (a), the State shall provide that the following terms and conditions shall be in effect under the demonstration project:

(1) FIELD TRIALS.—The project will consist of 2 field trials, conducted as follows:

(A) URBAN FIELD TRIAL.—1 field trial will be conducted in 1 or more of the following counties in the State:

(i) Anoka.
(ii) Carver.
(iii) Dakota.
(iv) Hennepin.
(v) Scott.
(vi) Washington.

(B) RURAL FIELD TRIAL.—1 field trial will be conducted in 1 or more counties in the State not specified in subparagraph (A).

(C) NUMBER OF FAMILIES INVOLVED.—The field trials will not involve more than a total of 6,000 families at any one time, excluding families whose sole involvement is as members of control groups needed to evaluate the project.

(2) AUTHORITY TO IMPLEMENT FIELD TRIALS DIFFERENTLY.—The implementation of the family investment plan in 1 field trial may be different from the implementation of such plan in the other field trial.

(3) WAIVERS REQUIRED BEFORE PROJECT BEGINS.—The project will not begin before all waivers required as described in subsection (e) have been granted.

(4) BEGINNING OF PROJECT.—

(A) IN GENERAL.—The project will begin during the first month of a calendar quarter.

(B) BEGIN DEFINED.—For purposes of this section, the project begins when the first family receives assistance under the project.

(5) PROJECT TO BE OPERATED IN ACCORDANCE WITH CERTAIN MINNESOTA LAWS.—The project will be operated in accordance with the 1989 Minnesota Laws, sections 6 through 11, 13, 130, and 132 of article 5 of chapter 282, and all amendments to the Laws of Minnesota, to the extent that such laws and amendments are consistent with the goals of the project and this subsection.

(6) PROJECT PARTICIPANTS INELIGIBLE FOR AFDC.—Each family which participates in the project will not be eligible for aid under the State plan approved under section 402(a) of the Social Security Act.

(7) MEDICAID ELIGIBILITY RULES APPLICABLE TO PROJECT.—

(A) ELIGIBILITY OF PARTICIPANTS.—

(i) IN GENERAL.—Each family which participates in the project and would (but for such participation) be eligible for aid under the State plan approved under section 402(a) of the Social Security Act will be treated as receiving such aid for purposes of the State plan approved under section 1902(a) of such Act.

(ii) ELIGIBILITY EXTENDED FOR PROJECT PARTICIPANTS WITH INCREASED EMPLOYMENT INCOME.—Each family which participates in the project and, during such participation, would (but for such participation) become ineligible for aid under the State plan approved under section 402(a) of the Social Security Act by reason of increased income from employment will, for purposes of section 1925 of such Act, be treated as a family that has become ineligible for such aid.

(B) ELIGIBILITY EXTENDED FOR PERSONS LEAVING PROJECT BECAUSE OF INCREASED RECEIPT OF CHILD SUPPORT.—Each family whose participation in the project is terminated by reason of the collection or increased collection of child support under part D of title IV of the Social Security Act will be treated as a recipient of aid to families with dependent children for purposes of title XIX of such Act for an additional 4 calendar months beginning with the month in which the termination occurs.

(8) AFDC RULES TO APPLY GENERALLY.—

(A) IN GENERAL.—Except where inconsistent with this subsection, the requirements of the State plan approved

under section 402(a) of the Social Security Act will apply to the project, unless waived by the Secretary of Health and Human Services in accordance with subsection (d).

(B) RULES RELATING TO PARTICIPATION IN EDUCATION, EMPLOYMENT, AND TRAINING ACTIVITIES.—

(i) PARTICIPATION GENERALLY NOT REQUIRED.—Except as provided in clause (ii), the State will not require any individual who applies for or receives assistance under the project to comply with any education, employment, or training requirement of title IV of the Social Security Act, unless required to do so under a contract entered into under the project.

(ii) AUTHORITY TO REQUIRE PARTICIPATION OF PARENT OF CHILD AGE 1 OR OLDER.—The State may require any individual to comply with any education, employment, or training requirement imposed under the project if the State plan approved under section 402(a) of the Social Security Act does not prohibit the State from requiring such compliance, and the individual—

(I) receives assistance under the project;

(II) is the parent or relative of a child who has attained the age of 1 year; and

(III) is personally providing care for the child.

(9) AVAILABILITY OF EDUCATION, EMPLOYMENT, AND TRAINING SERVICES.—The education, employment, and training services available under the State plan approved under part F of title IV of the Social Security Act will be made available to each family required to enter into a contract with a county agency under the 1989 Minnesota Laws, section 10 of article 5 of chapter 282.

(10) ASSISTANCE UNDER PROJECT NOT LESS THAN UNDER AFDC AND FOOD STAMP PROGRAM.—

(A) ESTABLISHMENT OF POLICIES AND STANDARDS.—The State will establish policies and standards to ensure that families participating in the project receive cash assistance under the project in an amount not less than the aggregate value of the assistance that such families would have received under the State plan approved under section 402(a) of such Act and under the food stamp program established under the Food Stamp Act of 1977 in the absence of the project.

(B) IDENTIFICATION OF CHARACTERISTICS OF PARTICIPANTS WHO MIGHT RECEIVE LESS BENEFITS THAN UNDER AFDC AND FOOD STAMP PROGRAM.—The State will identify the set or sets of characteristics of families that (but for this paragraph) might receive benefits under the project in an amount less than the amount required under subparagraph (A) to be provided to such family.

(C) DETERMINATION OF BENEFIT LEVEL FOR PARTICIPANTS WITH IDENTIFIED CHARACTERISTICS.—The State will establish a mechanism to determine, for each family with any set of characteristics identified under subparagraph (B), whether the family would (but for this paragraph) receive benefits under the project in an amount less than the amount required under subparagraph (A) to be provided to such family.

(D) ASSISTANCE UNDER PROJECT INCREASED WHERE NECESSARY.—The State will, for each family which would (but

for this paragraph) receive benefits under the project in an amount less than the amount required under subparagraph (A) to be provided to such family, increase the amount of such benefits to such family to the amount so required.

(11) TERMINATION OF PROJECT.—The project will terminate at the end of the 5-year period beginning on the first day of the month during which the project begins, or, if earlier—

(A) 180 days after the State notifies the Secretary of Health and Human Services that the State intends to terminate the project;

(B) 180 days after the Secretary of Health and Human Services, after 30 days written notice to the State and opportunity for a hearing, determines that the State has materially failed to comply with this section; or

(C) on agreement by the State and the Secretary of Health and Human Services.

(c) FUNDING.—

(1) IN GENERAL.—If an application submitted under subsection (a) by the State complies with the requirements specified in subsection (b) and contains an evaluation plan which meets the requirements of subsection (g), and the Secretary of Health and Human Services approves the application, then the Secretary shall, from amounts made available under parts A and F of title IV of the Social Security Act—

(A) pay the State for each calendar quarter, pursuant to section 403 of such Act, the amounts that would have been payable to the State during such calendar quarter, in the absence of the demonstration project, for cash assistance, child care, education, employment and training, and administrative expenses under the State plan approved under section 402(a) of such Act;

(B) reimburse the State at the rate of 50 percent, for expenses of evaluating the effects of the project.

(2) RULE OF CONSTRUCTION.—Paragraph (1) shall not be construed to prevent the State from claiming and receiving reimbursement for additional persons who would qualify for assistance under the State plan approved under section 402(a) of the Social Security Act, for costs attributable to increases in the State's payment standard under such plan, or for any other benefits and services for which Federal matching funds are available under part A of title IV of such Act.

(d) WAIVER AUTHORITY.—

(1) AFDC WAIVERS.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the Secretary of Health and Human Services shall, with respect to the demonstration project under this section, waive any requirement of part A or F of title IV of the Social Security Act that, if applied, would prevent the State from (i) carrying out the project in accordance with subsection (b), or (ii) effectively achieving its purposes, but only to the extent necessary to enable the State to carry out the project.

(B) LIMITATIONS.—The Secretary of Health and Human Services may not, with respect to the demonstration project under this section—

(i) waive any requirement of section 402(a)(4) or 482(h) of the Social Security Act;

(ii) permit the State to provide cash assistance to any family under the project in an amount less than the aggregate value of the assistance that would have been provided to such family under the State plan approved under section 402(a) of such Act and under the food stamp program established under the Food Stamp Act of 1977 in the absence of the project; or

(iii) waive any requirement of section 402(a)(19)(C) of such Act.

(2) OTHER WAIVERS.—If, under this section, the Secretary of Health and Human Services approves an application by the State to conduct a demonstration project relating to the State family investment plan, the Secretary of Health and Human Services shall, in order to enable the State to implement the demonstration project—

(A)(i) require that the State treat each family participating in the project as individuals eligible for medical assistance under section 1902(a)(10)(A) of the Social Security Act,

(ii) require that the State treat, for purposes of section 1925 of such Act, each family whose participation in the project is terminated by reason of increased income from employment as a family that has become ineligible for aid under the State plan approved under part A of title IV of such Act, and

(iii) require that the State treat each family whose participation in the project is terminated by reason of the collection or increased collection of child support under part D of title IV of the Social Security Act as a recipient of aid to families with dependent children for purposes of title XIX of such Act for an additional 4 calendar months beginning with the month in which such termination occurs; and

(B) make payment, under section 1903 of such Act, for medical assistance and administrative expenses for families participating in the project in the same manner as such payments may be made for medical assistance and administrative expenses for individuals entitled to benefits under title XIX of such Act, except that the aggregate amount of such payments may not exceed the aggregate amount of payments that would have been made for those families in the absence of such project.

(e) DEFINITIONS OF CERTAIN TERMS.—As used in this section, the terms "family" and "contract" shall have the meaning given such terms by the 1989 Minnesota Laws, sections 6 through 11, 13, 130, and 132 of article 5 of chapter 282.

(f) QUALITY CONTROL.—Cases participating in the demonstration project under this section during a fiscal year shall be excluded from any sample taken for purposes of determining under section 403(i) or 408 of the Social Security Act, whichever is applicable, the rate at which the State made overpayments under part A of title IV of such Act for the fiscal year. For purposes of such sections 403(i) and 408, payments made by the State under the project shall be treated as payments made under the State plan approved under section 402(a) of such Act.

(g) EVALUATION OF PROJECT.—

(1) EVALUATION PLAN.—The State shall develop and implement an evaluation plan designed to provide reliable information on the impact and implementation of the demonstration

project. The evaluation plan shall include groups of project participants and control groups assigned at random in the field trial conducted in accordance with subsection (b)(1)(A).

(2) EVALUATION.—The evaluation conducted under the evaluation plan shall measure the extent to which the project increases family employment and income, prevents long-term dependency, moves families toward self-support, reduces total assistance payments, and simplifies the welfare system.

(3) REPORTS.—The State shall issue an interim report and a final report on the results of the evaluation described in paragraph (2) to the Secretary of Health and Human Services at such times as the Secretary shall require.

(h) REPORT TO CONGRESS.—Within 3 months after receipt of the final report issued pursuant to subsection (g)(3), the Secretary of Health and Human Services shall report to the Congress the results of the evaluation described in subsection (g)(2).

SEC. 8016. INCREASE IN FUNDING FOR TITLE XX SOCIAL SERVICES BLOCK GRANT.

Section 2003(c) (42 U.S.C. 1397b(c)) is amended—

(1) in paragraph (3), by striking "and 1987, and for each succeeding fiscal year other than the fiscal year 1988; and" and inserting "1987, and 1989;";

(2) in paragraph (4), by striking the period and inserting "; and"; and

(3) by adding at the end the following:

"(5) $2,800,000,000 for each fiscal year after fiscal year 1989.".

TITLE IX—OFFSHORE OIL POLLUTION COMPENSATION FUND

SEC. 9001. PAYMENTS TO THE OFFSHORE OIL POLLUTION COMPENSATION FUND.

(a) IN GENERAL.—(1) Section 302(d)(1) of the Outer Continental Shelf Lands Act Amendments of 1978 (43 U.S.C. 1812(d)(1)) is amended by striking out "not to exceed".

(2) Section 302(d)(2) of the Outer Continental Shelf Lands Act Amendments of 1978 (43 U.S.C. 1812(d)(2)) is amended by striking out "not less than $100,000,000 and not more than" and adding in lieu thereof "not more than or less than".

43 USC 1812.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of enactment of this Act.

TITLE X—MISCELLANEOUS AND TECHNICAL SOCIAL SECURITY ACT AMENDMENTS

Miscellaneous and Technical Social Security Act Amendments of 1989.

42 USC 1305 note.

SEC. 10000. SHORT TITLE; TABLE OF CONTENTS.

This title may be cited as the "Miscellaneous and Technical Social Security Act Amendments of 1989".

Table of Contents

Subtitle A—Time-Sensitive Provisions

SEC. 10101. CONTINUATION OF DISABILITY BENEFITS DURING APPEAL.

Subsection (g) of section 223 of the Social Security Act (42 U.S.C. 423(g)) is amended—

(1) in paragraph (1)(iii), by striking "June 1990" and inserting "June 1991"; and

(2) in paragraph (3)(B), by striking "January 1, 1990" and inserting "January 1, 1991".

SEC. 10102. TRANSFER TO RAILROAD RETIREMENT ACCOUNT.

Subsection (c)(1)(A) of section 224 of the Railroad Retirement Solvency Act of 1983 (relating to section 72(r) revenue increase transferred to certain railroad accounts) is amended by striking "1989" and inserting "1990". 45 USC 231n note.

SEC. 10103. EXTENSION OF DISABILITY INSURANCE PROGRAM DEMONSTRATION PROJECT AUTHORITY.

(a) IN GENERAL.—Section 505 of the Social Security Disability Amendments of 1980 (Public Law 96-265), as amended by section 12101 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272), is further amended— 42 USC 1310 note.

(1) in paragraph (3) of subsection (a), by striking "June 10, 1990" and inserting "June 10, 1993";

(2) in paragraph (4) of subsection (a), by striking "in each of the years 1986, 1987, 1988, and 1989" and inserting "in 1986 and each of the succeeding years through 1992"; and

(3) in subsection (c), by striking "June 9, 1990" and inserting "June 9, 1993".

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act. 42 USC 1310 note.

Subtitle B—Technical Provisions

SEC. 10201. PROHIBITION OF TERMINATION OF COVERAGE OF U.S. CITIZENS AND RESIDENTS EMPLOYED ABROAD BY A FOREIGN AFFILIATE OF AN AMERICAN EMPLOYER.

(a) IN GENERAL.—Subsection (l) of section 3121 of the Internal Revenue Code of 1986 (relating to agreements entered into by American employers with respect to foreign affiliates) is amended— 26 USC 3121.

(1) in paragraph (2), by adding at the end the following: "Notwithstanding any other provision of this subsection, the period for which any such agreement is effective with respect to any foreign entity shall terminate at the end of any calendar quarter in which the foreign entity, at any time in such quarter, ceases to be a foreign affiliate as defined in paragraph (6).";

(2) by striking paragraphs (3), (4), and (5);

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

"(3) NO TERMINATION OF AGREEMENT.—No agreement under this subsection may be terminated, either in its entirety or with respect to any foreign affiliate, on or after June 15, 1989."; and

(4) by redesignating paragraphs (6) through (10) as paragraphs (4) through (8), respectively.

(b) CONFORMING AMENDMENTS.—(1) Subsection (a) of section 210 of the Social Security Act (42 U.S.C. 410(a)) and subsection (a) of section 406 of the Internal Revenue Code of 1986 (relating to treatment of employees of American employer) are each amended by striking "section 3121(l)(8)" and inserting "section 3121(l)(6)".

(2) Paragraph (3) of section 406(c) of the Internal Revenue Code of 1986 (relating to termination of status as deemed employee not be treated as separation from service for purposes of limitation of tax) is amended by striking "section 3121(l)(8)(B)" and inserting "section 3121(l)(6)(B)".

(3) Paragraph (1) of section 3121(l) of such Code (relating to agreements entered into by American employers with respect to foreign affiliates) is amended, in the matter preceding subparagraph (A), by striking "paragraph (8)" and inserting "paragraph (6)".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to any agreement in effect under section 3121(l) 26 USC 406 note.

of the Internal Revenue Code of 1986 on or after June 15, 1989, with respect to which no notice of termination is in effect on such date.

SEC. 10202. EXCLUSION FROM WAGES AND COMPENSATION OF REFUNDS REQUIRED FROM EMPLOYERS TO COMPENSATE FOR DUPLICATION OF MEDICARE BENEFITS BY HEALTH CARE BENEFITS PROVIDED BY THE EMPLOYERS.

42 USC 1395b note.

(a) OLD-AGE, SURVIVORS, AND DISABILITY, AND HOSPITAL INSURANCE PROGRAMS.—For purposes of title II of the Social Security Act and chapter 21 of the Internal Revenue Code of 1986, the term "wages" shall not include the amount of any refund required under section 421 of the Medicare Catastrophic Coverage Act of 1988.

(b) RAILROAD RETIREMENT PROGRAM.—For purposes of chapter 22 of the Internal Revenue Code of 1986, the term "compensation" shall not include the amount of any refund required under section 421 of the Medicare Catastrophic Coverage Act of 1988.

(c) FEDERAL UNEMPLOYMENT PROGRAMS.—

(1) FEDERAL UNEMPLOYMENT TAX.—For purposes of chapter 23 of the Internal Revenue Code of 1986, the term "wages" shall not include the amount of any refund required under section 421 of the Medicare Catastrophic Coverage Act of 1988.

(2) RAILROAD UNEMPLOYMENT CONTRIBUTIONS.—For purposes of the Railroad Unemployment Insurance Act, the term "compensation" shall not include the amount of any refund required under section 421 of the Medicare Catastrophic Coverage Act of 1988.

(3) RAILROAD UNEMPLOYMENT REPAYMENT TAX.—For purposes of chapter 23A of the Internal Revenue Code of 1986, the term "rail wages" shall not include the amount of any refund required under section 421 of the Medicare Catastrophic Coverage Act of 1988.

(d) REPORTING REQUIREMENTS.—Any refund required under section 421 of the Medicare Catastrophic Coverage Act of 1988 shall be reported to the Secretary of the Treasury or his delegate and to the person to whom such refund is made in such manner as the Secretary of the Treasury or his delegate shall prescribe.

(e) EFFECTIVE DATE.—This section shall apply with respect to refunds provided on or after January 1, 1989.

SEC. 10203. ELIMINATION OF ANY CARRYOVER REDUCTION IN RETIREMENT OR DISABILITY BENEFITS DUE TO RECEIPT OF WIDOW'S OR WIDOWER'S BENEFITS BEFORE ATTAINING AGE 62.

(a) IN GENERAL.—Section 202(q)(3) of the Social Security Act (42 U.S.C. 402(q)(3)) is amended—

(1) by striking subparagraphs (E), (F), and (G); and

(2) by redesignating subparagraph (H) as subparagraph (E).

(b) EFFECTIVE DATE.—The amendments made by this section shall apply— 42 USC 402 note.

(1) in the case of any individual's old-age insurance benefit referred to in section 202(q)(3)(E) of the Social Security Act (as in effect before the amendments made by this section), only if such individual attains age 62 on or after January 1, 1990, and

(2) in the case of any individual's disability insurance benefit referred to in section 202(q)(3) (F) or (G) of such Act (as so in effect), only if such individual both attains age 62 and becomes disabled on or after such date.

SEC. 10204. CLARIFICATION OF RULES GOVERNING TAXATION UNDER FICA AND SECA OF INDIVIDUALS OF CERTAIN RELIGIOUS FAITHS.

(a) EXEMPTION FROM SECA TAXATION FOR CERTAIN EMPLOYEES EXEMPT FROM FICA TAXATION.—

(1) IN GENERAL.—Paragraph (3) of section 1402(g) of the Internal Revenue Code of 1986 (relating to inapplicability of exemption to certain church employees) is amended— 26 USC 1402.

(A) in the heading, by striking "NOT TO APPLY" and inserting "TO APPLY"; and

(B) by striking "shall not" and inserting "shall".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply with respect to taxable years beginning after December 31, 1989. 26 USC 1402 note.

(b) TECHNICAL AMENDMENT CLARIFYING INCLUSION OF PARTNERSHIPS AMONG EMPLOYERS ELIGIBLE FOR RELIGIOUS EXEMPTION FROM FICA.—

(1) IN GENERAL.—Section 3127 of the Internal Revenue Code of 1986 (relating to exemption for employers and their employees where both are members of religious faiths opposed to participation in Social Security Act programs) is amended—

(A) in subsection (a)(1), by inserting "(or, if the employer is a partnership, each partner therein)" after "an employer";

(B) in subsection (a), in the matter following paragraph (2), by striking "his employees" and inserting "the employees thereof";

(C) in subsection (b), by inserting "(or a partner)" after "an employer";

(D) in subsection (c), by striking "his employees" and inserting "the employees thereof";

(E) in subsection (c)(1), by inserting "(or, if the employer is a partnership, each partner therein)" after "such employer"; and

(F) in subsection (c)(2), by striking "such employer or the employee involved ceases to meet" and inserting "such employer (or, if the employer is a partnership, any partner therein) or the employee involved does not meet", and by inserting "(or, if the employer is a partnership, any partner therein)" after "such employer" the second place it appears.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall be effective as if they were included in the amendments made by section 8007(a)(1) of the Technical and Miscellaneous Revenue Act of 1988 (102 Stat. 3781). 26 USC 3127 note.

SEC. 10205. TREATMENT OF GROUP-TERM LIFE INSURANCE UNDER RAILROAD RETIREMENT TAXES.

(a) IN GENERAL.—The second sentence of section 3231(e)(1) of the Internal Revenue Code of 1986 (defining compensation) is amended by striking ", (ii) tips" and inserting "or death, except that this clause does not apply to a payment for group-term life insurance to the extent that such payment is includible in the gross income of the employee, (ii) tips".

(b) EFFECTIVE DATE.— 26 USC 3231 note.

(1) IN GENERAL.—Except as provided in paragraph (2), the amendment made by subsection (a) shall apply to—

(A) group-term life insurance coverage in effect after December 31, 1989, and

(B) remuneration paid before January 1, 1990, which the employer treated as compensation when paid.

(2) EXCEPTION.—The amendment made by subsection (a) shall not apply with respect to payments by the employer (or a successor of such employer) for group-term life insurance for such employer's former employees who separated from employment with the employer on or before December 31, 1989, to the extent that such payments are not for coverage for any such employee for any period for which such employee is employed by such employer (or a successor of such employer) after the date of such separation.

(3) BENEFIT DETERMINATIONS TO TAKE INTO ACCOUNT REMUNERATION ON WHICH TAX PAID.—The term "compensation" as defined in section 1(h) of the Railroad Retirement Act of 1974 includes any remuneration which is included in the term "compensation" as defined in section 3231(e)(1) of the Internal Revenue Code of 1986 by reason of the amendment made by subsection (a).

SEC. 10206. TREATMENT OF CERTAIN DEFERRED COMPENSATION AND SALARY REDUCTION ARRANGEMENTS UNDER RAILROAD RETIREMENT TAXES.

(a) IN GENERAL.—The second sentence of section 3231(e)(1) of the Internal Revenue Code of 1986 (defining compensation) is amended by striking "or (iii)" and inserting "(iii)" and by inserting before the period ", or (iv) any remuneration which would not (if chapter 21 applied to such remuneration) be treated as wages (as defined in section 3121(a)) by reason of section 3121(a)(5)". 26 USC 3231.

(b) TREATMENT OF CERTAIN DEFERRED COMPENSATION AND SALARY REDUCTION ARRANGEMENTS.—Subsection (e) of section 3231 of such Code is amended by adding at the end thereof the following new paragraph:

"(9) TREATMENT OF CERTAIN DEFERRED COMPENSATION AND SALARY REDUCTION ARRANGEMENTS.—

"(A) CERTAIN EMPLOYER CONTRIBUTIONS TREATED AS COMPENSATION.—Nothing in any paragraph of this subsection (other than paragraph (2)) shall exclude from the term 'compensation' any amount described in subparagraph (A) or (B) of section 3121(v)(1).

"(B) TREATMENT OF CERTAIN NONQUALIFIED DEFERRED COMPENSATION.—The rules of section 3121(v)(2) which apply for purposes of chapter 21 shall also apply for purposes of this chapter.".

(c) EFFECTIVE DATES.— 26 USC 3231 note.

(1) SUBSECTION (a).—The amendment made by subsection (a) shall apply to remuneration paid after December 31, 1989.

(2) SUBSECTION (b).—Except as otherwise provided in this subsection—

(A) IN GENERAL.—The amendment made by subsection (b) shall apply to—

(i) remuneration paid after December 31, 1989, and

(ii) remuneration paid before January 1, 1990, which the employer treated as compensation when paid.

(B) BENEFIT DETERMINATIONS TO TAKE INTO ACCOUNT REMUNERATION ON WHICH TAX PAID.—The term "compensa-

tion" as defined in section 1(h) of the Railroad Retirement Act of 1974 includes any remuneration which is included in the term "compensation" as defined in section 3231(e)(1) of the Internal Revenue Code of 1986 by reason of the amendment made by subsection (b).

(3) SPECIAL RULE FOR CERTAIN PAYMENTS.—For purposes of applying the amendment made by subsection (b) to remuneration paid after December 31, 1989, which would have been taken into account before January 1, 1990, if such amendments had applied to periods before January 1, 1990, such remuneration shall be taken into account when paid (or, at the election of the payor, at the time which would be appropriate if such amendments had applied).

(4) EXCEPTION FOR CERTAIN 401(k) CONTRIBUTIONS.—The amendment made by subsection (b) shall not apply to employer contributions made during 1990 and attributable to services performed during 1989 under a qualified cash or deferred arrangement (as defined in section 401(k) of the Internal Revenue Code of 1986) if, under the terms of the arrangement as in effect on June 15, 1989—

(A) the employee makes an election with respect to such contributions before January 1, 1990, and

(B) the employer identifies the amount of such contribution before January 1, 1990.

(5) SPECIAL RULE WITH RESPECT TO NONQUALIFIED DEFERRED COMPENSATION PLANS.—In the case of an agreement in existence on June 15, 1989, between a nonqualified deferred compensation plan (as defined in section 3121(v)(2)(C) of such Code) and an individual, the amendment made by subsection (b) shall apply with respect to services performed by the individual after December 31, 1989. The preceding sentence shall not apply in the case of a plan to which section 457(a) of such Code applies.

SEC. 10207. TREATMENT OF ROWAN DECISION UNDER RAILROAD RETIREMENT TAXES.

(a) EXCLUSION OF MEALS AND LODGING.—Subsection (e) of section 3231 of the Internal Revenue Code of 1986 is further amended by adding at the end the following new paragraph:

"(10) MEALS AND LODGING.—The term 'compensation' shall not include the value of meals or lodging furnished by or on behalf of the employer if at the time of such furnishing it is reasonable to believe that the employee will be able to exclude such items from income under section 119.".

(b) INCOME TAX WITHHOLDING REGULATIONS NOT TO APPLY.—Paragraph (1) of section 3231(e) of such Code is amended by adding at the end the following new sentence: "Nothing in the regulations prescribed for purposes of chapter 24 (relating to wage withholding) which provides an exclusion from 'wages' as used in such chapter shall be construed to require a similar exclusion from 'compensation' in regulations prescribed for purposes of this chapter.".

26 USC 3231 note.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to remuneration paid after December 31, 1989.

SEC. 10208. INCLUSION OF CERTAIN DEFERRED COMPENSATION IN DETERMINATION OF WAGE-BASED ADJUSTMENTS.

(a) IN GENERAL.—Section 209 of the Social Security Act (42 U.S.C. 409) is amended by adding at the end the following new subsection:

"(k)(1) For purposes of sections 203(f)(8)(B)(ii), 213(d)(2)(B), 215(a)(1)(B)(ii), 215(b)(3)(A)(ii), 224(f)(2)(B), and 230(b)(2) (and 230(b)(2) as in effect immediately prior to the enactment of the Social Security Amendments of 1977), the term 'deemed average total wages' for any particular calendar year means the product of—

"(A) the SSA average wage index (as defined in section 215(i)(1)(G) and promulgated by the Secretary) for the calendar year preceding such particular calendar year, and

"(B) the quotient obtained by dividing—

"(i) the average of total wages (as defined in regulations of the Secretary and computed without regard to the limitation specified in subsection (a)(1) and by including deferred compensation amounts) reported to the Secretary of the Treasury or his delegate for such particular calendar year, by

"(ii) the average of total wages (as so defined and computed) reported to the Secretary of the Treasury or his delegate for the calendar year preceding such particular calendar year.

"(2) For purposes of paragraph (1), the term 'deferred compensation amount' means—

"(A) any amount excluded from gross income under chapter 1 of the Internal Revenue Code of 1986 by reason of section 402(a)(8), 402(h)(1)(B), or 457(a) of such Code or by reason of a salary reduction agreement under section 403(b) of such Code,

"(B) any amount with respect to which a deduction is allowable under chapter 1 of such Code by reason of a contribution to a plan described in section 501(c)(18) of such Code, and

"(C) to the extent provided in regulations of the Secretary, deferred compensation provided under any arrangement, agreement, or plan referred to in subsection (i) or (j).".

(b) CONFORMING AMENDMENTS.—

(1) Sections 203(f)(8)(B)(ii), 215(b)(3)(A)(ii), and 230(b)(2)(A) of the Social Security Act (42 U.S.C. 403(f)(8)(B)(ii)(I), 415(b)(3)(A)(ii)(I), and 430(b)(2)(A)), as amended by subsection (d)(2)(A)(i), are each further amended—

(A) by striking "the average of the total wages (as defined in regulations of the Secretary and computed without regard to the limitations specified in section 209(a)(1)) reported to the Secretary of the Treasury or his delegate" and inserting "the deemed average total wages (as defined in section 209(k)(1))";

(B) by striking "the average of the total wages (as so defined and computed) reported to the Secretary of the Treasury or his delegate" and inserting "the deemed average total wages (as so defined)"; and

(C) in section 215(b)(3)(A)(ii)(I), by striking "(after 1976)".

(2) Sections 213(d)(2)(B), 215(a)(1)(B)(ii), and 224(f)(2)(B) of such Act (42 U.S.C. 413(d)(2)(B), 415(a)(1)(B)(ii), and 424a(f)(2)(B)), as amended by subsection (d)(2)(A)(i), are each further amended—

(A) by striking "the average of the total wages (as defined in regulations of the Secretary and computed without regard to the limitations specified in section 209(a)(1)) reported to the Secretary of the Treasury or his delegate" and inserting "the deemed average total wages (as defined in section 209(k)(1))";

42 USC 413, 415.

(B) in section 213(d)(2)(B) and 215(a)(1)(B)(ii)(II), by striking "(as so defined and computed)" and inserting "(as defined in regulations of the Secretary and computed without regard to the limitations specified in section 209(a)(1))"; and

42 USC 424a.

(C) in section 224(f)(2)(B)(ii), by inserting "(I)" after "(ii)", by striking "as so defined and computed)" and inserting "(as defined in regulations of the Secretary and computed without regard to the limitations specified in section 209(a)(1))", and by inserting after "disability)" the following: ", if such calendar year is before 1991, or (II) the deemed average total wages (as defined in section 209(k)(1)) for the calendar year before the year in which the reduction was first computed (but not counting any reduction made in benefits for a previous period of disability), if such calendar year is after 1990".

(3) Section 215(i)(1)(G) of such Act (42 U.S.C. 415(i)(1)(G)) is amended by striking "the average of the total wages reported to the Secretary of the Treasury or his delegate as determined for purposes of subsection (b)(3)(A)(ii)" and inserting "the amount determined for such calendar year under subsection (b)(3)(A)(ii)(I)".

(4) Section 215(a)(1)(C)(ii) of such Act (42 U.S.C. 415(a)(1)(C)(ii)) is amended by striking "change." and inserting "change (except that, for purposes of subsection (b)(2)(A) of such section 230 as so in effect, the reference therein to the average of the wages of all employees as reported to the Secretary of the Treasury for any calendar year shall be deemed a reference to the deemed average total wages (within the meaning of section 209(k)(1)) for such calendar year).".

(5) Section 230(d) of such Act (42 U.S.C. 430(d)) is amended by striking "change." and inserting "change (except that, for purposes of subsection (b)(2)(A) of such section 230 as so in effect, the reference therein to the average of the wages of all employees as reported to the Secretary of the Treasury for any calendar year shall be deemed a reference to the deemed average total wage (within the meaning of section 209(k)(1)) for such calendar year).".

42 USC 430 note.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by subsections (a) and (b) shall apply with respect to the computation of average total wage amounts (under the amended provisions) for calendar years after 1990.

(2) TRANSITIONAL RULE.—For purposes of determining the contribution and benefit base for 1990, 1991, and 1992 under section 230(b) of the Social Security Act (and section 230(b) of such Act as in effect immediately prior to enactment of the Social Security Amendments of 1977)—

(A) the average of total wages for 1988 shall be deemed to be equal to the amount which would have been determined without regard to this paragraph, plus 2 percent of the amount which has been determined to the average of total wages for 1987,

(B) the average of total wages for 1989 shall be deemed to be equal to the amount which would have been determined without regard to this paragraph, plus 2 percent of the amount which would have been determined to be the aver-

age of total wages for 1988 without regard to subparagraph (A), and

(C) the average of total wages reported to the Secretary of the Treasury for 1990 shall be deemed to be equal to the product of—

(i) the SSA average wage index (as defined in section 215(i)(1)(G) of the Social Security Act and promulgated by the Secretary) for 1989, and

(ii) the quotient obtained by dividing—

(I) the average of total wages (as defined in regulations of the Secretary and computed without regard to the limitations of section 209(a)(1) of the Social Security Act and by including deferred compensation amounts, within the meaning of section 209(k)(2) of such Act as added by this section) reported to the Secretary of the Treasury or his delegate for 1990, by

(II) the average of total wages (as so defined and computed without regard to the limitations specified in such section 209(a)(1) and by excluding deferred compensation amounts within the meaning of such section 209(k)(2)) reported to the Secretary of the Treasury or his delegate for 1989.

(3) DETERMINATION OF CONTRIBUTION AND BENEFIT BASE FOR 1993.—For purposes of determining the contribution and benefit base for 1993 under section 230(b) of the Social Security Act (and section 230(b) of such Act as in effect immediately prior to enactment of the Social Security Amendments of 1977), the average of total wages for 1990 shall be determined without regard to subparagraph (C) of paragraph (2).

(4) REVISED DETERMINATION UNDER SECTION 230 OF THE SOCIAL SECURITY ACT.—As soon as possible after the enactment of this Act, the Secretary of Health and Human Services shall revise and publish, in accordance with the provisions of this Act and the amendments made thereby, the contribution and benefit base under section 230 of the Social Security Act with respect to remuneration paid after 1989 and taxable years beginning after calendar year 1989.

(d) CLERICAL AMENDMENTS.—

(1) DESIGNATION OF UNDESIGNATED PROVISIONS.—Section 209 of the Social Security Act is further amended— 42 USC 409.

(A) by redesignating paragraphs (1) through (9) of subsection (a) as subparagraphs (A) through (I), respectively;

(B) by redesignating clauses (1) through (3) of subsection (b) as clauses (A) through (C), respectively;

(C) by redesignating clauses (1) through (9) of subsection (e) as clauses (A) through (I), respectively;

(D) by redesignating paragraphs (1) and (2) of subsection (f) as subparagraphs (A) and (B), respectively;

(E) by redesignating paragraphs (1), (2), and (3) of subsection (g) as subparagraphs (A), (B), and (C), respectively;

(F) in subsection (h), by redesignating clauses (i), (ii), and (iii) as clauses (I), (II), and (III), respectively, by redesignating subparagraphs (A) and (B) of paragraph (2) as clauses (i) and (ii), respectively, and by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively;

(G) by redesignating paragraphs (1) and (2) of subsection (l) as subparagraphs (A) and (B), respectively;

(H) by redesignating paragraphs (1) and (2) of subsection (m) as subparagraphs (A) and (B), respectively;

(I) by redesignating paragraphs (1) and (2) of subsection (p) as subparagraphs (A) and (B), respectively;

(J) by redesignating subsections (a), (b), (d), (e), (f), (g), (h), (j), (k), (l), (m), (n), (o), (p), (q), (r), (s), and (t) (in the matter preceding subsection (k) added by subsection (a) of this section, and as amended by the preceding provisions of this paragraph) as paragraphs (1), (2), (3), (4), (5), (6), (7), (8), (9), (10), (11), (12), (13), (14), (15), (16), (17), and (18), respectively;

(K) by inserting "(a)" after "SEC. 209.";

(L) by striking "Nothing in the regulations" and inserting the following:

"(b) Nothing in the regulations";

(M) in the undesignated paragraph commencing with "For purposes of this title, in the case of domestic service", by inserting "(c)" at the beginning thereof, and by striking "subsection (g)(2)" each place it appears and inserting "subsection (a)(6)(B)";

(N) in the undesignated paragraph commencing with "For purposes of this title, in the case of an individual performing service, as a member", by inserting "(d)" at the beginning thereof, and by striking "subsection (a)" and inserting "subsection (a)(1)";

(O) by inserting "(e)" at the beginning of the undesignated paragraph commencing with "For purposes of this title, in the case of an individual performing service, as a volunteer";

(P) by inserting "(f)" at the beginning of the undesignated paragraph commencing with "For purposes of this title, tips received";

(Q) by inserting "(g)" at the beginning of the undesignated paragraph commencing with "For purposes of this title, in any case where";

(R) by inserting "(h)" at the beginning of the undesignated paragraph commencing with "For purposes of this title, in the case of an individual performing service under the provisions";

(S) by inserting "(i)" at the beginning of the undesignated paragraph commencing with "Nothing in any of the foregoing"; and

(T) by inserting "(j)" at the beginning of the undesignated paragraph commencing with "Any amount deferred".

(2) CONFORMING AMENDMENTS.—

(A) Title II of such Act is amended—

(i) in sections 203(f)(8)(B)(ii)(I), 213(d)(2)(B), 215(a)(1)(B)(ii)(I), 215(b)(3)(A)(ii)(I), 224(f)(2)(B)(i), and 230(b)(2)(A) (42 U.S.C. 403(f)(8)(B)(ii)(I), 413(d)(2)(B), 415(a)(1)(B)(ii)(I), 415(b)(3)(A)(ii)(I), 424a(f)(2)(B)(i), and 430(b)(2)(A)), by striking "section 209(a)" and inserting "section 209(a)(1)";

(ii) in section 203(f)(5)(C), by striking "subsections (a), (g)(2), (g)(3), (h)(2), and (j) of section 209" and inserting "paragraphs (1), (6)(B), (6)(C), (7)(B), and (8) of section 209(a)";

(iii) in clauses (B) and (C) of the last sentence of section 224(a), by striking "209(a)" and inserting "209(a)(1)"; 42 USC 424a.

(iv) in section 217(b)(1), by striking "209(e)(2)" and inserting "209(a)(4)(B)"; 42 USC 417.

(v) in section 218(c)(5), by striking "paragraph (2) of section 209(h)" and inserting "subparagraph (B) of section 209(a)(7)"; and 42 USC 418.

(vi) in section 203(f)(5)(C)(ii), by striking "209(m)(2)" and inserting "209(a)(11)(B)". 42 USC 403.

(B)(i) Section 6(f)(1) of the Fair Labor Standards Act of 1938 (29 U.S.C. 206(f)(1)) is amended by striking "209(g)" and inserting "209(a)(6)".

(ii) Section 1(h)(5)(iii) of the Railroad Retirement Act of 1974 (45 U.S.C. 231(h)(5)(iii)) is amended by striking "the third paragraph of section 209" and inserting "section 209(d)".

Subtitle C—Additional Amendments

SEC. 10301. ELIMINATION OF THE DEPENDENCY TEST APPLICABLE TO CERTAIN ADOPTED CHILDREN.

(a) IN GENERAL.—Section 202(d)(8)(D) of the Social Security Act (42 U.S.C. 402(d)(8)(D)) is amended—

(1) by adding "and" after the comma at the end of clause (i); and

(2) by striking clauses (ii) and (iii) and inserting the following new clause:

"(ii) in the case of a child who attained the age of 18 prior to the commencement of proceedings for adoption, the child was living with or receiving at least one-half of the child's support from such individual for the year immediately preceding the month in which the adoption is decreed".

(b) CONFORMING AMENDMENT.—Paragraph (8) of section 202(d) of such Act is further amended by striking the last sentence.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to benefits payable for months after December 1989, but only on the basis of applications filed on or after January 1, 1990. 42 USC 402 note.

SEC. 10302. AUTHORITY FOR SECRETARY TO TAKE INTO ACCOUNT MISINFORMATION PROVIDED TO APPLICANTS IN DETERMINING DATE OF APPLICATION FOR BENEFITS.

(a) OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE.—

(1) IN GENERAL.—Section 202(j) of the Social Security Act (42 U.S.C. 402(j)) is amended by adding at the end the following new paragraph:

"(5) In any case in which it is determined to the satisfaction of the Secretary that an individual failed as of any date to apply for monthly insurance benefits under this title by reason of misinformation provided to such individual by any officer or employee of the Social Security Administration relating to such individual's eligibility for benefits under this title, such individual shall be deemed to have applied for such benefits on the later of—

"(A) the date on which such misinformation was provided to such individual, or

"(B) the date on which such individual met all requirements for entitlement to such benefits (other than application therefor).".

42 USC 402 note.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to misinformation furnished after December 1982 and to benefits for months after December 1982.

(b) SUPPLEMENTAL SECURITY INCOME.—

(1) IN GENERAL.—Section 1631(e) of such Act (42 U.S.C. 1383(e)) is amended by adding at the end the following new paragraph:

"(5) In any case in which it is determined to the satisfaction of the Secretary that an individual failed as of any date to apply for benefits under this title by reason of misinformation provided to such individual by any officer or employee of the Social Security Administration relating to such individual's eligibility for benefits under this title, such individual shall be deemed to have applied for such benefits on the later of—

"(A) the date on which such misinformation was provided to such individual, or

"(B) the date on which such individual met all requirements for entitlement to such benefits (other than application therefor).".

42 USC 1383 note.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to misinformation furnished on or after the date of the enactment of this Act and to benefits for months after the month in which this Act is enacted.

SEC. 10303. SAME-DAY PERSONAL INTERVIEWS AT FIELD OFFICES OF THE SOCIAL SECURITY ADMINISTRATION IN CERTAIN CASES WHERE TIME IS OF THE ESSENCE.

(a) OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE.—Section 205 of the Social Security Act (42 U.S.C. 405) is amended by adding at the end the following new subsection:

"Same-Day Personal Interviews at Field Offices In Cases Where Time Is of The Essence

"(t) In any case in which an individual visits a field office of the Social Security Administration and represents during the visit to an officer or employee of the Social Security Administration in the office that the individual's visit is occasioned by—

"(1) the receipt of a notice from the Social Security Administration indicating a time limit for response by the individual, or

"(2) the theft, loss, or nonreceipt of a benefit payment under this title,

the Secretary shall ensure that the individual is granted a face-to-face interview at the office with an officer or employee of the Social Security Administration before the close of business on the day of the visit.".

(b) SUPPLEMENTAL SECURITY INCOME.—Section 1631(e) of such Act (42 U.S.C. 1383(e)) is amended by adding after the paragraph added by section 10302(b)(1) of this Act the following new paragraph:

"(6) In any case in which an individual visits a field office of the Social Security Administration and represents during the visit to an officer or employee of the Social Security Administration in the office that the individual's visit is occasioned by—

"(1) the receipt of a notice from the Social Security Administration indicating a time limit for response by the individual, or

"(2) the theft, loss, or nonreceipt of a benefit payment under this title,

the Secretary shall ensure that the individual is granted a face-to-face interview at the office with an officer or employee of the Social Security Administration before the close of business on the day of the visit.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to visits to field offices of the Social Security Administration on or after January 1, 1990. 42 USC 405 note.

SEC. 10304. AUTHORITY TO AMEND WAGE RECORDS AFTER EXPIRATION OF TIME LIMITATION.

Subparagraph (H) of section 205(c)(5) of the Social Security Act (42 U.S.C. 405(c)(5)(H)) is amended by striking "if" and all that follows through "period".

SEC. 10305. STANDARDS APPLICABLE IN CERTAIN DETERMINATIONS OF GOOD CAUSE, FAULT, AND GOOD FAITH.

(a) GOOD CAUSE FOR FAILURE TO MAKE EARNINGS REPORTS TIMELY.—Section 203(l) of the Social Security Act (42 U.S.C. 403(l)) is amended in the last sentence by striking "Secretary" and inserting "Secretary, except that in making any such determination, the Secretary shall specifically take into account any physical, mental, educational, or linguistic limitation such individual may have (including any lack of facility with the English language)".

(b) WAIVERS OF RECOVERY OF OVERPAYMENTS.—Section 204(b) of such Act (42 U.S.C. 404(b)) is amended by adding at the end the following new sentence: "In making for purposes of this subsection any determination of whether any individual is without fault, the Secretary shall specifically take into account any physical, mental, educational, or linguistic limitation such individual may have (including any lack of facility with the English language).".

(c) STANDARD OF REVIEW IN TERMINATION OF DISABILITY BENEFITS.—Section 223(f) of such Act (42 U.S.C. 423(f)) is amended by inserting after the first sentence in the matter following paragraph (4) the following new sentence: "In making for purposes of the preceding sentence any determination relating to fraudulent behavior by any individual or failure by any individual without good cause to cooperate or to take any required action, the Secretary shall specifically take into account any physical, mental, educational, or linguistic limitation such individual may have (including any lack of facility with the English language).".

(d) CONTINUATION OF BENEFITS PENDING APPEAL.—Section 223(g)(2)(B) of such Act (42 U.S.C. 423(g)(2)(B)) is amended by adding at the end the following new sentence: "In making for purposes of this subparagraph any determination of whether any individual's appeal is made in good faith, the Secretary shall specifically take into account any physical, mental, educational, or linguistic limitation such individual may have (including any lack of facility with the English language).".

(e) SUPPLEMENTAL SECURITY INCOME.—Section 1631(c)(1) of such Act (42 U.S.C. 1383(c)(1)) is amended by adding at the end the following: "The Secretary shall specifically take into account any physical, mental, educational, or linguistic limitation of such individual (including any lack of facility with the English language)

in determining, with respect to the eligibility of such individual for benefits under this title, whether such individual acted in good faith or was at fault, and in determining fraud, deception, or intent.".

42 USC 403 note.

(f) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to determinations made on or after July 1, 1990.

SEC. 10306. NOTICE REQUIREMENTS.

(a) APPLICABILITY TO BLIND BENEFICIARIES UNDER TITLE II OF NOTICE STANDARDS CURRENTLY APPLICABLE TO BLIND BENEFICIARIES UNDER TITLE XVI.—

(1) IN GENERAL.—Section 221 of the Social Security Act (42 U.S.C. 421) is amended by adding at the end the following new subsection:

"(l)(1) In any case where an individual who is applying for or receiving benefits under this title on the basis of disability by reason of blindness is entitled to receive notice from the Secretary of any decision or determination made or other action taken or proposed to be taken with respect to his or her rights under this title, such individual shall at his or her election be entitled either (A) to receive a supplementary notice of such decision, determination, or action, by telephone, within 5 working days after the initial notice is mailed, (B) to receive the initial notice in the form of a certified letter, or (C) to receive notification by some alternative procedure established by the Secretary and agreed to by the individual.

"(2) The election under paragraph (1) may be made at any time, but an opportunity to make such an election shall in any event be given, to every individual who is an applicant for benefits under this title on the basis of disability by reason of blindness, at the time of his or her application. Such an election, once made by an individual, shall apply with respect to all notices of decisions, determinations, and actions which such individual may thereafter be entitled to receive under this title until such time as it is revoked or changed.".

42 USC 421 note.

(2) APPLICATION TO CURRENT RECIPIENTS.—Not later than July 1, 1990, the Secretary of Health and Human Services shall provide every individual receiving benefits under title II of the Social Security Act on the basis of disability by reason of blindness an opportunity to make an election under section 221(l)(1) of such Act (as added by paragraph (1)).

42 USC 421 note.

(3) EFFECTIVE DATE.—The amendment made by this section shall apply with respect to notices issued on or after July 1, 1990.

42 USC 902 note.

(b) REPORT REGARDING NOTICES IN LANGUAGES OTHER THAN ENGLISH.—Not later than January 1, 1991, the Secretary of Health and Human Services shall submit a report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate setting forth—

(1) the procedures of the Social Security Administration currently in effect for issuing notices in languages other than English to individuals who have a limited capacity to communicate with such Administration in English, and

(2) reasonable options for expanding the use of notices in languages other than English.

SEC. 10307. REPRESENTATION OF CLAIMANTS.

(a) RECORDING OF IDENTITY OF REPRESENTATIVES IN ELECTRONIC INFORMATION RETRIEVAL SYSTEM.—

(1) OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE.—Section 206(a) of the Social Security Act (42 U.S.C. 406(a)) is amended by adding at the end the following new sentence: "The Secretary shall maintain in the electronic information retrieval system used by the Social Security Administration a current record, with respect to any claimant before the Secretary, of the identity of any person representing such claimant in accordance with this subsection.".

(2) SUPPLEMENTAL SECURITY INCOME.—Section 1631(d)(2) of such Act (42 U.S.C. 1383(d)(2)) is amended by adding at the end the following new sentence: "The Secretary shall maintain in the electronic information retrieval system used by the Social Security Administration a current record, with respect to any claimant before the Secretary, of the identity of any person representing such claimant in accordance with this paragraph.".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect June 1, 1991. 42 USC 406 note.

(b) NOTIFICATION OF OPTIONS FOR OBTAINING ATTORNEYS.—

(1) OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE.—Section 206 of such Act (42 U.S.C. 406) is further amended by adding at the end the following new subsection:

"(c) The Secretary shall notify each claimant in writing, together with the notice to such claimant of an adverse determination, of the options for obtaining attorneys to represent individuals in presenting their cases before the Secretary. Such notification shall also advise the claimant of the availability to qualifying claimants of legal services organizations which provide legal services free of charge.".

(2) SUPPLEMENTAL SECURITY INCOME.—Section 1631(d)(2) of such Act (42 U.S.C. 1383(d)(2)) is amended—

(A) by inserting "(A)" after "(2)"; and

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

"(B) The Secretary shall notify each claimant in writing, together with the notice to such claimant of an adverse determination, of the options for obtaining attorneys to represent individuals in presenting their cases before the Secretary. Such notification shall also advise the claimant of the availability to qualifying claimants of legal services organizations which provide legal services free of charge.".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to adverse determinations made on or after January 1, 1991. 42 USC 406 note.

SEC. 10308. EARNINGS AND BENEFIT STATEMENTS.

Part A of title XI of the Social Security Act is amended by adding at the end thereof the following new section:

"SOCIAL SECURITY ACCOUNT STATEMENTS

"Provision Upon Request

"SEC. 1142. (a)(1) Beginning not later than October 1, 1990, the Secretary shall provide upon the request of an eligible individual a social security account statement (hereinafter referred to as the 'statement'). 42 USC 1320b-13.

"(2) Each statement shall contain—

"(A) the amount of wages paid to and self-employment income derived by the eligible individual as shown by the records of the Secretary at the date of the request;

"(B) an estimate of the aggregate of the employee and self-employment contributions of the eligible individual for old-age, survivors, and disability insurance as shown by the records of the Secretary on the date of the request;

"(C) a separate estimate of the aggregate of the employee and self-employment contributions of the eligible individual for hospital insurance as shown by the records of the Secretary on the date of the request; and

"(D) an estimate of the potential monthly retirement, disability, survivor, and auxiliary benefits payable on the eligible individual's account together with a description of the benefits payable under the medicare program of title XVIII.

"(3) For purposes of this section, the term 'eligible individual' means an individual who—

"(A) has a social security account number,

"(B) has attained age 25 or over, and

"(C) has wages or net earnings from self-employment.

"Notice to Eligible Individuals

"(b) The Secretary shall, to the maximum extent practicable, take such steps as are necessary to assure that eligible individuals are informed of the availability of the statement described in subsection (a).

"Mandatory Provision of Statements

"(c)(1) By not later than September 30, 1995, the Secretary shall provide a statement to each eligible individual who has attained age 60 by October 1, 1994, and who is not receiving benefits under title II and for whom a current mailing address can be determined through such methods as the Secretary determines to be appropriate. In fiscal years 1995 through 1999 the Secretary shall provide a statement to each eligible individual who attains age 60 in such fiscal years and who is not receiving benefits under title II and for whom a current mailing address can be determined through such methods as the Secretary determines to be appropriate. The Secretary shall provide with each statement to an eligible individual notice that such statement is updated annually and is available upon request.

"(2) Beginning not later than October 1, 1999, the Secretary shall provide a statement on a biennial basis to each eligible individual who is not receiving benefits under title II and for whom a mailing address can be determined through such methods as the Secretary determines to be appropriate. With respect to statements provided to eligible individuals who have not attained age 50, such statements need not include estimates of monthly retirement benefits. However, if such statements provided to eligible individuals who have not attained age 50 do not include estimates of retirement benefit amounts, such statements shall include a description of the benefits (including auxiliary benefits) that are available upon retirement.".

Subtitle D—Human Resource and Income Security Provisions

SEC. 10401. INCREASE IN AUTHORIZATION FOR CHILD WELFARE SERVICES UNDER TITLE IV-B OF THE SOCIAL SECURITY ACT.

(a) IN GENERAL.—Sections 420(a), 427(b), 474(c)(4)(B), and 474(c)(4)(C) of the Social Security Act (42 U.S.C. 620(a), 627(b), 674(c)(4)(B), and 674(c)(4)(C)) are each amended by striking "$266,000,000" and inserting "$325,000,000".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on October 1, 1989. 42 USC 620 note.

SEC. 10402. EXTENSION AND PERMANENT INCREASE IN FOSTER CARE CEILING.

(a) PERMANENT INCREASE IN APPROPRIATIONS LEVEL WHICH TRIGGERS FOSTER CARE CEILING.—Section 474(b)(2)(A) of the Social Security Act (42 U.S.C. 674(b)(2)(A)) is amended—

(1) by striking "and" at the end of clause (ii);

(2) by striking the period at the end of clause (iii) and inserting "; and"; and

(3) by adding at the end the following new clause:

"(iv) with respect to each fiscal year succeeding the fiscal year 1989, only if $325,000,000 is appropriated under section 420 for such succeeding fiscal year.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on October 1, 1989. 42 USC 674 note.

SEC. 10403. MISCELLANEOUS TECHNICAL CORRECTIONS.

(a) TECHNICAL CORRECTIONS RELATING TO THE FAMILY SUPPORT ACT OF 1988.—

(1) CORRECTIONS TAKING EFFECT RETROACTIVELY.—

(A)(i) Section 407(b)(1)(B)(iii)(I) of the Social Security Act (42 U.S.C. 607(b)(1)(B)(iii)(I)), as amended by section 202(b)(8)(A), and redesignated by section 401(b)(1), of the Family Support Act of 1988, is amended by striking "409(a)(19)(C)" and inserting "402(a)(19)(C)".

(ii) The amendment made by clause (i) shall take effect as if such amendment had been included in section 202(b)(8)(A) of the Family Support Act of 1988 on the date of the enactment of such Act. 42 USC 607 note.

(B)(i) Sections 402(a)(30) and 452(d)(2)(B) of the Social Security Act (42 U.S.C. 602(a)(30) and 652(d)(2)(B)) are each amended by striking "automatic" and inserting "automated".

(ii) The amendments made by clause (i) shall take effect as if such amendments had been included in section 123(d) of the Family Support Act of 1988 on the date of the enactment of such Act. 42 USC 602 note.

(C)(i) Section 402(g)(1)(A) of the Social Security Act (42 U.S.C. 602(g)(1)(A)) is amended—

(I) in clause (iv), by striking "includes a child who is (or, if needy," and inserting "received aid to families with dependent"; and

(II) in clause (v), by striking the first comma.

42 USC 602 note.

(ii) The amendments made by clause (i) shall take effect as if such amendments had been included in section 302(c) of the Family Support Act of 1988 on the date of the enactment of such Act.

(2) CORRECTION TAKING EFFECT PROSPECTIVELY.—Effective September 30, 1998, section 407(d)(1) of the Social Security Act (42 U.S.C. 607(d)(1)) is amended by striking "participated" and all that follows and inserting "participated in a program under part F".

(b) TECHNICAL CORRECTION RELATING TO THE TAX REFORM ACT OF 1986.—

(1) CORRECTION.—Section 422(b)(1)(A) of the Social Security Act (42 U.S.C. 622(b)(1)(A)) is amended by striking "the individual or agency designated pursuant to section 2003(d)(1)(C) to administer or supervise the administration of the State's services program" and inserting "the individual or agency that administers or supervises the administration of the State's services program under title XX".

42 USC 622 note.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect as if such amendment had been included in section 1883(e)(1) of the Tax Reform Act of 1986 on the date of the enactment of such Act.

(c) TECHNICAL CORRECTION RELATING TO SECTION 474(b)(2)(B) OF THE SOCIAL SECURITY ACT.—

42 USC 674.

(1) CORRECTION.—Section 4(a)(1) of Public Law 98-617 is amended to read as follows:

"(1)(A) in paragraphs (1) and (4)(B), by striking out '1981 through 1984' and inserting in lieu thereof '1981 through 1985'; and

"(B) in paragraph (2)(B), by striking out '1982 through 1984' and inserting in lieu thereof '1981 through 1985'.".

42 USC 674 note.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) of this subsection shall take effect as if included in section 4 of Public Law 98-617 at the time such section became law.

Children and youth. Handicapped persons. Voluntarism. 42 USC 1395b-1 note.

SEC. 10404. DEMONSTRATION PROJECT.

(a) NUMBER OF PROJECTS.—In order to determine whether, and if so, the extent to which, the use of volunteer senior aides to provide basic medical assistance and support to families with moderately or severely disabled or chronically ill children contributes to reducing the costs of care for such children, not more than 10 communities may conduct demonstration projects under this section.

(b) DUTIES OF THE SECRETARY.—

(1) CONSIDERATION OF APPLICATIONS.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall consider all applications received from communities desiring to conduct demonstration projects under this section.

(2) APPROVAL OF CERTAIN APPLICATIONS.—The Secretary shall approve not more than 10 applications to conduct projects which appear likely to contribute significantly to the achievement of the purpose of this section.

(3) GRANTS.—The Secretary shall make grants to each community the application of which to conduct a demonstration project under this section is approved by the Secretary to assist the community in carrying out the project.

(c) REQUIREMENTS.—Each community receiving a grant with respect to a demonstration project under this section shall conduct the project in accordance with such requirements as the Secretary may prescribe.

(d) LIMITATION ON AUTHORIZATION OF APPROPRIATIONS.—For grants under this section, there are authorized to be appropriated to the Secretary of Health and Human Services not to exceed—

(1) $1,000,000 for each of the fiscal years 1990 and 1991; and

(2) $2,000,000 for each of the fiscal years 1992, 1993, and 1994.

(e) EFFECTIVE DATE.—This section shall take effect on October 1, 1989.

SEC. 10405. AGENT ORANGE SETTLEMENT PAYMENTS EXCLUDED FROM COUNTABLE INCOME AND RESOURCES UNDER FEDERAL MEANS-TESTED PROGRAMS.

(a) IN GENERAL.—

(1) TREATMENT OF PAYMENTS.—The payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.), shall not be considered income or resources in determining eligibility for the amount of benefits under any Federal or federally assisted program described in paragraph (2).

(2) PROGRAMS INVOLVED.—The program benefits described in this paragraph are—

(A) benefits under the supplemental security income program under title XVI of the Social Security Act;

(B) aid to families with dependent children under a State plan approved under section 402(a) of the Social Security Act;

(C) medical assistance under a State plan approved under section 1902(a) of the Social Security Act;

(D) benefits under title XX of the Social Security Act;

(E) benefits under the food stamp program (as defined in section 3(h) of the Food Stamp Act of 1977);

(F) benefits under the special supplemental food program for women, infants, and children established under section 17 of the Child Nutrition Act of 1966;

(G) benefits under section 336 of the Older Americans Act;

(H) benefits under the National School Lunch Act;

(I) benefits under any housing assistance program for lower income families or elderly or handicapped persons which is administered by the Secretary of Housing and Urban Development or the Secretary of Agriculture;

(J) benefits under the Low-Income Home Energy Assistance Act of 1981;

(K) benefits under part A of the Energy Conservation in Existing Buildings Act of 1976;

(L) benefits under any educational assistance grant or loan program which is administered by the Secretary of Education; and

(M) benefits under a State plan approved under title I, X, XIV, or XVI of the Social Security Act.

(b) EFFECTIVE DATE.—Subsection (a) shall take effect on January 1, 1989.

42 USC 627 note.

SEC. 10406. TREATMENT OF TRIENNIAL REVIEWS OF STATE FOSTER CARE PROTECTIONS FOR FISCAL YEARS BEFORE OCTOBER 1, 1990.

The Secretary of Health and Human Services shall not, before October 1, 1990, reduce any payment to, withhold any payment from, or seek any repayment from, any State under part B or E of title IV of the Social Security Act, by reason of a determination made in connection with any triennial review of State compliance with the foster care protections of section 427 of such Act for any Federal fiscal year preceding fiscal year 1991.

TITLE XI—MISCELLANEOUS

SEC. 11001. SECTION 202(b) EXCEPTION.

Any transfer of outlays, receipts, or revenues from one fiscal year to an adjacent fiscal year that occurs pursuant to any provision of this Act or any amendment made by this Act shall be considered a necessary (but secondary) result of a significant policy change as provided in section 202(b) of the Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987.

2 USC 902 note.

SEC. 11002. RESTORATION OF FUNDS SEQUESTERED.

President of U.S.

(a) ORDER RESCINDED.—(1) Upon the issuance of a new final order by the President under subsection (b)(4), the order issued by the President on October 16, 1989, pursuant to section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985 is rescinded.

(2) Except as otherwise provided in sections 6001, 6101, and 6201, and subject to subsection (b), any action taken to implement the order issued by the President on October 16, 1989, shall be reversed, and any sequesterable budgetary resource that has been reduced or sequestered by such order is restored, revived, or released and shall be available to the same extent and for the same purposes as if an order had not been issued.

(3) For purposes of section 702(d) and 1101(c) of the Ethics Reform Act of 1989, the order issued by the President on October 16, 1989, pursuant to section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985 is deemed to be rescinded on January 31, 1990.

(b) ADJUSTED REDUCTION.—

Reports.

(1) Before the close of the fifteenth calendar day beginning after the date of enactment of this Act, the Director of OMB shall issue a revised report using the exact budget baseline set forth in the report of October 16, 1989, and following the requirements, specifications, definitions, and calculations required by the Balanced Budget and Emergency Deficit Control Act of 1985 for the final report issued under section 251(c)(2) for fiscal year 1990, except that the aggregate outlay reduction to be achieved shall be an amount equal to $16.1 billion multiplied by 130 divided by 365. Calculations made to carry out the preceding sentence shall take into account the reductions and cancellations achieved by paragraphs (2) and (3) and shall not be affected by subsection (d).

(2) Notwithstanding any provision of law other than this paragraph, the reductions and cancellations in the student loan programs described in section 256(c) of the Balanced Budget and Emergency Deficit Control Act of 1985 achieved by the order

issued by the President on October 16, 1989, shall remain in effect through December 31, 1989, and no reductions or cancellations in such programs shall be made by the order issued under paragraph (4).

(3) Notwithstanding any provision of law other than this paragraph, any automatic spending increase suspended or cancelled by the order issued by the President on October 16, 1989, shall be paid at a rate that is 130/365ths less than the rate that would have been paid under the laws providing for such automatic spending increase.

(4) On the date that the Director submits a revised report to the President under paragraph (1) for fiscal year 1990, the President shall issue a new final order to make all of the reductions and cancellations specified in such report in conformity with section 252(a)(2) of the Balanced Budget and Emergency Deficit Control Act of 1985. Such order shall be deemed to have become effective on October 16, 1989. President of U.S.

(c) COMPLIANCE REPORT BY COMPTROLLER GENERAL.—Before the close of the thirtieth day beginning after the date the President issues a new final order under subsection (b)(4), the Comptroller General shall submit to the Congress and the President a compliance report setting forth the information required under section 253 of the Balanced Budget and Emergency Deficit Control Act of 1985 with respect to such order.

(d) NO DOUBLE REDUCTION IN MEDICARE.—With respect to items and services described in section 6001, 6101, or 6201 for periods for which reductions are made pursuant to the respective sections, no reduction shall be made under subsection (b).

Approved December 19, 1989.

LEGISLATIVE HISTORY—H.R. 3299 (S. 1750) (*See* S. 1726):

HOUSE REPORTS: No. 101-247 (Comm. on the Budget) and No. 101-386 (Comm. of Conference).

CONGRESSIONAL RECORD, Vol. 135 (1989):
Sept. 26-28, Oct. 3-5, considered and passed House.
Oct. 12, S. 1750 considered in Senate.
Oct. 13, H.R. 3299 considered and passed Senate, amended.
Nov. 21, House and Senate agreed to conference report.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 25 (1989):
Dec. 19, Presidential statement.

○

101st Congress
1st Session

HOUSE OF REPRESENTATIVES

Report
101-247

OMNIBUS BUDGET RECONCILIATION ACT OF 1989

REPORT

OF THE

COMMITTEE ON THE BUDGET HOUSE OF REPRESENTATIVES

TO ACCOMPANY

H.R. 3299

A BILL TO PROVIDE FOR RECONCILIATION PURSUANT TO SECTION 5 OF THE CONCURRENT RESOLUTION ON THE BUDGET FOR THE FISCAL YEAR 1990

together with

SUPPLEMENTAL AND ADDITIONAL VIEWS

September 20, 1989.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1989

CONTENTS

Title IV—Committee on Energy and Commerce

House of Representatives,
Committee on Energy and Commerce,
Washington, DC, September 15, 1989.

Hon. Leon Panetta,
Chairman, Committee on the Budget,
House of Representatives, Washington, DC.

Dear Mr. Chairman: I am transmitting herewith the recommendations of the Committee on Energy and Commerce for changes in laws within its jurisdiction pursuant to section 310 of the Congressional Budget Act of 1974 and section 5c(4) of the Concurrent Resolution on the Budget-Fiscal Year 1990 (H. Con. Res. 106).

The recommendations are embodied in the four enclosed Committee Prints (Nuclear Regulatory Commission user fees, Federal Communications Commission user fees, Securities and Exchange Commission user fees, and provisions relating to Medicare and Medicaid), approved by the Committee on July 12 and 13, 1989, together with the appropriate legislative report language and Congressional Budget Office cost estimates.

I believe that the enclosed recommendations, when combined with the non-duplicative savings achieved by Ways and Means in Medicare, will meet or exceed the budget resolution targets for this Committee.

I greatly appreciate your assistance and cooperation during this process, and I commend you for your outstanding leadership in this area.

Sincerely,

John D. Dingell, *Chairman.*

Table of Contents of Proposed Budget Reconciliation Provisions of the Committee on Energy and Commerce Along With Additional and Dissenting Views

TITLE IV—COMMITTEE ON ENERGY AND COMMERCE

Table of Contents of Title

Subtitle A-E—Health Care Provisions

The Committee on Energy and Commerce, having considered the Committee Print of July 17, 1989 entitled "Proposed Budget Reconciliation Provisions of the Committee on Energy and Commerce Relating to Medicare and Medicaid" (proposed Sections 4001 through 4403 of the House budget reconciliation bill), reports favorably thereon, with amendment, and recommends that it be referred to the Committee on the Budget pursuant to section 310 of the Congressional Budget Act of 1974.

Purpose and Summary

The purpose of the Medicare and Medicaid Health Budget Reconciliation Amendments of 1989 is to make revisions in Part B of the Medicare program and in the Medicaid program, in accordance with the budget instructions contained in the Concurrent Resolution on the Budget—fiscal year 1989 (H.Con.Res. 106).

The Committee bill consists of five subtitles. Subtitle A, containing Medicare Part B provisions, consists of three parts. Part A of subtitle A contains changes in payments for physician services under Medicare, changes in payments for other services covered under Medicare, and changes in the benefits and coverage rules for a variety of services. The most prominent provision in subtitle A, Part A is the comprehensive reform in the method of paying for physician services. The bill would replace the current "reasonable charge" method with a fee schedule, using a resource-based relative value scale. Most of the savings in the bill, in response to the

instructions of the budget resolution, are achieved through the elimination of the annual update for physician fees. This part also provides new coverage for pap smears, expands mental health services, refines several provisions from recent reconciliation acts, and requires several studies designed to help resolve policy issues in the future. It would also provide protection against out-of-pocket expenses for Medicare enrollees who have their cost-sharing paid under Medicaid.

Part B of subtitle A of the bill includes changes designed to improve the performance of health maintenance organizations and peer review organizations, an enhancement in payments for primary care residency programs, and a provision making information on preventive health practices available to Medicare enrollees.

Part C of subtitle A contains miscellaneous provisions relating to health programs within the jurisdiction of the Committee. It would instruct the Secretary of Health and Human Services to appoint administrative law judges who would hear health-related cases exclusively. It would make technical changes in the Bipartisan Commission on Comprehensive Health Care and would elevate the current Office of Rural Health Policy to the office of the undersecretary. It also includes a resolution expressing the sense of the House of Representatives that the Committee, and the Committee on Ways and Means, review the Medicare Catastrophic Coverage Act and hold hearings, and another resolution expressing the sense of the Congress that the Medicare benefits and premiums enacted last year in the catastrophic act be made voluntary during this session.

Subtitle B establishes the Agency for Health Care Research and Policy, and consists of four parts. Part A amends the Public Health Service Act to establish a new Agency for Health Care Research and Policy and, within the Agency, a Forum for Quality and Effectiveness in Health Care. Part B amends the Social Security Act to provide for a program of research on the outcomes of medical care, to be conducted through the Agency. Parts C and D contain general and transitional provisions needed to implement Parts A and B.

Subtitle C, containing Medicare provisions, consists of five parts. Part A consists of infant mortality provisions to expand Medicaid coverage for pregnant women and infants and provide appropriate services for this population. Part B, the "Child Health Amendments," phases in mandatory coverage of children up to 100 percent of the poverty level. Part C, the "Community and Facility Habilitation Services Amendments," extends, on a State option basis, the availability of community services to individuals with mental retardation or a related condition, establishes quality assurance guidelines for services in the community and institutions, and outlines protections for employees of institutions where services to this population are provided. Part D, the "Frail Elderly Community Care Amendments," establishes community care for the frail elderly as an optional, statewide service, and Part E mandates hospice care as a covered service under the Medicaid program. Part F contains miscellaneous amendments to the Medicaid program, including provisions relating to nurse aid training, preadmission screening, and other matters relating to nursing home reform contained in the Omnibus Budget Reconciliation Act of 1987.

Subtitle D is a reauthorization of the Maternal and Child Health Block Grant Program. It contains an increase in the authorization level and improvements in the program's structure and operation.

Subtitle E, "Miscellaneous Health-Related Provisions," includes technical amendments to the National Childhood Injury Vaccine Compensation program. It also includes a technical amendment on Congressional access to information from the Food and Drug Administration and mandates a study by the Comptroller General on health benefits for retirees of a bankrupt employer.

Background and Need for the Legislation

The Concurrent Resolution on the Budget—fiscal year 1990 (H. Con. Res. 106, adopted May 17, 1989) provided for unspecified savings in the Medicare program of $2.3 billion in fiscal years 1990 and 1991. The Budget Resolution assigns this savings target to both this Committee and the Committee on Ways and Means, without instructions as to how much is to be achieved in Part A, which is not within the jurisdiction of this Committee, and how much is to be achieved in Part B, which is within the jurisdiction of both committees. Therefore, this Committee does not have a specific target for the Medicare savings it must achieve. The net savings from this Committee are consolidated with the net savings from the Committee on Ways and Means to determine whether the target has been met. This year, as in the past, the Committee has attempted to achieve its savings without reducing benefits or increasing the out-of-pocket expenses of the Medicare enrollees. The Committee is also concerned, however, that continual reductions in payments to providers of service, without adequate evaluation of the effects of prior reductions, will inevitably impact on enrollees in the form of reduced quality of care or barriers to accessibility.

The Budget Resolution also provides $200 million in new entitlement authority for fiscal year 1990 to begin Medicaid initiatives to combat infant mortality, improve child health, make community-based services available to the frail elderly and individuals with mental retardation, and require coverage of hospice services. The Committee bill contains each of these initiatives. Under the bill, an additional 84,000 poor pregnant women and 64,000 poor infants would receive Medicaid coverage for prenatal care in fiscal year 1991. An additional 355,000 poor children between the ages of 1 and 7 would receive the preventive health care services under Medicaid that same year. About 15,000 individuals with mental retardation or a related condition would receive services in the community rather than an institution. And commnity-based services would reach approximately 15,000 low-income frail elderly to help them avoid placement in a nursing home. In the view of the Committee, these modest, incremental improvements respond effectively to the most urgent unmet needs of the three populations the Medicaid program serves: poor women and children, poor elderly, and poor disabled individuals.

Hearings

The Committee's Subcommittee on Health and the Environment held one day of hearings on Medicaid and the Mentally Retarded

on September 30, 1989, and heard testimony from 19 witnesses, including three Members of Congress and the Congressional Budget Office. On February 8th, 1989, the Subcommittee held hearings on the Medicaid Infant Mortality Initiatives. Testimony was received from 7 witnesses, representing the chairman of the National Commission to Prevent Infant Mortality, a member of Congress and 5 other organizations. The Subcommittee also held a one day hearing March 13th, 1989 on the development and use of medical practice guidelines in assuring quality of health care. Testimony was received from 7 witnesses, representing the Physician Payment Review Commission, a health insurance association, and 5 medical associations. On May 25th, 989, the Subcommittee held a one day hearing on Medicare Physician Payment Reform. Testimony was received from 12 witnesses, including 2 Members of the House of Representatives, Chairman of the Physician Payment Review Commission, and 9 other organizations. The Subcommittee held a one day hearing on June 8th, 1989 on Miscellaneous Medicare and Medicaid Reconciliation Provisions. Testimony was received from 24 witnesses, including a Member of Congress, the Congressional Budget Office, the Health Care Finance Administration, and 9 other organizations. Finally, on June 16, 1989, the Subcommittee held a hearing on H.R. 2601, Health Care Research and Policy. Testimony was received from 7 witnesses, representing the Deaprtment of Health and Human Services, and 6 other organizations.

Committee Consideration

The Subcommittee on Health and the Environment met for three days, on June 22nd, 27th, and 28th, 1989, in closed session to discuss proposed Medicare and Medicaid reconciliation provisions. The Subcommittee met in an open mark up session on June 29th, 1989, and ordered a Committee Print. On July 12th and 13th the Committee met in an open mark up session and ordered the Committeee Print with proposed amendments, transmitted to the Budget Committee by a recorded vote of 30 to 13, a quorum being present.

Committee Oversight Findings

Pursuant to clause 2(l)(3)(A) of rule XI of the Rules of the House of Representatives, no oversight findings or recommendations have been made to the Committee.

Committee on Government Operations

Pursuant to clause 2(l)(3)(D) of rule XI of the Rules of the House of Representatives, no oversight findings have been submitted to the Committee by the Committee on Government Operations.

Committee Cost Estimate

In compliance with clause 7(a) of rule XIII of the Rules of the House of Representatives, the Committee believes that the bill will achieve budget savings in the Medicare program of $525 million in fiscal year 1990, and result in new Medicaid program outlays of $183 million in fiscal year 1990.

Congressional Budget Office Estimate

U.S. Congress,
Congressional Budget Office,
Washington, DC, August 1, 1989.

Hon. John Dingell,
Chairman, Committee on Energy and Commerce,
House of Representatives, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has prepared the attached cost estimate for the provisions relating to spending in programs within the jurisdiction of the House Committee on Energy and Commerce, as ordered transmitted to the House Committee on the Budget by the House Committee on Energy and Commerce, July 13, 1989.

The estimates include in the attached report represent the 1990–1994 effects on the federal budget and on the budget resolution baseline of the Committee's legislative proposals. CBO understands that the staff of the Committee on the Budget will be responsible for interpreting how the savings contained in these legislative proposals measure against the budget resolution reconciliation instructions.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

Robert D. Reischauer,
Director.

HEALTH PROVISIONS OF 1990 RECONCILIATION BILL—ENERGY AND COMMERCE COMMITTEE—OUTLAYS IN MILLIONS OF DOLLARS BY FISCAL YEAR

	1990	1991	1992	1993	1994
SUBTITLE A—MEDICARE					
Part A—Provisions Relating to Part B of Medicare					
Subpart 1—Payment for physicians' services and related professional services:					
4001. Application of resource-based relative value scale to physicians' services	0	0	0	0	0
4002. Freeze in Medicare economic index during 1990	−705	−70	−815	−920	−1,035
4003. Payment for radiology services	3	1	0	0	0
4004. Payment for anesthesiology services:					
a. Reduce anesthesiologists	−45	−45	−55	−60	−65
b. Set CRNA factors	70	185	205	230	255
c. No payment for medical direction	0	0	0	0	0
4005. Payment for pathology services	0	0	0	0	0
4006. Waiver of liability	15	0	0	0	0
Subpart 2—Payment for other services:					
4011. Durable medical equipment:					
a. Enteral and parenteral equipment	−6	−12	−15	−15	−20
b. Reduce selected fees	−12	−20	−25	−25	−30
4012. Clinical diagnostic laboratory tests:					
a. Cap payments at 95 percent of median	−55	−85	−100	−115	−135
b. Eliminate "shell" labs	0	0	0	0	0
4013. Reduction in capital payments for outpatient hospital services	−15	−45	−55	−65	−75
4014. Federally qualified health centers	13	30	35	45	50
4015. Physical and occupational therapy services	(1)	(1)	1	1	1
Subpart 3—Changes in coverage and miscellaneous:					
4021. Mental health services:					
a. Direct payment for psych's, LCSW's	20	40	45	50	50

HEALTH PROVISIONS OF 1990 RECONCILIATION BILL—ENERGY AND COMMERCE COMMITTEE—OUTLAYS IN MILLIONS OF DOLLARS BY FISCAL YEAR—Continued

	1990	1991	1992	1993	1994
b. Eliminate $1,100 limit	20	55	75	90	115
c. Interaction of a. and b	2	9	13	16	19
4022. Nurse practitioner services—direct payment to NP's	10	15	15	20	20
4023. Coverage of screening pap smears	65	135	155	165	175
4024. Rural health clinic services	(1)	1	1	2	2
4025. Charge limits for Medicare benefits	(1)	(1)	(1)	(1)	(1)
Part B—Provisions Relating to Parts A and B of Medicare					
4041. Health maintenance organizations and competitive medical plans	150	220	25	280	320
4042. Peer review organizations	0	0	0	0	0
4043. Payment for end stage renal disease services (Eff. 1/1/90)	−60	−110	−135	−165	−200
4044. Payments for direct medical education	0	0	0	0	0
4045. Distribution of information on recommended preventive health practice	5	6	7	8	9
Part C—Provisions Relating to Medicare and Health Related Programs					
4061. Administrative law judges for health-related cases	(1)	(1)	(1)	(1)	(1)
Total for Medicare provisions	−525	−320	−398	−458	−544
SUBTITLE B—HEALTH CARE RESEARCH AND POLICY					
Part A—Agency for Health Care Research and Policy					
4101. Establishment of Agency	0	0	0	0	0
Part B—Outcomes of Health Care Services and Procedures					
4111. Establishment of program of research (subject to appropriation)	25	38	50	0	0
Part C—Additional Authorities and Duties With Respect to Agency for Health Care Research and Policy					
4121. Advisory council, peer review, administrative authorities, and other general provisions (subject to appropriations)	35	50	70	0	0
Part D—General Provisions					
4131. Terminations	0	0	0	0	0
4133. Technical and conforming amendments to Public Health Service Act	0	0	0	0	0
4134. Transitional provisions	0	0	0	0	0
Total for health care research (subject to appropriations)	60	88	120	0	0
SUBTITLE C—MEDICAID					
Part A—Infant Mortality Provisions					
4201. Medicaid coverage of pregnant women and infants:					
(a) Phased-in coverage	60	140	165	320	500
(b) Flexibility in income methodology/computation	1	2	3	3	4
(c) Prohibit resource test	7	30	35	40	40
(d) Errors in eligibility	0	0	0	0	3
4202. Presumptive eligibility and outreach for pregnant women:					
(b) Extend period	0	0	0	0	0
(c) Application flexibility	(1)	(1)	(1)	(1)	(1)
4203. Optional coverage of prenatal and postpartum home visitation services	3	10	10	10	15
4204. Payment for obstetrical and pediatric services:					
(a) Codification of adequate levels	0	0	0	0	0
(b) Assuring adequate levels	1	3	3	3	3
(c) Payment in federally funded health centers	9	10	10	15	15
4206. Role in paternity determination	(1)	(1)	(1)	(1)	(1)
4207. Required Medicaid notice and coordination with special supplemental food program for women, infants, and children	1	2	2	2	2
Part B—Child Health Amendments					
4211. Phased-in mandatory coverage of children up to 100 percent of poverty level:					
(a) In general	8	75	125	175	240
(b) Outreach applications	13	45	50	60	70

HEALTH PROVISIONS OF 1990 RECONCILIATION BILL—ENERGY AND COMMERCE COMMITTEE—OUTLAYS IN MILLIONS OF DOLLARS BY FISCAL YEAR—Continued

	1990	1991	1992	1993	1994
(c, d) Conforming amendments	0	0	0	0	0
4212. Extension of Medicaid transition coverage	0	5	25	55	65
4214. Early and periodic screening and diagnostic services defined	0	0	0	0	0
4215. Extension of payment provisions for medically necessary services in disproportionate share hospitals to children under 18 years of age	5	20	20	25	25
4216. Requiring "section 209(b)" States to provide medical assistance to disabled children receiving SSI benefits	3	15	15	15	20
4217. Mandatory continuation of coverage for children otherwise qualified for benefits until redetermination	2	5	5	10	10
4218. Optional Medicaid coverage for foster children	5	20	20	20	20
Part C—Community and Facility Habilitation Services Amendments					
Subpart 1—Community habilitation and supportive services	25	105	115	135	160
Subpart 2—Quality assurance for habilitation facility services	2	3	3	3	4
Subpart 3—Appropriate placement for individuals with mental retardation or related condition	1	2	2	2	3
Subpart 4—Payment for community habilitation and supportive services and habilitation facility services	2	5	5	5	10
Subpart 5—Employee protections and miscellaneous	3	4	4	5	5
4248. Use of State Developmental Disabilities Agency in certain Medicaid administrative functions	0	0	0	0	0
Part D—Frail Elderly Community Care Amendments					
4251. Community care as optional, statewide, service	35	145	165	180	200
Part E—Hospice Coverage					
4261. Mandating hospice coverage	1	5	5	10	10
Part F—Miscellaneous					
4271. Amendments relating to nursing home reform	−3	0	0	0	0
4272. Medicare buy-in provisions	(1)	1	5	7	10
4273. State matching payments for voluntary and State taxes	0	0	0	0	0
4274. Disproportionate share hospitals	0	0	0	0	0
4275. Miscellaneous provisions:					
a. Fraud and abuse technical amendment	0	0	0	0	0
b. Clarification of coverage of inpatient psychiatric hospital services	0	0	0	0	0
c. Medically needy income methodologies	0	0	0	0	0
d. HMO provisions	0	0	0	0	0
e. Personal care services	0	0	0	0	0
f. NP's and CNS in nursing homes for routine visits	−1	−2	−2	−2	−3
g. Codification of rehab services	0	0	0	0	0
h. Study of institutions for MD	0	0	0	0	0
i. Timely payment for FQC providers	0	0	0	0	0
j. Home and community based waiver clarifications	0	0	0	0	0
k. Spousal impoverishment clarifications	0	0	0	0	0
l. Medicaid transition coverage	0	0	0	0	0
m. State utilization review systems	0	0	0	0	0
n. Health insuring organizations	0	0	0	0	0
o. Day habilitation services	0	0	0	0	0
p. Miscellaneous technical corrections	0	0	0	0	0
Total for Medicaid provisions	183	650	790	1,098	1,431
SUBTITLE D—MATERNAL AND CHILD HEALTH PROGRAM					
4301. Increase in authorization of appropriations	100	100	100	100	100
4302. Allotments to State and Federal set-asides	0	0	0	0	0
4303. Use of allotments and application for block grant funds	0	0	0	0	0
4304. Reports	0	0	0	0	0
4305. Federal assistance in data collection mechanisms	0	0	0	0	0
4306. Development of model application form for maternal and child assistance programs	0	0	0	0	0
4307. Research on infant mortality and Medicaid services	0	0	0	0	0

HEALTH PROVISIONS OF 1990 RECONCILIATION BILL—ENERGY AND COMMERCE COMMITTEE—OUTLAYS IN MILLIONS OF DOLLARS BY FISCAL YEAR—Continued

	1990	1991	1992	1993	1994
Total for subtitle D (subject to appropriations)	100	100	100	100	100
SUBTITLE E—MISCELLANEOUS HEALTH RELATED PROVISIONS					
4401. Congressional access to information	0	0	0	0	0
4402. Vaccine injury compensation technicals—authorization levels (subject to appropriations):					
a. HRSA Administration	2	2			
b. Attorney General	2	2			
c. U.S. Claims Court	2	2			
Total for subtitle E (subject to appropriations)	6	6	0	0	0
Total (direct spending)	−432	330	392	640	887
Total (subject to appropriation)	166	194	220	100	100

[1] Less than $500,000 per year.

Note. All estimates contained in this document are subject to the following caveats: (1) All estimates are relative to the CBO February 1989 baseline. (2) Studies which have no direct spending impact are not listed in this table.

Inflationary Impact Statement

Pursuant to clause 2(l)(4) of rule XI of the Rules of the House of Representatives, the Committee makes the following statement with regard to the inflationary impact of the reported bill: The Committee believes this measure will result in net savings to the U.S. Government in the amounts indicated by the Congressional Budget Office.

Section-by-Section Analysis

Subtitle A—Medicare

PART A—PROVISIONS RELATING TO PART B OF MEDICARE

Subpart 1—Payment for physicians' services and related professional services

Section 4001—Application of resource-based relative value scale to physicians' services

Section 4001 sets forth a systematic and comprehensive reform of the methodology used under Medicare to pay for physicians' services. This reform would be phased in over four years and would be budget neutral in each year, vis-a-vis the total expenditures that would have been made under Medicare for physicians' services in the absence of the reform. At the conclusion of the phase-in, physicians' services would be paid for under a fee schedule, rather than under the current "reasonable charge" methodology. The fee schedule would be based on a nationally uniform "resource-based relative value scale" ("RBRVS") and would use a national conversion factor that would be adjusted to take into account geographical variations in the costs of furnishing physicians' services.

This reform is one of the key elements in any strategy to improve the Medicare program. It will simplify the current, complex payment rules, thereby improving both the ability of the enrollees

and physicians to understand the rules and the ability of the Medicare contractors to administer them. Moreover, by improving the equity among payments for these services, the Committee believes this reform will contribute to a more appropriate mix and distribution of services than is now the case, which will greatly benefit the Medicare enrollees.

This reform, by itself, will not resolve broader, vitally important, issues regarding the appropriateness and effectiveness of the care delivered under Medicare or the countinuing high rate of increase in Medicare expenditures. Additional measures are needed as part of a long term strategy, including those set forth in subtitle B of this bill dealing with research on patient outcome and the development of clinical practice guidelines. Implementation of this reform can, however, facilitate the discussion and resolution of these issues, while helping to assure continued access to quality care.

Background.—Under current law, physicians services are typically reimbursed on a fee-for-service basis. The payment amount is based on a complicated method established when the program was enacted in 1965 and embellished over the years. Payment amounts are influenced by several factors, the most prominent of which are the historical pattern of charges billed by each physician and the Medicare economic index, which imposes a limit on the rate of increase in payment amounts from year to year.

The current methodology has numerous shortcomings and problems that are of grave concern to the Committee. These include significant disparities among allowable payment amounts—for example, different payment amounts according to the geographical or institutional site of service, the physician specialty designation, or the technological intensity of service—that cannot be rationally explained by analytically derived considerations. Rather, they are founded on historical patterns of charges, and do not reflect demonstrable variations in the cost of producing the service or the physician's skill.

These problems have been of concern to the Committee for several years, as evidenced by numerous hearings, several mandated studies, and various legislative initiatives directed toward eventual systematic reform. These problems have also been well documented by several studies and published reports, by both governmental and non-governmental agencies and parties. Among the most notable governmental studies are those from the Office of Technology Assessement (Payment for Physician Services: Strategies for Medicare Reform, February 1986) and the Congressional Budget Office (Physician Reimbursement under Medicare: Options for Change, April 1986) and the three annual reports from the Physician Payment Review Commission (see, in particular, Annual Report to Congress, March 1989).

The most recent Physician Payment Review Commission (PPRC) annual report documents the progress that has been made in developing the concepts, data and analysis needed for comprehensive reform. It is also evident that a broad consensus had developed among many of the physician and patient organizations on the broad outlines for such reform. The Committee, which for some time has viewed such a fee schedule as its goal for payment reform,

is now in a position to formulate the fee schedule and begin making more substantial progress in achieving that goal.

Strategy for reform.—The strategy embodied in this section is to enact legislation this year, and begin implementation on April 1, 1990, for a four year plan of transition to a fully implemented fee schedule based on a resource-based relative value scale. The Committee recognizes that we do not yet have all the answers needed for full implementation of an RBRVS fee schedule. Research is continuing on some of the important issues involved. Many procedures have yet to be surveyed, or are scheduled for re-survey, by the research project at the harvard School of Public Health that is developing the relative value scale. Further studies and analyses will be conducted by the PPRC and the Department of Human Services. However, it is also the Committee's view that we know enough to begin implementation on a phased-in basis. It is further the Committee's view that we may not be able to identify all the issues and questions until the Secretary has actually begun to construct and implement the fee schedule.

We have learned a great deal about physician payment reform over the last five years and we know enough to set our ultimate objective and begin promptly to make substantial progress toward that objective. Since the first adoption of the fee freeze in 1984, we have mandated studies by the Secretary of Health and Human Services and we have created the Physician Payment Review Commission to evaluate alternative reforms and make recommendations to us. The Commission's recent third annual report provided us with a comprehensive and thoughtful set of specific recommendations, which are supported by a number of important physician and beneficiary groups.

Moreover, by implementing this provision on a four year phase-in, we have time to resolve those questions for which we do not have complete answers, and we will be better able to answer them based on real experience gained during the initial implementation stages. Undoubtedly, there will be new issues raised during implementation that we have not anticipated. Over the next two years, there will also be generated better data and information, and more thorough analyses, to answer both currently identified issues and new issues that arise.

The Committee also recognizes, however, that implementation in this manner, and this learning process, should be undertaken in a way that minimizes any risk of a serious mistake or an over-correction of current deficiencies. Physicians, patients and policy-makers all need time to understand the changes, to adjust to them, and to monitor the consequences carefully. It will be particularly important to monitor closely the potential effects on access to care, on quality of care, and on patient out-of-pocket expenditures. Changes in the mix, intensity and volume of services will also be of great interest to the Committee.

The Committee's strategy for minimizing errors and disruptions during the phase-in is to begin by making marginal adjustments in the current reasonable charge methodology, by reference to the ultimate objective of a RBRVS fee schedule. During the first two years of the phase-in, the Secretary of HHS would construct a "reference fee schedule", based on a resource-based relative value

scale. However, payments would not be made directly under this reference fee schedule. Rather, it would be used to increase or decrease the current prevailing charge screens for individual services, depending on the relationship of those prevailing charges to the reference fee schedule. The reference fee schedule would, however, be as complete as possible in incorporating all of the essential components and elements of the final fee schedule, based on the best available information.

In order to expedite the initial implementation, and avoid delays that might ensue if the Department had to resolve various policy issues, the Committee bill is quite specific in giving directions to the Secretary on how to begin the initial implmentation in 1990. In particular, there are the three appendices attached to this Committee report. The first one would identify the specific procedures for which the payment amounts would be adjusted and specify the relative value for each. The second appendix contains instructions on calculating the conversion factor so as to preserve budget neutrality and the third set forth specific geographic adjustments in the conversion factor.

The Committee bill leaves more discretion to the Secretary to resolve important issues after 1990. The Committee expects the Secretary to consult widely with interested parties in resolving such issues and the normal requirements for notice and comment rulemaking would apply. The Committee also anticipates that it will review this legislation periodically and is likely to amend and refine it to reflect subsequent research and the experience gained during the interim.

Application in 1990 to selected procedures.—The Committee recognizes that it is not practical at the time of the initial implementation to make adjustments in the payment amounts for all of the more than 7000 procedure codes used in the Medicare program. Nor is it necessary to do so in order to make substantial progress on reform. Only those 389 procedures listed in Appendix A would be subject to adjustments under this reform in 1990. However, the procedures on this list represent many of the most significant services furnished under Medicare.

The list in Appendix A is based on the recommendations of the PPRC. It was developed with technical consultation with the Health Care Financing Administration and was subject to review by physician organizations. The list is comprised of services that were surveyed by the Harvard research team and services that are closely related to those surveyed. The specific relative values for the procedures on the list have been established by the PPRC based on the findings of the Harvard research team. Services were removed from the list whenever there was any indication of a problem or serious concern with the relative value assigned to it—such as change in coding, insufficient or faulty data, or concern that a service was too dissimilar from those actually surveyed to warrant an extrapolation. As a result, the list represents services for which the Committee has a high degree of confidence that the relative value is sufficiently accurate to begin the phase-in.

The list in Appendix A does not include services for several important medical specialties, which have not yet been surveyed by the Harvard research team or for which relative values could not

confidently be determined. In particular, the schedule does not include radiology and anesthesia services. The Omnibus Budget Reconciliation Act of 1987 contained specific provisions, which originated in this Committee, calling for fee schedules for those two specialties. The Committee intends for the fee schedules developed under the 1987 legislation to be incorporated into the payment reform contained in this bill, beginning in 1991. This means that the work done by these specialties in developing the relative values among the services they perform should be retained to the extent consistent with overall reform. Adjustments will be made in the payment amounts for these services, as appropriate, to make sure that the payment levels for these services, as appropriate, to make sure that the payment levels for these services are consistent with their relative value compared to other services covered by the RBRVS fee schedule. The Secretary would be instructed by the bill to do this.

In the case of anesthesia services, the most practical way of doing this would appear to be to retain the relative value guide and make adjustments in the conversion factor. Since the preliminary analysis for anesthesia services indicates that they are overvalued relative to many other services, this would mean a reduction in the conversion factor.

For radiology services, it would be possible to do a similar adjustment in the conversion factors. However, this would mean that radiology services, for which the methodology of the fee schedule is otherwise identical to all services other than anesthesia, would have relative values that are not comparable and unique conversion factors. The Committee concluded that the radiology fee schedule should conform as much a possible to the remainder of the fee schedule. Consequently, the bill would require the Secretary to use the same conversion factor (and geographical adjustments) as he would for other services, and to ajust the recently constructed relative values for radiology services, as a class, to bring them into line with the RBVS generally. In doing so, the Secretary would retain the relationships among the values assigned to radiology services under the current radiology fee schedule.

This method of treating anesthesiology and radiology places great reliance on the judgment of the physicians affected by the fee schedule for determining the relative weights to be accorded within the range of services they furnish. It also preserves the effort made in constructing the current fee schedule and consistent with the development of the RBVS to date.

Specialty differentials.—As a general matter, the Committee bill does not preserve the current specialty differentials that are frequently used by Medicare carriers under current law to pay differing amounts for apparently comparable services depending on the specialty designation of the physician furnishing the service. There has been considerable criticism about such specialty differentials, particularly since they are not applied in a consistent manner around the country, since physicians are permitted to designate their own specialty in the absence of definitive standards, and since it is difficult to prove whether the services are dissimilar. The PPRC recommended that specialty differentials be eliminated for like services and the bill does so.

It is the Committee's view that those instances in which differential payments are warranted, based on the training and expertise of a specialist, can normally be accommodated with proper use of the procedure codes. Changes in the present codes may be necessary to implement this policy. There may be also particular instances, however, in which payment differentials are warranted and the Committee expects the PPRC and the Secretary to review this issue carefully.

The general policy against specialty differentials does not mean, however, that specialty identifiers should be elimianted from claims forms currently submitted to Medicare. It will remain important to have claims data by specialty for several reasons. For one, treatment of malpractice expenses under the fee schedule may well be done on a specialty basis, when changes are made in 1992 as discussed below. Second, the volume and mix of services will be closely monitored along several dimensions, one of which should be by specialty. Third, specialty identifiers are important during utilization review to make sure payments for concurrent care are appropriately made. Fourth, the claims data generated by Medicare can be an important resource for valuable research, some of which is likely to require specialty designations.

Subsequent application and modification of relative values.—After 1990, the reform would be applied to all of the procedures for which payment is made under Medicare. The Secretary would be responsible for establishing the relative values, based on the Harvard research project and the recommendations of the PPRC. The Secretary would also be responsible for keeping the relative values as current as possible and modifying them, as appropriate, to reflect changes in the practice of medicine, in the delivery of services, or in technological innovation. Two avenues are provided for making such changes. The Secretary, at any time during the year, could establish a new relative value for a service that had not had a value assigned. In addition, on an annual basis, the Secretary would be expected to review some or all of the existing relative values and revise them as appropriate. However, the bill is explicit in stating that such changes can only be done to reflect corrections in relative values. Adjustments could not be made solely for the purpose of achieving reductions in expenditures.

It is important to note that, under this method, there will be a single, uniform relative value scale applicable throughout the country. This will facilitate understanding of the relative values and the derivation of the fee schedule, as well as making subsequent updates and revisions easier. However, it should also be noted that this approach means that the geographical adjustments described below, to take account of regional differences in the cost of furnishing services, will be made on the conversion factors. Consequently, while there will be a national average conversion factor, there will not be a single, standard conversion factor for each fee schedule area. Rather, each service will have an individual local conversion factor. (An "average" local conversion factor can be computed for purposes of making general comparisons, but could not be used to construct the actual payment amount for any individual service under the local fee schedule.) While the complexity of this methodology may cause some confusion, the Committee believes it is the

most accurate and logical method of constructing the fee schedule and, overall, the most straightforward way of understanding it.

Adjustments in prevailing charges.—The reference fee schedule would be used to adjust the prevailing charges otherwise calculated for 1990 for the services on the list in Appendix A. The amount of the adjustment would be one-fifth of the difference between the prevailing charge and the reference fee schedule. This adjustment is substantial enough to result in significant progress toward the RBRVS fee schedule, without being so large as to cause a serious disruption or to run the risk of an erroneously large adjustment that will require subsequent correction. For many services, the actual amount of the adjustment will be less than two or three percent of the current payment amount.

Most services would be individually adjusted in this manner. However, this section sets out a special rule for office visits, hospital visits, consultations, and other services identified in the bill under the caption "evaluation and management services". These services would all receive an increase in the payment level. However, under the Committee bill, they would all receive the same percentage increase, rather than individually calculated increases. This uniform percentage increase would be based on the weighted average of the increase each would have received under the statutory formula. The reason for this special treatment is to take into account concerns expressed by the PPRC and others about the accuracy of the relative values for some of these services, due to ambiguities in the definitions and inconsistencies in the coding used by physicians for these services.

The Committee bill instructs the Secretary to revise the definitions and coding for these services so that individual adjustments and payments can be made accurately in the future. The bill instructs the Secretary to apply these revisions beginning January 1, 1992. It also instructs the Secretary, in making the revisions, to take into account the time spent in furnishing such services. Although time is arguably an implicit element in the current definitions of visits and similar procedures, the Harvard research team and the PPRC concluded that there is great variation among physicians in how they interpret the current definitions. Both also concluded that explicit treatment of time would clarify the definitions and make their application more consistent. The Committee notes, however, that time should not be the exclusive factor and that the intensity, risk, or other factors will also continue to be important. For some procedures in particular, such as emergency room services, giving appropriate weight to factors other than time will be important in arriving at a valid relative value. The PPRC and the American Medical Association are currently undertaking a joint project on these issues, and the Committee expects the Secretary to take the results of that project into consideration in carrying out this provision. As a related matter, the bill delays the requirement in the Omnibus Budget Reconciliation Act of 1986 that the Secretary consolidate procedure codes, so that such a requirement would not interfere with this project.

Until these improvements in the definitions and coding of evaluation and management services are ready in 1992, using the group average will avoid any serious miscalculation for any of

these services, while assuring that all of them receive a significant increase. The increase is expected to be approximately five percent in 1990, which is in the same range as the project Medicare economic index for that year.

This same approach of a marginal adjustment in prevailing charges would be used in 1991, the second year of the transition, except that all 7,000-plus procedure codes would be adjusted and the relative values used in the reference fee schedule would be assigned by the Secretary of HHS, based on the Harvard study and the recommendations of the PPRC. In the second year, the adjustment would be one fourth of the difference between the prevailing charge for that year and the reference fee schedule amount.

For 1991, the Secretary would not recalculate prevailing charges in the normal manner, to reflect the customary charges, for the services that were listed in Appendix A. Rather, the prevailing charge for these services would be the adjusted prevailing charge for 1990 further adjusted by the Medicare economic index for 1991. This will make implementation in 1991 easier, less costly, and less confusing. Customary charges would still have to be calculated for 1991, however, since the current payment methodology would still be in effect. In addition, prevailing charges would be calculated in the normal manner for services not on the list.

Elimination of customary charges.—In 1992, customary charges would be dropped altogether and would not have to be calculated. The customary charges would not be needed in 1992 in order to determine prevailing charges, because the prevailing charges in 1992, for purposes of making fee schedule adjustments, would simply be the adjusted prevailing charges for 1991 updated by the Medicare economic index. Moreover, customary charges would no longer be needed as a fee screen, since the reform would switch in 1992 from the current reasonable charge methodology to a fee schedule.

By 1992, the third year of implementation, the level of confidence in the fee schedule should be sufficient, when combined with any refinements made by the Congress in the interim, to permit payments to begin to be made under a fee schedule. However, since the amount of increases and decreases in payments may still be substantial, payments during the third year of transition would be made under an adjusted fee schedule. The dollar amounts under the adjusted fee schedule would be derived by splitting the difference between the reference fee schedule and what the prevailing charges (calculated as discussed above) would have been.

When the methodology for payments is changed in 1992 from the current reasonable charge method to the fee schedule, Medicare would pay 80 percent of the fee schedule amount or 80 percent of the physician's actual charge, whichever is lower.

Conversion factors.—The other critical component of the fee schedule, in addition to the relative value scale, is the conversion factor. The conversion factor is expressed in terms of dollars per unit of relative value. The fee schedule is constructed by multiplying the relative value for each service by the conversion factor.

The Committee bill would require the Secretary to calculate a national conversion factor each year, in a budget neutral manner. It would also require the Secretary to adjust this national conversion factor among designated geographical areas (labeled "fee

schedule areas" in the bill) to take account of differences among such areas in the cost of furnishing services.

The Committee bill assumes that measures other than this reform will be taken to achieve whatever savings are required under the instructions in the Budget Resolution. For 1990, in particular, such savings are achived primarily by a one-year freeze in the Medicare economic index (see section 4002, below). It is important to the successful implementation of this reform that it not become a vehicle for budget reductions or be viewed as a means of achieving some desired level of spending for Medicare. At the same time, however, the Committee does not want this reform to be the cause of an increase in volume or higher expenditures.

The Secretary would be responsible for calculating the appropriate conversion factor that achieves budget neutrality, based on the best data available information regarding the volume and mix of services that would be furnished under the reform and that would have been furnished in the absence of reform. One of the critical questions in this matter is how the payment reform will influence the volume and mix of services as physicians and patients react to changes in payment levels. There is a good deal of speculation about what will happen, but very little reliable information.

For the initial implementation in 1990, the Committee bill would give the Secretary explicit instructions on how to take such behavioral responses into account. These instructions are contained in Appendix B. They were prepared for the Committee by the Congressional Budget Office ("CBO") and are based on the best information available at this time. The model used by CBO for this purpose is based heavily on analyses of the experience in the 1970's when carrier locales were consolidated and Medicare fees were extensively revised in the state of Colorado. The analysis done by CBO, using 1986 data and the specifications for payment reform set forth in the Committee bill, indicates that the adjustment needed to account for such behavioral response would be very small—on the order of a fraction of one percent. The bill would require the Secretary to use the same analysis undertaken used by CBO, as specified in Appendix B, in calculating the conversion factor for 1990. The result might vary to some small degree when claims data for 1987 is used, rather than data for 1986, but the adjustment would still be expected to be a fraction of one percent.

For 1991 and subsequent years, the Secretary would be responsible for calculating the budget neutral conversion factor, taking into account the recommendations of the PPRC, the percentage increase in the MEI, and projected changes in the volume and mix of services. The Secretary would be required to submit a report to the Congress explaining his analysis of such projected changes. The Secretary's calculations would be based on the projection of what the aggregate expenditures would be under the payment reform and projections as to what they would have been in the absence of payment reform. This provision would not authorize the Secretary to adjust the conversion factor for 1991 (or for any subsequent year) in order to recover amounts that were expended in the previous year in excess of the amount originally projected. The Secretary could, of course, correct his analytical model to avoid subsequent inaccuracies in his projections, but could not recoup amounts previ-

ously expended. The Secretary would also be expected to seek to identify changes in the volume and mix of services that would have occurred even in the absence of payment reform—much as changes due to technological innovation or improved utilization review—and to exclude these changes from the adjustments made under this section.

Geographical adjustments.—Once a national, budget neutral conversion factor was calculated, the Secretary would adjust this for each fee schedule area, to take account of differences in the value of the resources used in furnishing services. For 1990 and 1991, these fee schedule areas would be the current carrier locales, because the capacity does not currently exist to use other areas. However, the Committee believes that it would be more appropriate to use either statewide fee schedule areas or to use metropolitan statistical areas along with combined non-MSA areas. Further analysis on these, and possibly other alternatives, will be undertaken by the PPRC and the Secretary, so that a decision can be made at a later date. The bill states that the Secretary will make a decision prior to 1992, but it is the Committee's expectation that the Congress is likely to make such a decision before that date.

The geographical adjustment for 1990 and 1991 would be applied to each of the two components of the RBRVS—one representing the "practice expenses" (the costs a physician must incur in producing a service) and the other representing the physician's personal resources. (The bill uses the term "physician work effort" for the second component, although some persons prefer the term "earnings".) For this purpose, practice expenses include such items as office rent, wages of personnel, equipment, and the like, but do not include the physician's own earnings or his own fringe benefits (including any automobile for which expenditures are charged to his practice). Malpractice costs would initially be included in the practice cost component, but the bill would instruct the Secretary to separate malpractice from the remainder of practice costs by 1992 and adjust it by a unique index. Thus, beginning in 1992, there would be three components to the geographic adjustment.

The relative value for each service would be divided into two components, to reflect the particular mix of practice expenses and physician work effort for that service. (This split is specified in Appendix A for purposes of services that will be subject to adjustments in 1990.) The national average conversion factor is then split into two components, service code by service code, to reflect the same ratio between practice costs and physician work effort. Each component of the conversion factor would then be adjusted by an index, consisting of weighting factors that take account of geographical variations in the costs represented in the component. There is one index for the practice expense component and another for the physician work component.

The two indices to be used for this purpose in 1990 are specified in Appendix C. Appendix C was developed by the PPRC at the Committee's request, and is based on a research conducted by the Urban Institute under contract with the Health Care Financing Administration. For 1991 and thereafter, the Secretary would be responsible for refining this index, or developing a new one, as appropriate.

The index used to adjust the practice expense component is based on data from the Bureau of Labor Statistics, from the Department of Housing and Urban Development, and from comparably reliable sources of information regarding variations in the costs of office space, salaries of nonphysician employees, and medical equipment. The index developed by the Urban Institute has been reviewed and widely accepted by other researchers and policy analysts. The Committee notes that this practice expense index would also be used to adjust the so-called technical component of services, such as radiology services, when these are identified and reimbursed separately from the professional component.

The index used to adjust the physician work effort component is an adaptation of the index developed by the Urban Institute. It is based on data from the 1980 Census on the incomes of professionals around the country. This is the best proxy currently available to assess the variation among geographical areas in the valuation placed on the physician's time and effort. The index initially developed by the Urban Institute took the variations in such professional incomes fully into account. The Committee, however, requested the PPRC to develop an adjusted index that reduces by half the magnitude of the adjustments that would be made under the original index.

The PPRC, in its annual report for 1989, recommended that the physician work effort component of the fee schedule not be adjusted at all for geographical variations, on the grounds that the physician's time and effort should be given the same valuation everywhere in the country. The Committee does not agree with this recommendation. The Committee recognizes that the cost of living varies around the country and that other professionals are compensated differentially, based on where they perform their srvices. The Committee is concerned that, if no adjustment is made in the physician work effort component, fees in high cost areas may be reduced to such an extent that physician services in such areas would become inaccessible. The Committee is also concerned, however, that a full adjustment of this component, in accord with the index developed by the Urban Institute, would be disadvantageous to the low valuation areas and would not serve the Committee's policy goal of fostering a better distribution of physician personnel. Fees in those areas might be too low to attract physicians and to resolve problems of access that have occurred.

The index chosen by the Committee tries to balance these concerns. It makes an adjustment in the physician work effort component, but cuts the impact of the original Urban Institute index in half. Arithmetically, this is achieved by adding 1.00 to each index value derived by the Urban Institute, and dividing the sum by two. For example, a fee schedule area that had a physician work effort component index value of 1.12 under the original Urban Index would have an index value of 1.06 under the Committee's index. Similarly, an area with an original value of 0.94 would have a value of 0.97 under the Committee index. In 1991, and for subsequent years, the Secretary would establish the index, using this same approach of cutting in half the effect of an index that took variations in professional incomes fully into account.

Beneficiary protection against excessive balance billing.—The Committee bill also contains a provision designed to protect beneficiaries against excessive balance billing. The current MAAC limits would expire on December 31, 1990, and would not be renewed. Beginning January 1, 1991, physicians who had not signed a participating physician agreement would be allowed to charge up to 120 percent of the Medicare allowable charge. In 1990 and 1991, this Medicare allowable amount would be the prevailing charge, as adjusted in accordance with the reform set forth in this section. Beginning in 1992, it would be the fee schedule amount.

Secretarial monitoring of impact of fee schedule reform.—The Committee recognizes that it will be important to have extensive and reliable information, on a timely basis, about the effects of this reform. Accordingly, the Secretary would be required to monitor the effects of this reform and report annually to the Congress. The Committee is particularly concerned about the effects of the reform on the rate of assignment and the burden of balance billing placed on beneficiaries, as well as changes in the mix and volume of services furnished. The Committee is advised that the Health Care Financing Administration is proposing to implement a new Current Beneficiary Survey. Such a survey would facilitate the implementation of this provision and this reform, and the Committee urges the Secretary to institute the survey as promptly as possible. In addition to the annual reports called for in the bill, the Committee anticipates making specific requests to the Secretary and the PPRC from time to time for additional information and analysis.

Change in participating physician agreements.—Physicians are normally given a period of time before the start of the calendar year to sign a participation agreement for the coming calendar year. In order to make an informed decision on whether to sign the agreement, a physician should know what the Medicare payments will be for the services he furnishes and the upper limit on what he is permitted to charge a patient if he does not sign the agreement.

Because the adjustments in the prevailing charges not be effective until April 1, 1990, and information about the adjustments will not likely be available before January 1, the bill revises the normal sign-up period for 1990. Physicians would be given a sign-up period prior to April 1, 1990, after the adjustments in prevailing charges and recalculation of the physician's MAAC limits have been made. The normal sign-up during November 1989 would be eliminated. Since section 4002 would essentially result in a three-month freeze in the current fees, and since there would only be a three month period before the fees changed, it does not seem necessary to go through that sign-up period. Current participation agreements would be extended for three months, but physicians with a current agreement who wished to terminate it on January 1, 1990, would be given the opportunity to do so. Physicians who do not have a current agreement would not be given an opportunity to sign one just for the three month period January through March 1990. They would have to await the sign-up period for April 1990.

Various other technical and conforming changes are made in the bill, including adjustments in payments to other health care practi-

tioners whose payment methodologies are dependent on payments for physician services.

The Committee recognizes that the reform set forth in this section is by no means the panacea for solving all the concerns being raised about the Medicare program or the health care delivery system. We must continue to pursue a coordinated approach that entails improved policies on graduate medical education and health manpower, along with enhanced research on technology assessment, quality assurance and the effectiveness and appropriateness of health care services. We also need improvements in peer review and utilization review. The Committee intends to continue reviewing and seeking improvements in these related areas of health policy.

Section 4002—Freeze in Medicare economic index during 1990

The Medicare economic index is essentially an inflation adjustment that acts as a restraint on the extent to which the "prevailing charges" recognized by Medicare as reasonable may increase from year to year. It was initially enacted by the Congress in 1972 and is based on the costs of a representative set of inputs, including salaries and earnings, that go into furnishing physician services.

The MEI is normally calculated each year by the Secretary and is announced in October of each year for the following year. During the last five years, however, the Congress has been statutorily establishing MEI increases lower than would otherwise be the case, as a means of achieving budget savings. The Congressional Budget Office estimates that, in the absence of Congressional action, the MEI for 1990 would allow a 5.3 percent increase in prevailing charges.

The Committee bill would eliminate the MEI increase for calendar year 1990. This is the principal Medicare savings item in the Committee bill, in response to the instructions in the budget resolution for fiscal year 1990.

The Committee is interested in pursuing fundamental reform in Medicare payments for physician services, as set forth in section 4001, as expeditiously as possible. This provision, eliminating the MEI for 1990, is the simplest and most straightforward means of achieving savings. The Committee has voiced displeasure in the past at provisions such as this and has previously attempted a different, more targeted approach to combining savings measures with efforts to achieve policy objectives. In this instance, however, this provision allows the Secretary to pursue the implementation of payment reform without the distraction of first implementing complicated savings provisions. The payment reform provisions, which would be implemented in a budget neutral manner, would promote the policy goals of increasing the payments for undervalued services and reducing those for over-valued services, thereby improving the mix distribution of services.

Taken in conjunction with the payment reform provision in section 4001, this provision would result in a three month freeze on all fees, from January 1 through March 31, 1990. Fees would then be adjusted under the payment reform.

As noted previously, in the description for section 4001, physicians who currently have participating physician agreements due

to expire on December 31, 1989, would be given an opportunity to become a non-participating physician on that date, under the terms of section 4001. If the physician did not request that his participation agreement be terminated, it would be extended through March 31. All physicians would be given a new opportunity prior to April 1 to sign a participation agreement, but the sign-up period due in November 1989 would be eliminated.

Section 4003—Payment for radiology services

The Omnibus Budget Reconciliation Act of 1987 called for the Secretary, in consultation with the physician groups affected, to establish a relative value scale and a fee schedule for radiologists' services. These tasks have been completed and the fee schedule was implemented earlier this year. While many aspects of the fee schedule have been implemented in a satisfactory way, two problems have arisen that are addressed in this provision.

The Committee, in initiating the fee schedule proposal in 1987, anticipated that the Secretary would develop a method of adjusting the fee schedule to reflect geographical differences in the cost of furnishing services, in a manner similar to that set forth in section 4001 of this bill. This was not done. Rather, the conversion factors used to derive the fee schedule in each area were based on prior charges submitted by physicians practicing in the area. As a result, the fee schedule incorporated undesirable geographical variations that existed prior to the fee reform.

The Committee bill would require the Secretary to calculate a national average conversion factor and to adjust that factor by the geographical indexes developed under section 4001. This reform of the radiology fee schedule would be phased in over two years, by setting the fee schedule amounts in 1990 at half the difference between what they would have been under this method of geographic adjustment and what they would have been under the current fee schedule. In 1991, they would be fully adjusted in accordance with the geographic indices set forth in section 4001. The provision would be implemented in a budget neutral way. Thus, in both years, the conversion factor is to be calculated by the Secretary so that total payments under this provision are the same as they would have been in the absence of this change.

A second concern is that nuclear physicians have been subjected to an inordinate decrease under the new fee schedule. The Committee is advised that the fee schedule did not adequately account for the differing manner in which nuclear physicians furnish services subject to the fee schedule. The Committee is also advised that efforts are being made by the Secretary, the radiologists, and the nuclear physicians to resolve this matter. The Committee bill would exempt nuclear physicians from the fee schedule for one year, in order to permit a resolution to be worked out.

Section 4004—Payment for anesthesiology services

Anesthesiology fee schedule.—Anesthesiology services are currently paid by Medicare under a unique system. Services are assigned "base units", which vary according to the complexity and risk involved in each procedure. In addition, the time spent caring for the patient is counted, typically in 15 minute time units.

(Thirty minute time units are used if an anesthesiologist is supervising a nurse anesthetist who is not employed by the anesthesiologist.) The actual charge for anesthesiology services is calculated by adding the base units and time units together, and the multiplying the sum of those by a conversion factor. The Omnibus Budget Reconciliation Act of 1987 required the Secretary to develop a uniform relative value guide for base units under this system, which would be consistently applied throughout the country with appropriate conversions factors.

The time element of this methodology is currently counted in whole units and is always rounded upward. Thus, if the anesthesiologist spends any portion of a time unit with the patient, a whole time unit is counted. Under this approach, for example, any amount of time between 16 minutes and 30 minutes would be counted as two time units. This clearly inflates the time units and the corresponding charges for these services.

The Committee bill would require that time be counted using fractional time units, based on the actual time spent on patient care. For example, 16 minutes would be counted as one and one-fifteenth time units, rather than two whole time units.

CRNA fee schedule.—The Omnibus Budget Reconciliation Act of 1986 included a provision, which originated in this Committee, authorizing payments for certified registered nurse anesthetists under a fee schedule. Among the other statutory elements applicable to this fee schedule were the requirements that the fee schedule be based on the costs incurred by hospitals in employing CRNAs and that adjustments be made in the fee schedule, as necessary, to achieve budget neutrality compared to what payments would be in the absence of this reform.

The Secretary has developed the CRNA fee schedule and has published it for public comment. Because of the budget neutrality requirement, the conversion factors used in the fee schedule are considerably lower than was expected, in comparison to hospital costs.

The Committee bill would raise the conversion factors, to make them more commensurate with the data from the hospital cost reports.

The bill would also preclude a surgeon from billing for the medical discretion of a CRNA. This practice is currently permitted by some of the Medicare contractors, but not by others. The Department of Health and Human Services has proposed having all contractors conform by not permitting such billing. The Committee concurred with the reasoning that a physician should not be billing for anesthesia supervisory services performed simultaneously with furnishing surgical procedures.

In addition, the bill would extend and expand the authority of small rural hospitals to be reimbursed for employing a CRNA. Under current law, if the CRNA (or CRNAs) employed by the hospital agrees not to file a claim under the fee schedule, a hospital that previously received cost reimbursement can elect to continue that arrangement. This permits the hospital to retain the services of the CRNA, even though the number of services performed at the hosptial is too few to generate sufficient revenues under the fee schedule to support a CRNA. The current provision is limited, how-

ever, to hospitals performing 250 or fewer procedures requiring anesthesia services per year and it would expire at the end of 1991. These limitations have hindered the ability of some rural hospitals to sustain access to surgical procedures. The Commitee bill would increase the qualifying threshold to 500 procedures per year and would make the provision permanent.

Section 4005—Payment for pathology services

Pathology services are currently reimbursed under the reasonable charge metholodogy generally applicable to other physician services. There have been a number of serious concerns raised, however, regarding the appropriateness of those charges, because of various legislative and regulatory revisions implemented over the last few years. The Omnibus Budget Reconciliation Act of 1987 contained a provision, which was initiated by this Committee, requiring the Secretary, in consultation with physicians performing pathology services, to develop a relative value scale and a fee schedule for pathology services. The provision did not authorize the Secretary to implement the fee schedule. Rather, it required him to report to the Congress, which would then have to enact further enabling legislation before the fee schedule could be implemented.

The Secretary has developed a fee schedule for pathology services, based on the reasonable charges for pathology services contained in Medicare claims data. This fee schedule is currently under review by the physician community, prior to submission to the Congress. Meanwhile, the Harvard research project developing a resource-based relative value scale, described above in section 4001, has surveyed some of these pathology services and concluded that further review is necessary before satisfactory results are available.

The Commitee bill would authorize implementation of the fee schedule on January 1, 1989, and would also require that geographic adjustments in a national fee schedule be made in a manner comparable to that made under section 4001. The Committee recognizes that further analysis and development of this fee schedule may be necessary between now and the date of implementation. The Committee intends to review carefully the response of the physician community to the Secretary's proposed fee schedule and to monitor the issues closely before implementation. The Commitee urges the physicians who would be affected by this fee schedule to work closely with the Secretary and the Physician Payment Review Commission to develop a relative value scale that reflects its best judgement of the relative resource costs of these services.

Section 4006—Waiver of liability limiting recoupment in certain cases

During the middle 1980's, the Health Care Financing Administration (HCFA) required all Medicare carriers to adopt a nationally uniform system of coding known as the HCFA Common Procedure Coding System (HCPCS). The carriers had previously been using a variety of different coding systems for processing claims for physician services. Most carriers were able to convert to the new system without encountering serious problems with inappropriate payments. However, the conversion did cause problems in some in-

stances, particularly when it was not clear what new code was the most appropriate substitute for the prior code.

When this problem arose in the State of Texas, the carrier implemented statewide fees, rather than different fees in each of the carrier locales, for some services for a substantial period of time. HCFA later concluded that this was incorrect and that a overpayments had been made in a significant number of cases. HCFA has been seeking recoupment of these overpayments.

The Committee bill would preclude this recoupment, whether it was attempted by means of a direct recoupment action against a physician or beneficiary or by withholding funds from payments that are subsequently due the physician or beneficiary. The bill would accomplish this by applying the provisions of section 1870(c) of the Social Security Act to these cases. Under that provision, the physician and patients who received overpayments under the statewide fee schedule, during a specified period of time, would be deemed to be "without fault" and, therefore, a successful recoupment procedure could not against them under section 1870. The Committee believes that the Secretary should also make reasonable efforts to repay those individuals from whom a recoupment has already been effected.

Subpart 2—Payment for other services

Section 4011—Durable medical equipment

The Omnibus Budget Reconciliation Act of 1987 contained a comprehensive reform of the methodology used under Medicare to pay for durable medical equipment, prosthetics and orthotics. The provision, which originated in this Committee, required the Secretary to develop fee schedules for these items. The items subject to this provision were divided into six different categories, with instructions for each category on how the fee schedules were to be derived. The Committee bill makes a number of refinements in the fee schedules developed under this provision.

Durable medical equipment fee schedules.—For two of the six categories (including most durable equipment and most prosthetics and orthotics), the 1987 legislation provided for a gradual phase-in of regional payment rates, beginning in 1991 and concluding in 1993. The purpose of these regional rates was to smooth out unwarranted variations in fees that might occur from state to neighboring states. It also set upper and lower bounds on the amount by which the fee schedule amount in any fee schedule area could depart from the average of the amounts for all fee schedule areas. This limit would first go into effect in 1991 and would tighten further in 1992.

Now that these fee schedules have been developed, sizeable variations have been revealed. The Committee bill would accelerate the application of these provisions that limit the degree of variation. It would start the phase-in of regional rates in 1990, instead of 1991, and would conclude in 1992, instead of 1993. It would also move the initial application of the upper and lower bounds to 1990 rather than 1991, the would narrow further the band of allowable variation.

Enteral and parenteral equipment.—The 1987 reform exempted enteral and parenteral nutrients, supplies and equipment from the new fee schedule. It did so on the grounds that these had previously been legislatively subjected to the so-called "lowest charge level" payment methodology by the Omnibus Budget Reconciliation Act of 1986, and that provision appeared to be working satisfactorily.

The Health Care Financing Administration (HCFA) has advised the Committee, however, that the equipment used in furnishing these services is comparable to other prosthetic devices and durable medical equipment for which payment is made under the new fee schedule. HCFA has urged that such equipment be reimbursed under the fee schedule, which should result in some savings to the program. The Committee bill would remove enteral and parenteral equipment from the exception, which would place such equipment under the appropriate category of the fee schedule established under the 1987 legislation. Nutrients and supplies would remain subject to the lowest charge level provision.

Reductions in selected items.—The Inspector General for the Department of Health and Human Services has identified serious concerns regarding Medicare payments for selected items of durable medical equipment, including seat lift chairs, power operated vehicles, and transcutaneous electrical nerve stimulators. The Inspector General's findings indicate there is substantial over-utilization of these items. The Committee bill would reduce the fee schedule payment amounts for these items by 15 percent. While the Committee acknowledges that a comprehensive response to these concerns might appropriately include additional strategies, such as stronger utilization review and payment safeguards, it seems clear to the Committee that a reduction in fees is likely to reduce the incentives and opportunities for abuse identified by the Inspector General.

Power driven wheelchairs.— Power driven wheelchairs are currently paid for in the same manner as most durable medical equipment, which is on a rental basis for up to fifteen months. This method does not well serve the needs of the patients who need these items. Typically these are patients who are severely handicapped and heavily dependent on their wheelchairs. The power driven wheelchairs used by them are normally built to the specifications suitable for each individual patient. In addition, they require frequent and substantial maintenance and repairs, and have to be replaced after a few years of use. It seems more appropriate for this item to be paid on a purchase basis in most cases, rather than on a rental basis. However, the Health Care Financing Administration has concluded that this cannot be done consistent with the current definitions and conditions of the purchase categories of the 1987 fee schedule reform.

The Committee bill would amend the 1987 reform to include wheelchairs under the category of "routinely purchased durable medical equipment". This would allow them to be reimbursed under Medicare on either a rental or purchase basis, subject to the proviso that total rental payments for a particular item furnished to a specific patient may not exceed the allowable purchase price.

The Committee is apprised that available data on previous charges and payments may be flawed, due to inconsistencies in

coding and other carrier practices. The Committee will continue to review this and urges the Secretary to use appropriate means of analyzing the data to assure that payment levels are reasonable.

The Committee also understands the Secretary has adopted policies that provide for appropriate payments for maintenance and repair of items covered under the "routinely purchased" category. Although such payments are not explicitly authorized under this provision, it is the Committee's expectation that such payments will be authorized.

Ostomy supplies.—Ostomy supplies are frequently used by patients reveiving home health services. These are low cost, disposable supplies that are used and replaced on a frequent basis by patients. Prior to the 1987 reform, the home health agency typically provided such supplies and was reimbursed on a cost basis. The patient did not incur any deductible or coinsurance under these circumstances. Under the 1987 reform, these supplies are now reimbursed under the fee schedule. This means that itemized claims must be submitted by or on behalf of the patient and the patient is responsible for the regular Part B deductible and coinsurance amounts. This appears to be unnecessarily cumbersome and difficult for patients, given the nature of these supplies.

The Committee bill would reinstate payment for these items through the home health agency. It would, moreover, go a step further. It would not only include these items under the definition of home health services, but it would also require that any home health agency providing services to a patient who needs such supplies must offer to furnish them as part of its home health services. Payment would be made to the home health agency on a cost basis. Because these supplies would be a home health service, the patient would not be responsible for deductible and coinsurance.

There will continue to be some beneficiaries who need these supplies, but who are not receiving home health services. In those cases, reimbursement would continue to be made under the fee schedules developed under the 1987 reform.

Section 4012—Clinical diagnostic laboratory services

Clinical diagnostic laboratory tests are currently reimbursed under Medicare on the basis of statewide fee schedules. This reform was originally enacted in the Deficit Reduction Act of 1984 and has been revised several times during subsequent budget reconciliation acts. The Committee bill contains further refinements in the current fee schedules.

Limit on payment amount.—The current statewide fee schedules are subject to an upper limit. Medicare will not pay more for a given test than the median, for that test, of all of the statewide fee schedules. Analyses of these fee schedules undertaken by the HHS Inspector General and the Comptroller General indicate that this limit could be moderately reduced without creating a substantial risk of impairing access to quality service. Accordingly, the Committee bill, in response to the instructions of the budget resolution, would reduce the limit to achieve additional savings. The limit would be reduced to 95 percent of the median of the statewide fee schedules. The Committee bill would retain the statutory annual update, which is equivalent to the Consumer Price Index and is es-

timated by the Congressional Budget Office to be approximately 4.6 percent for 1990.

The Committee also reviewed the reasonableness of Medicare payments for panels of tests (several tests done for a given patient simultaneously on a single laboratory instrument) and for test profiles (several tests ordered and performed concurrently, as a package for a given patient, using various testing methods and instruments). Studies by the HHS Inspector General have raised questions about these techniques resulting in unnecessary utilization and excessive payments. The Committee urges the Secretary to review the practice of test panels and test profiles, with regard to the appropriateness of both utilization and payment amounts, and to take appropriate action under existing authority or make recommendations for legislative amendments.

Restriction on payment to referring laboratory.—The 1984 reform included a provision, commonly referred to as "direct billing", which required that, as a general rule, payment for laboratory services could only be made to the laboratory that actually performed the test. A few exceptions to this general rule were provided, including one authorizing payment to a laboratory that had referred a sample to another laboratory. This exception was intended to deal primarily with tests done by rural hospitals, or by other small laboratories, that performed most of the testing for which they filed claims but did not have the capacity to do some particularly difficult or sophisticated tests.

The Committee has been advised that some laboratories have been taking advantage of this exception in a manner that was not intended. Parties have created laboratories that have only a limited capacity to do testing, or indeed have virtually no capacity to do testing, but that act as conduits for referrals to other laboratories. This arrangement allows the owners and operators of the referring laboratory to obtain substantial discounts from the testing laboratory or to make other financial arrangements so that, even though there is a limit on Medicare payments, the referring laboratory is able to make inappropriate profits on testing done for Medicare patients. This is likely to be an inducement for unnecessary testing and contravenes the intent of the direct billing requirement. This is not acceptable to the Committee.

The Committee bill would narrow the current exception, so that it would apply only to laboratories that are an integral part of a rural hospital and to other laboratories that referred no more than 30 percent of their tests per year to be done by other laboratories. The Committee concluded that the exception for rural hospitals is essential in order to assure appropriate access to laboratory testing in such communities. It also concluded that limiting the exception to laboratories that do at least 70 percent of the testing for which they submit claims on their own premises would assure that the laboratory is a *bona fide* facility and is not merely a shell operation created to generate a profitable practice. This provision would not affect in any way the current statutory provisions prohibiting kickbacks or payments made to induce the referral of items or services for which payment may be made under Medicare (see 42 U.S.C. 1320a–7b).

Repeal of nationwide fee schedule.—The 1984 reform included the requirement that the Secretary implement a uniform nationwide fee schedule, to replace the statewide fee schedules, within three years. That requirement has been postponed repeatedly in subsequent budget reconciliation acts. The Secretary was also instructed to submit a report to Congress on how such a nationwide fee schedule would be developed. That report has not been submitted. In the meantime, the Congress has imposed, and periodically reduced, the upper limits on fee schedule amounts discussed above, while allowing increases in the lower fees.

The Committee bill would repeal the instruction to the Secretary to implement a nationwide fee schedule. The Committee will continue to review the merits of such a fee schedule and how it might be accomplished, including a review of the Secretary's report if that is eventually submitted, with a view towards possible subsequent legislation.

Repeal of Medicare certification of "high volume" physician office laboratories.—The Omnibus Budget Reconciliation Act of 1987 included a requirement that the Secretary, by January 1, 1990, begin certifying physician office laboratories that perform more than 5,000 clinical diagnostic laboratory tests per year. Physician office laboratories (POLs) were previously exempt from both the licensure requirements of the Clinical Laboratory Improvement Act of 1967 and the certification requirements applicable to other laboratories under Medicare.

The 1987 amendment reflected Congressional recognition that POLs have been growing rapidly, in both number and sophistication, and have been furnishing an increasingly significant proportion of laboratory testing. There was increasing concern that they might not be furnishing services of acceptable quality. The 1987 amendment did not, however, specify what certification standards should apply to POLs under this required certification. It was not this Committee's understanding that all POLs would necessarily be subject to the identical standards applicable to independent laboratories and hospital laboratories.

Last year, the Committee developed a comprehensive program to improve the reliability and accuracy of clinical laboratory services. (Clinical laboratory Improvement Amendments of 1988, Public Law 100-578). That act sets forth detailed requirements for Federal certification of all laboratories, including POLs. These provisions, most of which are also effective on January 1, 1990, apply differential standards to laboratories, depending on the nature of the testing being done in the laboratory, but do not otherwise differentiate between independent laboratories and POLs. The Committee believes that these 1988 amendments establish a comprehensive regulatory program that supersedes any other standards. The 1987 reconciliation provision requiring Medicare certification of high-volume laboratories is now superfluous and is also potentially confusing, should it be interpreted as requiring POLs to comply with standards different from those in the 1988 legislation. The Committee bill, therefore, repeals the 1987 provision.

Section 4013—Reduction in capital payments for outpatient hospital services

The expenses incurred by hospitals for capital are currently reimbursed by Medicare on a cost basis, in proportion to the number of patient days or services furnished to Medicare enrollees. Costs attributable to inpatient services are reimbursed under Part A of the program, while costs attributable to outpatient hospital care are reimbursed under Part B.

Under the Omnibus Budget Reconciliation Act of 1987, Medicare payments under Part for capital-related expenses have been reduced by 12 percent in fiscal year 1988 and by 15 percent in 1989, but payments under Part B have continued to be made at 100 percent of Medicare's proportional share of capital costs. In response to the instructions of the budget resolution, the Committee bill would reduce payments for hospital outpatient capital costs by 15 percent, beginning with cost reporting periods (or portions thereof) beginning on or after October 1, 1989. An exception would be made for sole community hospitals, which would continue to be reimbursed for 100 percent of their outpatient capital costs.

Section 4014—Federally qualified health center services

Community health centers and migrant health centers receiving grants under section 329 and 330 of the Public Health Service Act are also currently able to receive Medicare payments for services furnished to Medicare enrollees. There is no explicit statutory authority for such Medicare payments, however. Payments are made under regulations and program instructions issued by the Health Care Financing Administration. There are about 550 such health centers and they provide vitally needed access for medically underserved populations.

Concerns have been expressed to the Committee regarding the precarious nature of the current authority for Medicare payments. Various specific concerns have been raised, as well. Among these concerns are: the ineligibility of community centers that are comparable to those receiving Medicare payments but are not receiving PHS grants under the two sections noted above; constraints on the range of covered benefits; inadequate reimbursement; and potential liability under the anti-kickback provisions of the Medicare statute for waiving deductibles and coinsurance for indigent patients. (Under the terms of their grants from PHS, these centers must charge patients on a sliding scale, based on the patients ability to pay.)

The Committee bill would provide statutory authority for Medicare payments to these health centers. The bill would essentially treat these centers, for coverage and reimbursement matters, in the same manner that rural health clinics are treated under the current statute. In particular, it would extend eligibility to additional centers, would expand covered services, waive the Medicare Part B deductible, and protect the centers from violations of the anti-kickback provision.

Section 4015—Physical and occupational therapy services

Outpatient physical therapy and occupational therapy services are reimbursed under Medicare in a variety of settings and by a variety of methods. Among these, they are covered when furnished by an independently practicing therapist (i.e., services that are neither part of the services of an organization or agency nor furnished under arrangements with an organization or agency) in the therapist's office or in the patient's home. In this situation, the services are reimbursed on a charge basis, but there is a statutory maximum of $500 per year on the amount Medicare will recognize. (Medicare pays 80 percent of the recognized amount.) This amount has remained unchanged for many years and there is a growing concern that it creates a barrier to appropriate care.

The Committee bill would increase the upper limit for these services to $750 per year. It would also request the Comptroller General to undertake a comprehensive study of how physical therapy and occupational therapy services are covered and reimbursed under Medicare. The Committee is interested in a better understanding of how such services are furnished in various settings and under various conditions, the effects which Medicare requirements have on the availability and quality of such services, and the appropriateness of the reimbursement rules. The study would be due January 15, 1991.

Section 4016—Study of reimbursement for ambulance services

Ambulance services are currently covered under Part B of Medicare and reimbursed on a charge basis. Reimbursement has been restrained by the Medicare economic index, as well as being subjected to the freezes imposed on Part B charges under previous budget reconciliation acts and the "inflation-indexed charge" restraint promulgated by the Health Care Financing Administration in 1986. Meanwhile, many ambulance providers have been subject to increased regulatory requirements, from state and local governments, regarding the scope and quality of the services they must provide. As a consequence, there is growing concern that the level of Medicare payments is inadequate to assure reasonable access to appropriate ambulance services.

The Committee recognized these concerns, but concluded that it did not have sufficient information and analysis to undertake a reform of Medicare payments at this time. The Committee bill, therefore, includes a study to be undertaken or arranged by the Secretary of HHS of the appropriateness of Medicare payment rates. The Committee is interested in a comprehensive review of the various types of ambulance services and the conditions under which they are furnished, as well as an analysis of the effects which the current payment rules have on the availability and quality of services. The study results, and any recommendations from the Secretary for policy changes, would be due one year after enactment.

The Committee is advised that the health Care Financing Administration has been reviewing the coverage and reimbursement of air ambulance services, with a view towards potential changes in the current policies governing these services. While the Committee

does not have a view at this time on the merits of these issues and is interested in having them included in the study, the Committee does not intend for HCFA to withhold policy changes which it might otherwise make, in order to await the outcome of this study.

Section 4017—Physician Payment Review Commission study of assistants at surgery

Medicare currently reimburses under Part B for the services of a surgeon or a physician assistant, acting as an assistant, at surgery. The former are reimbursed on a the basis of reasonable charges and the latter on the basis of special charge rules enacted in the Omnibus Budget Reconciliation Act of 1986. Other health care practitioners, including residents and registered nurses with special training for this purpose, perform these services.

The Committee is interested in a comprehensive review of the appropriateness of the use of assistants at surgery, including the appropriateness of current Medicare policies on coverage and reimbursement. The Congress had previously asked the Physician Payment Review Commission to study the issue of what surgical procedures should require prior approval of the assistant at surgery, as a condition for Medicare reimbursement. The Committee bill would expand the previous request of PPRC to include the broader study described above.

Section 4018—Study of reimbursement for blood clotting factor for hemophilia patients

Of the nation's 20,000 people with hemophilia, 6.5%—approximately 1,300—are Medicare beneficiaries and most of these are on Medicare because of disability. Most hemophiliacs are dependent on clotting factor which makes their blood clot normally and prevents bleeding. Uncontrolled bleeding into joints and muscles causes crippling. Some hemophiliacs face life-threatening hemorrhages. Advances in management or acute bleeding episodes have brought a remarkable change in the lifestyle of persons with hemophilia, significantly reducing morbidity, disability, days lost from work or school, unemployment and patient costs.

In recent years, partly in response to the spread of Acquired Immune Deficiency Syndrome, the blood products industry has developed virally-safe, highly purified clotting factor concentrates through the use of monoclonal antibodies. Many physicians treating hemophiliacs prefer these products over heat-treated products out of a belief that they have a reduced risk of transmitted viruses or contamination with extraneous blood proteins and better record of efficacy.

However, the cost of these products has in some cases has at least doubled over the past five years. According to Glen F. Pierce, et al., in a June 16, 1989, *Journal of the American Medical Association* article, average treatment costs have escalated from $10,000 to more than $60,000 per year. The reasons for the increase in price are not clear to the Committee at this time.

The Committee is concerned that Medicare reimbursement rates for clotting factor have not kept pace with these medical and technological developments and is directing the Department to conduct a study, within six months of enactment, to review the current

methodology for reimbursing for blood clotting factor under part B of Medicare and to evaluate the effect of current reimbursement rates on the accessibility and affordability of clotting factor to beneficiaries. The Committee expects the Department's report to include recommendations. The Committee recognizes that definitive human studies to demonstrate unequivocally the superiority of the newer clotting factor concentrates would be beyond the time frame of this study. The Committee expects the Department to look to the best judgment of the medical profession and the basic science literature on viral and immune aspects of blood products in making its recommendations.

Subpart 3—Changes in coverage and miscellaneous

Section 4021—Mental health services

Psychotherapy and other treatments for mental illness and disorders are covered under Part B, subject to various conditions that can be a restraint on access. Services furnished by psychologists are currently covered only in community mental health centers. In addition, the patient is responsible for 50 percent coinsurance, instead of the standard 20 percent, and the maximum amount of Medicare reimbursement is $1,100 per year.

The Committee bill would expand access to mental health benefits through several measures. It would eliminate the $1,100 annual limit, while retaining the 50 percent coinsurance. It would also cover the services of clinical psychologists and clinical social workers, to the extent such services would have been covered if furnished by a physician and if the services are ones which the psychologists or social worker is legally authorized to perform under state law.

The Committee was concerned that a patient receiving mental health services might have physiological or medical problems, or be suffering from drug reactions or interactions, that are contributing to or causing his or her mental illness or disorder. This concern is particularly warranted in the case of elderly patients, who often have multiple health problems and frequently are taking one or more prescription drugs. To make sure that such problems are detected, the bill would also require the psychologist or social worker furnishing mental health services to take appropriate measures to inform the patient about the desirability of seeing his primary care physician and to notify that physician of the care being furnished to the patient.

Section 4022—Nurse practitioner services

In the Omnibus Budget Reconciliation Act of 1986, the Congress authorized coverage and reimbursement for the services of physician assistants. Previously, such services had only been covered when furnished "incident to" a physician service. The 1986 provision, which was initiated by this Committee, covered the services of a physician assistant when furnished in a hospital or nursing home or as an assistant at surgery. An amendment in 1987 added services furnished in a physician's office located in a rural health manpower shortage area. The 1986 provision also included a special payment formula and several other conditions on coverage and

payment. The principal objective of this provision was to increase the delivery of appropriate services to residents of nursing homes. A Medicare demonstration program was indicating that furnishing physician assistant services on a regular basis to nursing home residents improved the quality of care and greatly reduced the need for hospital services.

Nurse practitioners perform many of the same services as physician assistants and do so in a generally comparable manner. They were also part of the Medicare nursing home demonstration project noted above. The Committee bill would add nurse practitioners to the provision authorizing payments for physician assistants. It would generally apply the existing conditions and requirements to nurse practitioners, except that nurse practitioners would be required to work "in collaboration" with a physician (as defined in the statute), rather that acting "under the supervision" of a physician.

The Committee bill also contains another provisions designed to assure proper utilization of these services by nursing home residents. It would require the Secretary to instruct the Medicare carriers to develop utilization review mechanisms which permit payments, on a routine basis, for up to one-and-a-half visits per month per resident by a members of a team consisting of a physician and a physician assistant or nurse practitioner. It is the Committee's understanding that, to be practical at this time, this review would have to be carried out on a patient-by-patient basis, although it would clearly have to be done by averaging the number of visits for a particular patient over several months. Moreover, the review is not intended to preclude medically necessary visits to a patient, but rather to act as a screen to monitor routine visits. The bill also contains a provision requiring the Secretary to conduct at least one demonstration project to determine whether this screening provision can be implemented by averaging the number of visits for a given month over all of the patients being furnished services by the team.

Section 4023—Coverage of screening pap smears

Medicare generally does not cover screening or preventive services. Exceptions to this include flu vaccinations, pneumococcal vaccinations, hepatitis B vaccinations, and mammography screenings. According to the recently published report of the U.S. Preventive Services Task Force (Guide to Clinical Preventive Services, 1989) pap smears, used to detect cervical cancer, are another important screening service.

The Committee bill would authorize payments for pap smears, including a physician's interpretation of the results, in accordance with frequency guidelines recommended by the Task Force. As a general rule, the exam would be reimbursed once every three years, but could be furnished more frequently in accordance with factors identified by the Secretary which indicate the patient is at high risk. The Committee expects the Secretary to consult the Task Force report when implementing this provision.

Section 4024—Rural health clinic services

Rural health clinics are reimbursed under Medicare in accordance with extensive conditions and requirements. When these provisions were enacted in 1977, the Congress anticipated there would be a large number of clinics established, but this has not proven to be the case. The Committee report includes several provisions designed to promote the development of rural health clinics and improve access to their services.

First, it would change the current regulatory requirement that clinics have a physician assistant or nurse practitioner available to furnish services at least 60 percent of the time. It would change the rule to 50 percent and would allow the clinic to count the time of a nurse mid-wife.

Second, the bill would include coverage of clinical social workers among those who can furnish services at a rural health clinic.

Third, the bill would expand the number of areas which are eligible to have a qualified rural health clinic. Under current law, the area must be rural and must have been designated by the Secretary of HHS either under section 1302(7) of the Public Health Service Act as having a shortage of personal health services or under section 332(a)(1)(A) of that Act as being a health manpower shortage area. The Committee bill would allow governors, with the approval of the Secretary, to designate additional rural areas as having a shortage of personal health services for purposes of being qualifying under this provision. It would also cite additional sections of the Public Health Service Act which, if a rural area has been designated by the Secretary for purposes of that Act, would serve to qualify the area under this provision.

Fourth, the bill requires the Secretary, in consultation with the Office of Rural Health Policy, to disseminate information on how to qualify to become a rural health clinic to appropriate agencies within 60 days of the enactment of this provision.

Fifth, the bill permits the Avalon Municipal Hospital on Santa Catalina Island to qualify as a rural health clinic. Avalon is the sole hospital and outpatient provider for the island's residents and tourists. Under the Rural Health Clinic Act, a rural health clinic must utilize the services of a physician assistant or nurse practitioner. The population served by the hospital's outpatient clinic is so small that the hospital can not employ both a physician and a nurse practitioner or physician assistant. The Committee bill would waive the requirement for a nurse practitioner or physician assistant so that the hospital could be certified as a rural health clinic. The hospital would have to meet all other requirements of the Act.

Section 4025—Limitations on charges for Medicare beneficiaries eligible for Medicaid benefits

Approximately ten percent of Medicare beneficiaries are also eligible for full Medicaid benefits under the eligibility criteria established in each state. These are commonly referred to as "dual eligibles". In addition, a significant number of Medicare beneficiaries is entitled to have Medicaid pay their Medicare premiums and cost-sharing, because they meet income and resource standards estab-

lished by the Medicare Catastrophic Coverage Act of 1988. These are referred to in the statute as "qualified Medicare beneficiaries".

Although the current statute does not explicitly require that physicians accept assignment for services furnished to dual eligibles, the requirements of the Medicaid program have had that result as a practical matter. Since physicians are precluded from billing patients under Medicaid, they must accept assignment in order to obtain any reimbursement from Medicaid. The Medicaid fiscal agents typically have arrangements with the Medicaid program so that the physician can submit a single claim to the Medicare program; the Medicare carrier, after processing the claim, will transmit it to the Medicaid administrator for further processing. The Medicaid programs typically pay the Medicare coinsurance only to the extent that their payment, plus the Medicare payment, does not exceed what the Medicaid program would pay for the service in question.

The current statute does not require that physicians take assignment for qualified Medicare beneficiaries. However, because these beneficiaries are not actually determined to be eligible for Medicaid under the state's eligibility criteria, they are not dual eligibles. Consequently, the Medicaid rules that result in assignment being accepted for all dual eligibles are not applicable to qualified Medicare beneficiaries. Thus, physicians are able to bill these patients directly and to charge amounts in excess of what Medicare determines to be reasonable and what Medicaid will reimburse. This appears to create an anomaly and defeats the Congressional purpose of protecting qualified Medicare benficiaries from high out-of-pocket expenses for health care.

The Committee bill would amend current law to require that physicians take assignment under Medicare for all services furnished to dual eligibles and qualified Medicare beneficiaries (if such services are also covered under the Medicaid program in the state). Thus, it codifies the current practice with respect to dual eligibles and extends it to qualified Medicare beneficiaries. It does not change the current policy regarding the amount which a Medicaid program must reimburse on such claims. It would also apply existing sanctions against a physician who knowingly and willfully bills a patient directly in violation of this new rule.

Section 4026—Study by Physician Payment Review Commission

The Physician Payment Review Commission (PPRC) was created by the Consolidated Omnibus Budget Reconciliation Act of 1985, based on provisions which originated in this Committee. Its purpose is to review and evaluate the methodology for reimbursing physician services under Medicare and related issues, and to make recommendations to the Congress on policy changes. The Congress has enlarged the responsibilities of the PPRC since its original enactment, both through formal amendments to the statute and through informal requests. The PPRC has issued three annual reports, the most recent of which presents thoughtful recommendations for comprehensive reform of the Medicare payment system. These recommendations form the basis for the Committee's payment reform proposal set forth in section 4001. The PPRC will continue to evaluate and monitor this reform and make recommenda-

tions to the Congress on further revisions. Section 4001 of the Committee bill extends the PPRC's continuing responsibilities in this regard.

The Committee is also interested in having the PPRC do a similar analysis of payments for physician services under Medicaid. Consequently, the bill would charge the PPRC with reviewing the adequacy and appropriateness of payments for physician services under state Medicaid plans.

The Committee is particularly concerned that low Medicaid payment levels may be discouraging physicians from participating in Medicaid, although the Committee recognizes that payment levels are only one determinant of physician participation. A state-by-state comparison of Medicaid and Medicare payments for 1986 shows that, on average, Medicaid payments were 67 percent of the Medicare allowable charge for a brief follow-up office visit and 61 percent of the Medicare allowable charge for an appendectomy. In some states, the Medicaid rates were less than 40 percent of the Medicare rates. (see *Medicaid Source Book* (1988), Appendix G.) The Committee anticipates that the PPRC will develop recommendations to the Congress with respect to changes in Medicaid payment policy that would improve beneficiary access to physician services of high quality, taking into account the circumstances unique to each of the three major beneficiary populations serviced by Medicaid (mothers and children, the elderly, and the disabled).

PART B—PROVISIONS RELATING TO PARTS A AND B OF MEDICARE

Section 4041—Health maintenance organizations and competitive medical plans

Temporary waiver for Watts Health Foundation.—Section 9312(c) of the Omnibus Budget Reconciliation Act of 1986 provided for a temporary waiver of the "50/50 rule" in section 1876 of the Social Security Act (which requires that no more than 50% of an MHOS enrollees be Medicare and Medicaid beneficiaries) for the federally qualified HMO operated by the Watts Health Foundation. The Committee bill would extend the waiver for four additional years, to January 1, 1994, with the requirement for an annual review by the Secretary of the plan's compliance with the quality assurance requirements of section 1876. Because the Foundation's HMO will not be in compliance with the rule by January 1, 1990, an extension is essential if the HMO is to continue its section 1876 contract with Medicare.

The "50/50 rule" requires an HMO to attract at least one-half of its enrollees through contracts with employers in the service area or through other means of enrolling individuals who are not eligible for either Medicare or Medicaid. The purpose of the rule is to assure Medicare and Medicaid beneficiaries that their HMO will provide quality care and serve the entire community well. The Committee believes the Watts Health Foundation has a long history of such service to the Watts community and surrounding areas. As an additional assurance of continued high quality of care during the waiver, the Secretary would conduct an annual review of the plan's compliance with the quality assurance requirements of sec-

tion 1876. In the absence of this provision, such a review would normally be conducted every two years.

Limit on charges for emergency services and out-of-area coverage.—Section 1842(h) of the Social Security Act provides for limits on the charges that physicians can bill for services furnished to Medicare beneficiaries. Physicians who have signed a participation agreement must accept the Medicare reasonable charge as payment in full and physicians who have not signed such an agreement cannot bill the patient more than the "maximum allowable actual charge" ("MAAC"), as determined under the statute.

In the circumstance where a physician is providing care to a Medicare beneficiary enrolled with an HMO or CMP and has no contract with the plan, these Medicare limits do not currently apply. The physician, whether he has signed a participation agreement or not, can charge any amount to the plan, since the plan has no protection against ureasonable charges.

HMOs and CMPs are required to provide all medically necessary services, including emergency and out-of-area services. While these plans have contracts with physicians to provide care to their enrollees, emergency care and medically necessary physician care provided outside the plan's service area (when a Medicare enrollee is traveling, for example) are often provided by physicians who do not have contracts with the plans. The Committee's amendment would prohibit non-contract physicians from billing more than they could bill a Medicare aptient under the limits established in accordance with section 1842. Participating physicians would have to accept the amount of the Medicare reasonable charge as payment in full from the HMO. Non-participating physicians could not charge the HMO more than their individual MAAC amounts prescribed under section 1842.

Disclosure of AAPCC assumptions.—The Committee bill would require the Secretary to give HMOs advance notice of any changes in the methodology and assumptions used in the calculation of the payment rates for HMOs and CMPs under section 1876. Notice would be required 45 days prior to the announcement of payment rates for the following year.

Changes in methodology and assumptions can have a major impact on payment rates. The Committee believes plans should have an opportunity to comment to the Secretary before any such changes take effect.

Incentive payment plans.—The Omnibus Budget Reconciliation Act of 1986 included a provision which was designed to prohibit financial incentives between physicians and HMOs that might have an adverse impact on the quality of care being furnished. This provision was to take effect on April 1, 1990. The Committee bill would repeal the provision.

Since this provision was enacted, there have been several studies on the subject. None has produced any evidence that HMO physician incentive plans have resulted in Medicare beneficiaries being denied medically necessary services. In the absence of such evidence, the Committee believes there is no basis for deciding which particular incentive arrangements should be prohibited. Under these circumstances, it would be unwise to legislate any prohibitions.

Increase to 100 percent of AAPCC.—Under current law, payment rates for HMOs and CMPs are equal to 95 percent of the AAPCC. The Committee's bill would increase the rate to 100 percent.

In the last two years, over 60 HMOs have dropped out of the Medicare section 1876 risk contract program, leaving approximately 130 risk contracts with HMOs. Many have cited inadequate payment rates as the reason for terminating their contracts. Because it is advantageous to Medicare beneficiaries to have the choice of getting health care through the fee for service system or through HMOs, the Committee believes steps should be taken to encourage HMOs to continue in the risk program. The Committee would also expect the Secretary to pay HMOs participating in demonstration projects at 100 percent of the AAPCC (unless the percentage amount was itself an issue being evaluated under the demonstration).

Section 4042—Peer review organizations

Practitioner right to reconsideration of PRO determination prior to notice to beneficiary.—Under section 1154(a) of the Social Security Act, peer review organizations ("PROs") are required to review services to determine whether they are medically necessary, whether their quality meets professionally recognized standards of care, and whether they were furnished in the appropriate setting. The section authorizes the PROs to conclude that Medicare payments should be denied for services that do not satisfy these requirements. It also requires the PRO to notify both the provider of the service and the patient when it has made such a determination. Both the provider and the patient then have a right to have the PRO reconsider its determination that payment should be denied.

When these notice and reconsideration provisions were enacted, the PROs did not have authority to deny payments for failure to meet professionally acceptable standards of quality. The provisions appeared to work reasonably well for denials based on the other two requirements. The authority of PROs to deny payment for substandard care was added by the Consolidated Omnibus Budget Reconciliation Act of 1985, but no change was made in the statutory requirements for notice and reconsideraiton.

The Secretary issued a notice of proposed rulemaking, implementing the COBRA amendment, in January of this year. That proposed regulation retained the patient notice requirement as it had previously been implemented. Secretary concluded that the statute gave him no discretion regarding when the notice of the denial was sent to the patient. Both the PROs and the physician community, as well as some beneficiary groups, have expressed concern, however, about this arrangement. Many view it as likely to encourage unwarranted malpractice claims. Some also point out that it can be very confusing to patients if the PRO reverses its determination after the provider has received a reconsideration and the PRO then has to send a second notice to the patient and the PRO reversed its determination, there would be no notice to the patient reversing its earlier notice. This is not an infrequent occurrence.

The Committee bill would address these concerns by amending section 1154 to require that, in the case of denials for substandard

care, the provider or practitioner would receive its notice and have its right to reconsideration made available before the notice to the beneficiary. If the provider chose to have its reconsideration prior to the notice to the patient and the PRO reversed its determination, there would be no notice to the patient. If the provider chose to have its reconsideration prior to notice to the patient. If the provider chose to have its reconsideration prior to notice to the patient and the PRO reversed its determination, there would be no notice to the patient, and the PRO did not reverse its determination, the provider would not be entitled to another reconsideration after the notice to the patient. The patient would retain the current right to a reconsideration following the notice.

The Committee bill would also revise the language of the notice to the patient, in an attempt to make it clear that the denial was based on the PRO's judgement and did not necessarily represent conclusive evidence of malpractice. The notice would also state that the matter had been discussed with the patient's physician and provider, as an indication that the patient might want to pursue further discussions with either or both of them. The Committee intends, however, that the PRO will be responsive to the patient should the patient inquire further of the PRO on the issues involved in the notice.

Clarification of willing and able test for physician sanctions.—Under current law, PROs are authorized to recommend to the Secretary that a physician be fined or excluded from the Medicare program for failure to provide care of acceptable quality, either in a substantial number of cases or in a gross and flagrant manner. The PROs recommendations are reviewed by the HHS Inspector General, under authority delegated to him by the Secretary. If the sanction is approved by the Inspector General, the physician has the right to a formal hearing by an administrative law judge.

In addition to being found to have violated his obligation to provide quality care, the physician must be found to be unwilling to comply, or to lack the ability substantially to comply, with this obligation. This "willing and able" test is applied throughout the sanction process—by the PRO, the Inspector General and the administrative law judges. Several cases have arisen in which this test has been used by the physician unreasonably to undermine the sanction process. In these cases, the physician has demonstrated that he is not willing to cooperate with the PRO in pursuing a course of remedial education or corrective action and has also refused to cooperate with the Inspector General. However, when it became clear that the evidence before the administrative law judge of his violation was too strong to rebut, he has declared to the judge his willingness and ability to take corrective action. In this circumstance, some judges have dismissed the charges against the physician, despite having concluded that the physician had acted in gross and flagrant violation of his obligation, because they thought they had no discretion to impose a sanction on a physician who had now declared his willingness, albeit belatedly, to comply.

The PROs have expressed concern that results such as these clearly undermine the integrity of the sanction process and discourage PROs from initiating sanction cases, even when clearly warranted. Several years and considerable resources can be con-

sumed in the process that turns out to be quite futile. The Administrative Conference of the United States recently reviewed this matter thoroughly and adopted a recommendation that the Congress delete or modify the willing and able test.

The Committee bill would respond to these concerns and recommendations by clarifying the willing and able test. First, it would incorporate into the statute the current practice followed by nearly all PROs of trying to achieve voluntary compliance with a plan of remedial action prior to pursuing a recommendation for sanction. Second, it would make it clear that the administrative law judge, in making the final determination whether the physician is willing and able to comply with his obligations, should consider the physicians prior actions in cooperating with or defying the PRO. The judge would be expected to review whether the remedial plan recommended by the PRO was appropriate and, if so, whether the physician acted responsibly in light of the weight of evidence against him. The judge could also consider other corrective action the physician took on his own initiative, in lieu of following the PRO recommendation.

Increase in population threshold for pre-exclusion hearing.—The Omnibus Budget Reconciliation Act of 1987 amended the administrative process followed when a PRO recommends that a physician be excluded from the Medicare program for failure to fulfill his obligation under the Medicare statute to furnish care of acceptable quality. An exclusion would normally become effective upon the Inspector General's concurrence with the PRO recommendation and would remain in effect during the conclusion of the administrative appeal. The 1987 amendment provides that physicians furnishing services in a rural health manpower shortage area or in a county of less than 70,000 population may receive a prompt, preliminary hearing before an administrative law judge to determine whether their continuation in the program poses an unacceptable risk to patients. The purpose of the amendment was to avoid creating a problem of access to services in underserved areas.

Experience to date has not demonstrated any serious problems with this provision. The bill would increase the population threshold for areas to which this provision is applicable. The threshold would increase form 70,000 to 140,000.

Increase in civil monetary penalties.—A physician who fails to meet his obligation under the Medicare statute to provide care of acceptable quality may be excluded from the program. As an alternative sanction, he may be fined in an administrative proceeding. Under current law, the fine may not exceed the actual or estimated cost of the medically improper or unnecessary services that were furnished. In some cases, this may be a small amount, even though the actions of the physician were serious enough to warrant a sanction proceeding. The small amount of such fines as a disincentive to PROs to recommend such sanctions. Therefore, the Committee bill would increase the fine to $2500.

Section 4043—Payments for end stage renal disease services

Under current law, Medicare reimburses for dialysis treatments furnished patients with end stage renal disease under either of two methods. One method is an all inclusive rate per treatment, known

as the "composite rate" because it is based on a blend of the costs entailed in furnishing dialysis services in a treatment facility and the costs of furnishing them in the patient's home. The same rate is paid irrespective of the site of service.

The other method of payment, commonly referred to as "method II", is the standard reasonable charge method used for Medicare Part B services. Method II is offered as an alternative to the composite rate in order to allow the patient to make his or her own arrangements for supplies and equipment. By doing so, the patient is often able to save on coinsurance expenses.

Composite rate.— The current composite rate has been in effect since October 1, 1986, when it was established under the terms of the Omnibus Budget Reconciliation Act of 1986. The Congress established the rate at that time in order to preclude HCFA from implementing a proposed substantial reduction. Under the terms of OBRA '86, the rate was to remain in effect until October 1, 1988, at which time HCFA ould revise it. It was the Committee's understanding of the provision that HCFA would be required to obtain more current cost data and to satisfy the procedure for notice and public comment prior to making a change. In presenting its fiscal year 1990 budget proposals, the Administration, argued to the contrary, that it had authority to reinstate the 1986 proposed reductions. HCFA has also indicated that it has obtained more recent cost data that support a reduction in the current rate.

The Committee does not have a basis at this time for determining what the composite rate should be. It notes that the Institute of Medicine, at the request of the Congress, is conducting a comprehensive review of the ESRD program that should be of assistance in resolving this issue. The study is due for completion next year.

Under these circumstances, the Committee is concerned about HCFA's apparent intention to proceed with a reduction in the rate. Therefore, the Committee bill would require that the current rate be maintained until October 1, 1989. At that time, HCFA would be authorized to change the rate. However, the bill would also require that the notice and comment requirements of the Medicare statute be followed before any change becomes effective. The Committee also expects HCFA to base any proposed change on cost data that is less than two years old at the time of the proposed change.

Method II.—The Committee bill would also make a change in method II. As noted above, the purpose of this method is to allow patients to make their own arrangements, as a matter of convenience for themselves or to save out-of-pocket expenses. The Committee has learned, however, that firms are taking advantage of method II to furnish dialysis equipment and supplies to patients and to submit claims on a reasonable charge basis that exceed what payments would be under the composite rate. The Committee bill would not repeal method II nor prohibit suppliers from arranging services on behalf of patients. however, it would preclude payments under method II from exceeding the composite rate.

Section 4044—Payments for direct medical education

Under current law, hospitals receive payments under Medicare for a portion of their direct medical education costs under a formula that takes into account the number of full-time-equivalent (FTE)

medical residents in the hospital's approved training programs. Residents who are in their initial residency period are counted as 1.0 FTEs, and those who are in more advanced training are counted as 0.5 FTEs.

The current direct medical education system pays the same, hospital-specific average amount per resident, regardless of the specialty for which a resident is training. This fails to promote the Congression policy of fostering primary care training and greater access to primary care services. Moreover, primary care training programs are at a disadvantage, compared to other specialties, in trying to obtain other resources to support residency programs.

The physician payment reform set forth in section 4001 is expected to reduce the current imbalance in the financial incentives that favor specialty physician services over primary care physician services. The Committee hopes that this will also have a beneficial influence on the similar imbalance between specialty training programs and primary care residency programs. This provision reflects the Committee's resolve to take further, direct measures to adjust graduate medical education payments in order to promote the Congressional policy that favors primary care residency programs.

Under this provision, primary care residents would be counted at 1.25 FTEs, thus increasing payments to programs in proportion to their relative number of primary care residents. This weighting is based on the overwhelming proportion of graduates of such programs who actually practice as primary care physicians. Other residents in primary care specialties would be counted as 1.10 FTEs. This reflects the fact that such physicians, although generally going on to establish specialty practices, actually deliver a substantial amount of primary care as well. All other residents would continue to be counted in the same manner as under current law.

The primary care residents to be counted as 1.25 FTEs are those in general training programs. This would include all residents in approved Family Medicine programs, as well as residents in general internal medicine and general pediatrics. The Committee notes that there is no formal approval mechanism for general internal medicine or general pediatrics training programs at this time, and has determined that the Secretary should identify such programs using the following criteria: (1) any program component or track that has ever had an application approved for a grant under Section 784 of the Public Health Service Act, whether funded or not; (2) any program identified by the Society for General Internal Medicine or the Ambulatory Pediatric Association as a general program; or, (3) any other program that meets criteria established by the Secretary, including: at least 20 percent of training experience devoted to providing continuing care to a defined panel of patients, not to include subspecialty clinics or emergency room rotations; well-defined biopsychosocial or behavioral curriculum taught in primary care settings; emphasis on teaching in primary care settings, particularly community-based ones; and, a defined curriculum in health promotion, disease prevention, and social aspects of medicine. When a general program is a component or a track of a larger traditional program, only those residents actually in the

general track will count as 1.25 FTEs, and the others are to count as 1.10 FTEs.

To keep this provision budget-neutral, a limitation is established on the amount that can be approved per resident in any program. Programs with hospital-specific average per-resident expenses above that level will be paid at the ceiling rather than the amount that would otherwise be calculated under current law. The limits are adjusted for the proportion of primary care residents, so as not to undermine the main objective of this provision. Thus, equally expensive programs are treated differently depending on their proportion of primary care trainees.

Section 4045—Distribution of information on recommended preventive health practices

According to the U.S. Preventive Services Task Force, the most promising role for prevention in current medical practice may lie in changing the personal health behavior of patients before clinical disease develops. (See "Guide to Clinical Preventive Service," 1989.) There is a growing body of evidence linking personal behavior to the leading causes of death in this country. Unfortunately, many elderly Americans lack information on how personal behavior might affect their health. Busy clinicians often lack the time to discuss or provide preventive care services to their patients. Many other elderly persons lack information becuase they do not regularly visit a physician until after they are enrolled in Medicare.

The Committee bill seeks to promote greater awareness and compliance with preventive health measures among Medicare enrollees. This provision requires the Secretary of Health and Human Services to develop and distribute two documents. One is a personal medical history form, which will be given to all new Medicare beneficiaries when they enroll in the program. The second is a summary of preventive health care information. The summary will be made available to all new Medicare beneficiaries, and will be included in future mailings made to all Medicare beneficiaries. The medical history form would be one full-sized page. The Committee expects the summary to be brief, so that it is convenient for mailing and use by enrollees, but should be sufficiently long to adequately convey the full range of useful information. Both documents are to be developed by the Secretary in consultation with national physician organizations (such as the American Association of Family Practitioners), consumer groups, and other health-related organizations.

The medical history form should provide space for the individual to enter information on personal and family medical history, weight and blood pressure, and other relevant basic medical information. The Committee believes that, for the medical history form to be useful, it should also do the following:

1. Inform individuals of the importance of preventive care in reducing the incidence of clinical problems and the importance of their providing their physician with adequate background information for prescribing appropriate preventive treatments.

2. Encourage individuals to fill out the form, using community health facilities, when available, to get information such as blood pressure reading or visual or hearing tests.

3. Encourage individuals to share the information on the form with their physician on their next regular visit, to discuss appropriate preventive health care measures.

4. Encourage the physician to carefully review the information provided by the patient, discuss its implications with the patient, and make the form part of the patient's permanent file.

The summary of preventive health care information would provide basic information on preventive care practices, screening, tests, and immunizations recommended for elderly individuals. In developing the form, the Secretary should incorporate recommendations, as they pertain to persons over age 65, of an appropriate task force or similar group established by the Secretary, such as the U.S. Preventive Task Force.

The summary should indicate, where appropriate, which recommended procedures are not reimbursable under Medicare, so there will be no confusion on the part of the Medicare enrollees, who might otherwise infer that recommended procedures would be paid under the program.

The summary and form are to be developed by April 1, 1990, and distribution is to begin no later than October 1, 1990.

PART C—OTHER PROVISIONS RELATING TO MEDICARE AND HEALTH-RELATED PROGRAMS

Section 4061—Administrative law judges for health related cases

A variety of administrative appeal procedures utilizing administrative law judges are contained in the Medicare program, the Medicaid program, the Peer Review Program and the fraud and abuse provisions contained in title XI of the Social Security Act. Currently, most of these appeals are heard by administrative law judges from the Office of Hearings and Appeals in the Social Security Administration, although some of the sanction cases initiated by the Inspector General are now heard by judges who are part of the Department Appeals Board.

The Committee, on two prior occasions—in its reports for the budget reconciliation provisions for 1985 and 1986—has urged the Secretary to appoint administrative law judges who would focus exclusively on health related cases. The subject matter of these cases is sufficiently different from the nature of other cases heard under the Social Security and disability programs, and the case load for health-related cases is sufficiently great, to warrant this specialization. The Secretary has not yet done so, in part because of disagreements on where such judges should be located within the organizational structure of the Department.

The Committee has concluded that this action will not take place unless the Secretary is directed to do so legislatively. The Committee believes that health related cases will be resolved more satisfactorily if they are handled exclusively by a single set of judges and, therefore, places this requirement in the statute.

The Committee does not instruct the Secretary as to where in the organizational structure of the Department such judges should be located. It is explicitly not requiring that they be placed under the supervision and control of the Administrator of HCFA. The Departmental Appeals Board would appear to be an appropriate loca-

tion for these judges and the Committee urges the Secretary to give serious consideration to that option. The Board is an independent office within the Department, established to review disputes between departmental agencies and their grantees, to adjudicate civil remedies cases, and to perform other review and mediation services assigned by the Secretary. It has developed a reputation for objectivity and competence.

The Committee assumes that appropriate funds would be transferred from the Social Security Administration to whatever other unit of the Department takes over this responsibility.

Section 4062—Amendments Relating to the United States Bipartisan Commission on Comprehensive Health Care

This section of the Committee's bill makes a number of small changes in the structure and operation of the U.S. Bipartisan Commission on Comprehensive Health Care. The purpose of the Commission, as established in the 1988 Medicare Catastrophic Coverage Act (Public Law 100-360), is to study and make recommendations to the Congress on both long-term care services for the elderly and comprehensive health care for all Americans.

Under this section, five modifications are made to the law which created the Commission. These include increasing the number of vice-chairman of the Commission to four; providing franking privileges to the Commission; establishing printing procedures for the Commission's mandated reports; and changing the date by which the Commission's reports must be concurrently submitted to the Congress to November 9, 1989. The final modification provides that the Bipartisan Commission is also be known as the "Claude Pepper Commission" or the "Pepper Commission", in tribute to the late Congressman Claude Pepper, the Commission's first chairman.

The Committee notes that all of the statutory changes included within this section of the bill were discussed and unanimously agreed to by the members of the Commission during its meetings held earlier this year. Thus, the purpose of this section is to implement these decisions and recommendations of the full Commission membership.

Section 4063—Office of Rural Health Policy

Under current law, there is a statutorily created Office of Rural Health Policy. It is located in the Health Resource and Services Administration in the Public Health Service. It is responsible for making sure health issues of particular concern to rural areas are given appropriate attention within the Department and that the interests of rural areas are adequately represented in the discussion and resolution of health issues.

The Committee bill would upgrade the Office by placing it in the office of the Under Secretary and making the head of the Office a Deputy Under Secretary. This is intended to give the Office more influence on a broader range of issues. The bill would also expand the responsibilities of the Office by explicitly listing a broad range of subject areas within its purview.

Section 4064—Expressing the sense of the Congress respecting making receipt of Medicare benefits added, and premiums imposed, by the Medicare Catastrophic Coverage Act of 1988 voluntary

Members of the Committee have received a substantial volume of complaints about certain aspects of the Medicare Catastrophic Coverage Act enacted last year, which added new benefits and premiums to the Medicare program and made improvements in the Medicaid program. The Committee members discussed the concerns being expressed, as well as ways in which the Committee might be responsive to them.

A large percentage of these complaints concern the supplemental premium, which is imposed on all persons who are eligible for coverage under Part A (and have sufficient income to become liable for such premium) irrespective of whether they have alternative health insurance coverage or whether they desire coverage of the new benefits. It is not within the jurisdiction of the Committee to make changes in the supplemental premium rates established in the current statute, so the Committee was not well situated to make comprehensive revisions in the Act. Rather than passing inadequate and unsatisfactory measures, the Committee adopted a resolution that it is the sense of the Congress that legislation should be passed this session which would make the new CATASTROPHIC benefits optional and would impose the supplemental premium only on those who chose such coverage.

Section 4065—Expressing the sense of the House of Representatives respecting review of, and hearings on, the Medicare Catastrophic Coverage Act of 1988

As noted in the discussion regarding section 4064 above, there is strong interest in the Committee in trying to be responsive to the concerns and criticisms being expressed about the Medicare Catastrophic Coverage Act of 1988. Prior to acting on the resolution set forth in section 4064, the Committee adopted a resolution setting forth the sense of the House that the two committees having jurisdiction with respect to the Act—this Committee and the Committee on Ways and Means—should hold hearings and review the Act.

Subtitle B—Health Care Research and Policy

PART A—AGENCY FOR HEALTH CARE RESEARCH AND POLICY

Section 4101—Establishment of agency

This section amends the Public Health Service Act by creating a new Title IX to establish within the Public Health Service a new agency, the Agency for Health Care Research and Policy.

Under current law, a broad range of responsibilities for health services research, evaluation, and demonstration projects is assigned to the National Center for Health Services Research and Health Care Technology Assessment (NCHSR), located within the Office of the Assistant Secretary for Health. Most of this work is supported by appropriations from general revenues for conducting health services research. In addition, Section 1875 of the Social Security Act provides for the transfer of funds from the Medicare

Part A and Part B trust funds to NCHSR to conduct research on the outcomes of medical care. The Committee believes that carrying out these broad mandates requires a far greater federal effort than has been conducted to date by NCHSR. Full agency status should help assure the stature and resources needed for the task.

The purpose of the new Agency for Health Care Research and Policy is to enhance the quality, appropriateness, and effectiveness of health care services, and to improve access to such services. The Agency is to do this through the establishment of a broad base of scientific research and through the promotion of improvements in clinical practice and in the organization, financing, and delivery of health care services. The agency will conduct and support research, demonstration projects, evaluations, training, and the dissemination of information to carry out its purpose.

Research on the outcomes of health care services and procedures is an important part of the Agency's mandate. Such research, however, must be carried out in accordance with provisions of the Social Security Act that are described below.

Under current law, a specific percentage of funds are set aside for intramural research by the National Center for Health Services Research. The Committee has decided not to constrain the authority of the Administrator with specific set-asides at this time. Nevertheless, the Committee expects the Agency to continue a vigorous intramural research program, just as the National Institutes of Health does.

The Committee has identified certain high-priority areas for the Agency. These include medical liability and clinical practice, specifically primary care and practice-based research.

The small amount of good research, evaluations and demonstration projects on medical liability that exist show that this area has received far too little attention. Our medical liability system is intended to be a last-ditch quality control measure that constrains negligent behavior by physicians. All too often, however, it affects the character of the physician-patient relationship by introducing a litigious atmosphere. The medical liability situation is also cited as a factor in stimulating defensive medicine and increasing health care costs. In addition, the Subcommittee on Health and the Environment has heard repeated testimony that medical liability problems have seriously compromised the willingness of obstetricians and family physicians to provide pregnancy care, particularly in rural areas. Medical liability difficulties have even shut down obstetrical care at Community Health Centers.

The Committee believes that medical liability is a ripe area for innovative research, evaluations and demonstration projects. This topic is of far greater importance that the current level of effort would suggest. The Committee expects such work to be a significant component of the Agency's activities.

Research on primary care, particularly research based in clinical practice, is another area of health care that has not received adequate attention. Fostering practice-based research requires a series of activities. Individuals already engaged in, or just entering, active clinical work must be adequately trained in research methodologies. Collaborative networks must be established to have a representative base for research. Research agendas should be developed.

All of these activities are necessary for the Agency to have an appropriate program in primary care and office-based research.

The Committee also expects the Agency's activities to include research on methods of improving communications between physicians and patients and of encouraging patient compliance with treatment and prevention regimens.

The Agency's program of conducting and supporting research is to be complemented by a substantial program of dissemination and related activities. Health care research and policy must reach a wider audience and do so on a more timely basis than permitted just by publication in scientific journals. Of equal importance, the Agency must make data tapes developed by the intramural program available as promptly as possible for analysis by researchers in the field. Such tapes are important public resources that should not be restricted to the intramural program or retained until they are outdated.

The bill makes certain changes with respect to technology assessment. Under Section 309 of the Public Health Service Act, the Secretary has made grants to the National Academy of Sciences to establish a council on health care technology. While recognizing the difficulties involved in setting up such a new entity, the Committee believes that the approach under current law has not brought about the kind or level of activity that it had anticipated, particularly with respect to the review of existing health care technologies, and the collection and analysis of data concerning specific health care technologies. The Committee has decided to phase out the Council over the next year and the place responsibility for this set of activities within the new Agency. The Agency, as under current law, also will make recommendations to HCFA on reimbursement of specific technologies.

Training opportunities in health care research and policy are essential for the field to expand to the level warranted by the importance of such work. Accordingly, the Agency is given specific authority to conduct training activities. In addition, the existing authority of NCHSR to administer one-half of one percent of National Research Service Awards is transferred to the new Agency. Individual and institutional awards will allow training of physicians, dentists, social scientists, and other professionals in health care research and policy.

The Committee notes that dramatic changes have occurred in the organization, financing, and delivery of dental care. So, too, have changes taken place in population demographics and dental disease rates. Understanding these changes and their effect on health care is vital to maintaining high quality care while improving the cost-effectiveness and accessibility of our nation's oral health care delivery system. Because of the importance of dental health care research and policy, the Committee expects that the training program of the Agency, including individual and institutional NRSA awards, will include an appropriate representation of dental researchers.

This section also establishes a Forum for Quality and Effectiveness in Health Care. The purpose of the Forum is to convene nongovernmental panels of experts, physicians, and consumers, and to contract with private nonprofit organizations, to develop and

update clinically relevant practice guidelines and standards of quality, performance measures, and medical review criteria. After consultation with appropriate experts, the Forum will establish priorities and strategies for the development of the guidelines, standards, measures and criteria. It will also establish criteria and standards to be used by panels and contractors in such development.

The Forum structure is designed to accommodate and balance the growing interest of a broad range of parties and organizations in the development of guidelines, which interests sometimes have disparate perspectives. There is a broad consensus that the Federal government should not develop these guidelines. The Forum satisfies this concern, since no one in the Forum or the Department of HHS would have any authority to review, modify, approve or disapprove the guidelines developed by panels or contractors. On the other hand, the Committee believes it is essential that there be a focal point for this activity and that a Federal official be held accountable to make sure the activity is carried out properly.

The Forum can either convene panels or contract with appropriate groups that satisfy criteria established for this purpose. The Committee expects there to be a balance of both types of activity. At the outset, the Forum may need to rely more heavily on contracting, in order to get a program underway promptly, with emphasis gradually shifting more heavily toward the use of panels. The Committee bill also makes it clear that the Forum can put its imprimatur on guidelines developed by other appropriate groups.

To be credible, guidelines developed under this provision must be formulated by objective, representative people of recognized authority and expertise. The Forum would be required to consult widely before selecting these panels of experts.

The panels and contractors would be expected to survey the available research literature and patient care data and to select the best information in developing guidelines. However, expert judgement would also be required and the Forum should not become stymied in its efforts because the research is less than perfect. Similarly, the guidelines are intended to help physicians provide services in a more effective and appropriate manner. The Forum should not consider itself compelled to come up with the single best approach to a patient problem or condition, if consensus cannot be reached on a single approach but there is agreement that care can be improved through the use of a set of guidelines. In such circumstances, the Forum can provide for alternative approaches, with appropriate commentary on which ones appear to be preferable under various circumstances.

The Forum is to assist in the dissemination of guidelines, standards, measures, and criteria. Dissemination would primarily be the responsibility of organizations representing providers or consumers of health care, peer review organizations, and other entities. The Forum will evaluate the effect of its products on clinical practice and provide feed back to the Agency on research needed to carry out its purpose.

The Committee notes that the term "physician" used in this subtitle is intended to encompass a range of health care practitioners, including, in many cases, all those practitioners who are qualified

to participate in the Medicare program. It is especially important that the process of developing guidelines under the Forum include the practitioners for whom the particular guidelines will be pertinent.

PART B—OUTCOMES OF HEALTH CARE SERVICES AND PROCEDURES

Section 4111—Establishment of program of research

This section amends the Social Security Act to establish a program of Research on Outcomes of Health Care Services and Procedures. Under current law, section 1875 of the Social Security Act provides for the transfer of $10 million from the Medicare trust funds to the National Center for Health Services Research for outcomes studies. The Committee bill establishes a similar, but greatly expanded, program. Because the National Center for Health Services Research is eliminated and replaced by the new Agency for Health Care Research and Policy, the bill requires the Secretary to conduct and support such research through that new Agency.

Although the research program is to be conducted through the Agency, these provisions in the Social Security Act are the ones that establish the processes for setting priorities for outcomes research and for improving such research.

The program allows the Administrator to conduct preliminary assessments to select the services and procedures that are to be given highest priority in outcomes research. In particular, it would be appropriate for the outcomes research to focus on services and procedures that vary in utilization rates, have uncertain effects, or are inappropriately used. For that reason, the Administrator could conduct preliminary assessments to identify the services and procedures that demonstrate those characteristics.

The bill identifies four factors to be considered when the Administrator is establishing priorities for outcomes research. While these factors are always to be considered, it is not the Committee's intent that all four factors necessarily be fully satisfied before an area is identified as appropriate for research. For example, research on the outcomes of primary care might well be considered a high priority, even though the data necessary for such evaluations are not readily available or readily developed, if the other three factors weigh heavily.

To carry out the program of outcomes research, the bill authorizes appropriations of $8.3 million in FY 90, $12.5 million in FY 91, and $16.7 million in FY 92, and in addition authorizes transfers of $16.7 million in FY 90, $25 million in FY 91, and $33.3 million in FY 92 from the Federal Supplementary Medical Insurance (Medicare Part B) Trust Fund.

PART C—ADDITIONIAL AUTHORITIES AND DUTIES WITH RESPECT TO AGENCY FOR HEALTH CARE RESEARCH AND POLICY

Section 4121—Advisory council, peer review, administrative authorities, and other general provisions

This section adds further provisions to the new Title IX of the Public Health Service Act created by section 4101.

The bill establishes a public-private council known as the National Advisory Council for Health Care Research, Evaluation, and Policy to advise the Agency. The Council is to advise the Secretary and the Administrator with respect to the carrying out the broad mandate of the Agency. Among its activities, the Council is to make recommendations regarding priorities for a national agenda for research, for the program of clinical practice guidelines and for the development of technology assessments.

The Council is to consist of both federal and private individuals. The majority are to be distinguished researchers in related fields of health policy and practice. These researchers can and should include physicians, particulary physicians involved in primary care and clinical practice research.

Other members of the Council would include distinguished medical practitioners, other distinguished professionals, and consumer representatives. Among the distinguished professionals are to be persons from the fields of business, law, ethics, economics, and public policy. Business representatives would appropriately include individuals from, for example, the health insurance industry, and the manufacturers of medical care products.

As under current law, the bill requires scientific peer review of all grants and contracts. The Committee notes that it has received numerous examples of areas in which the current peer review system could be improved. In particular, a number of researchers have commented that the peer review process does not assure that reviewers of particular proposals will actually be researchers with appropriate training and interests—i.e., peers. The Committee expects the Agency to establish study sections with a composition and organization that will assure appropriate review by persons with experience and training directly relevant to the proposed research or other activities.

In addition, for proposals of less than $50,000, an exception is made to the general requirement of peer review. The Administrator is permitted to establish a separate, and less burdensome, review process for such proposals. One purpose of doing so is to remove barriers for new researchers entering the field. This process should encourage new and future researchers, including those from institutions with future promise but limited track record, as well as those from clinical-practice situations rather than research-based institutions.

To carry out the activities other than research on the outcomes of health care, the Committee bill authorizes appropriatioins of $35 million for FY 90, $50 million for for FY 91 and $70 million for FY 92, and sets aside 40% of departmental evaluation funds for use by the Agency (estimated at approximately $30 million for FY 90).

PART D—GENERAL PROVISIONS

Sections 4131 through 4135

The Committee bill also contains a variety of other provisions to implement the new agency authority and transfer functions and resources from existing agencies. It repeals the Natioinal Center for Health Services Research and Health Care Technology Assessment and the Council on Health Care Technology, but provides for a one

year contract with the Institute of Medicine to complete current projects being undertaken by the Council and to facilitate a transition to the new Agency. It also makes other technical and conforming changes, including continuation of the National Center for Health Statistics.

Subtitle C—Medicaid

PART A—INFANT MORTALITY PROVISIONS

The United States ranks 19th among industrialized nations in infant mortality, behind Japan, Canada, Hong Kong, Singapore, and 14 other countries. About 40,000 American infants die each year before their first birthdays. A black infant in this country is twice as likely as a white child to die before the age of one year.

In August, 1988, the bipartisan National Commission to Prevent Infant Mortality issued a report, **"Death Before Life: The Tragedy of Infant Mortality."** The Commission called for universal access to early maternity and pediatric care for all mothers and infants. One element of the Commission's action plan for assuring universal access was upgrading coverage under Medicaid, the Federal-State entitlement for the poor. Another element was improving the Title V Maternal and Child Health Block Grant program. As contemplated by the FY 90 Budget Resolution, the Committee bill revises both the Medicaid and MCH programs to target Federal resources more effectively on low-income pregnant women and infants in order to improve birth outcomes.

Section 4201—Phased-in mandatory coverage of pregnant women and infants up to 185 percent of poverty level

(a) Phased-in Mandatory Coverage.—Under current law, States are required to offer Medicaid coverage to pregnant women and infants up to age 1 with incomes below 75 percent of the Federal poverty level. Effective July 1, 1990, States must extend coverage to all pregnant women and infants with incomes below 100 percent of poverty. States have the option of extending Medicaid coverage to all pregnant women and infants with incomes up to 185 percent of the poverty level. In each case, the coverage determination is based on income, not on whether the woman or infant is receiving cash assistance, or whether the family unit has one parent or two, or whether the principal earner is unemployed. States also have the option of applying a resource test in determining eligibility for these individuals. Coverage for pregnant women is limited to services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions which may complicate the pregnancy. Coverage for infants includes all the services the State offers to an individual receiving cash assistance under the Aid to Families with Dependent Children (AFDC) program.

Over the past few years, a number of States have made substantial progress in improving Medicaid coverage for pregnant women and infants. The National Governors' Association reports that, as of July, 1989, 44 States (including D.C.) extended coverage to all pregnant women and infants with incomes at or below 100 percent of the Federal poverty level; 14 States offered coverage to those

with incomes at or below 185 percent of poverty; and an additional 6 States offered coverage to those with incomes above 100 and below 185 percent of poverty. (See Table 1). While these expansions are important, they are not, in the view of the Committee, sufficient to assure financial access to prenatal care for all poor and near-poor women and infants in this country.

TABLE 1.—MEDICAID COVERAGE OF PREGNANT WOMEN, INFANTS AND CHILDREN JULY 1989

	Pregnant women and infants percent poverty	Children under poverty coverage to age	
		2–5	5–8
Alabama	100		
Alaska	100	X	
Arizona	100		X
Arkansas	100		X
California	185		
Colorado	75		
Connecticut	185		
Delaware	100	X	
District of Columbia	100	X	
Florida	150		X
Georgia	100	X	
Hawaii	100		
Idaho	75		
Illinois	100		
Indiana	125	X	
Iowa	185		X
Kansas	150		X
Kentucky	125	X	
Louisiana	100		X
Maine	185		X
Maryland	185	X	
Massachusetts	185		X
Michigan	185	X	
Minnesota	185		X
Mississippi	185		X
Missouri	100	X	
Montana	100		
Nebraska	100	X	
Nevada	75		
New Hampshire	75		
New Jersey	100	X	
New Mexico	100	X	
New York	[1] 185		
North Carolina	100	X	
North Dakota	75		
Ohio	100		
Oklahoma	100	X	
Oregon	85	X	
Pennsylvania	100	X	
Rhode Island	185	X	
South Carolina	[1] 185	X	
South Dakota	100		
Tennessee	100		X
Texas	[1] 130	X	
Utah	100	X	
Vermont	185	X	
Virginia	100		X
Washington	185		X
West Virginia	150		X
Wisconsin	82		
Wyoming	100		

TABLE 1.—MEDICAID COVERAGE OF PREGNANT WOMEN, INFANTS AND CHILDREN JULY 1989—Continued

	Pregnant women and infants percent poverty	Children under poverty coverage fo age	
		2–5	5–8
Total	51	21	14

[1] Effective January 1, 1990, in New York; Oct. 1, 1989, in South Carolina; Sept. 1, 1989 in Texas.

Source: National Governors' Association.

In its August, 1988, report, the National Commission to Prevent Infant Mortality concluded that universal access to early maternity and infant care was an essential element of a national effort to reduce infant mortality. "The first step toward guaranteeing pregnant women and infants the care they need," the Commission found, "is assuring access to maternity and infant care. The primary responsibility for achieving this goal rests with the private sector and employers who help provide the vast majority of health care in this country. But the government must assure more responsibility for those who lack private insurance or are unable to pay." With respect to the government's responsibility, the Commission recommended that Medicaid be expanded to cover all pregnant women and infants with family income at or below 200 percent of the Federal poverty level. "Death Before Life: The Tragedy of Infant Mortality" at pp. 17–18.

The Committee concurs. We as a nation must invest in prenatal and maternity care services for poor and near-poor women and infants. It is obvious from data presented by the Commission and by other witnesses before the Subcommittee on Health and the Environment, that private insurance coverage of low-income women and children is limited and cannot realistically be expected to fill the coverage gap. A sensible response at this point is to require of the States what is not optional: extend Medicaid coverage of pregnant women and infants up to age 1 with incomes at or below 185 percent of the Federal poverty level ($18,611 for a family of 3 in 1989).

Under the Commission bill, the mandate would be phased in over four years. As recommended by the Administration in its February 9, 1989, budget submission, "Building a Better America," States would be required to extend Medicaid coverage to all those at or below 130 percent of the Federal poverty level effective April 1, 1990. As of July 1, 1992, this minimum income threshold would increase to 150 percent of the poverty level. Effective July 1, 1993, all States would be required to cover all pregnant women and infants with incomes below 185 percent of the poverty level. In determining income eligibility, medical expenses are not taken into account; unlike the "medically needy" option, pregnant women and infants with incomes above 185 percent of poverty cannot "spend down" into eligibility on the basis of high medical bills.

States that, as of enactment, already extend, or are scheduled to extend, coverage to pregnant women and infants with incomes above 130 percent of the poverty level must keep their eligibility thresholds at the higher of that level or the levels mandated under

the Committee bill. For example, a State which, as of July, 1989, has elected to cover pregnant women and infants with incomes below 185 percent of the poverty level would be required to continue to do so, even though other States that currently set their thresholds at 75 percent of poverty would have until July 1, 1993, to phase up to 185 percent. Of course, the current law option allowing States to extend coverage immediately to pregnant women and infants below 185 percent of poverty would remain in effect; it is the hope of the Committee that all States will elect this option well before the July 1, 1993, deadline.

The Committee recognizes that some of the pregnant women and infants who will qualify for Medicaid coverage under this bill are covered under employment-based health insurance coverage. As under current law, this coverage would be treated as a third party liability. In the case of all prenatal or preventive pediatric care (including EPSDT services) covered under the State's Medicaid plan, the State would first make payment for the services, under its usual payment schedule, and then seek recovery from the insurer. In the case of all other services, including inpatient hospital delivery, the insurer would pay first, and the State would pay only to the extent that the services were covered under the State plan and that the insurer was not liable.

As under current law, section 1902(1)(4)(A) of the Social Security Act, the mandatory phase-in of coverage for pregnant women and infants, and other mandates in the Committee bill (including the phase-in of coverage of pregnant children, flexibility in income methodology, prohibition of a resource test, payment of obstetrical and pediatric services, role in paternity determinations, coordination with WIC, and outreach locations), apply to Arizona in the same manner as they apply to other States, notwithstanding the section 1115 waiver under which Arizona operates its Medicaid program.

This requirement would apply with respect to determinations (or redeterminations) of eligibility for Medicaid occurring on or after April 1, 1990, without regard to whether or not final regulations to carry out such amendments have been promulgated by that date. In the case of Texas, the requirement would not apply before September 1, 1991.

(b) Flexibility in income methodology and deduction of child care in computation of income.—Under current law, in determining income eligibility for pregnant women and infants, States are required to use the same methodology they use in determining income under their AFDC programs. One exception is that, regardless of the rules for AFDC purposes, States may not, for Medicaid eligibility purposes, deem available to the pregnant woman the income or resources of any grandparent or any sibling living in the same home with the pregnant woman or her infant. Another exception is that States must, for Medicaid eligibility purposes, treat a pregnant woman as though her child were born and living with her at the time she applies for benefits; thus, unlike AFDC, the smallest assistance unit in the case of a pregnant woman would, for Medicaid purposes, be a family unit of two.

The Committee bill would allow States, at their option, to use less restrictive income methodologies than those employed under

their AFDC programs. For this purpose, a methodology is no more restrictive if, under the alternate methodology, (1) additional pregnant women and infants may be eligible for Medicaid, and (2) no pregnant women or infants who would be eligible under the AFDC methodology would be made ineligible for Medicaid under the alternate methodology.

Under current law, in determining eligibility for cash assistance under AFDC, States are required to disregard child care costs of up to $160 per month per child. As of April 1, 1990, States will be required, in determining income eligibility for Medicaid transitional coverage for families leaving AFDC cash assistance due to employment, to disregard the costs of child care that are necessary for the employment of the caretaker relative. There is no cap on the amount of necessary child care costs that must be disregarded.

The purpose of the Committee bill is to reduce infant mortality by assuring that low-income pregnant women, including working poor pregnant women, have financial access to needed prenatal and maternity care. If the minimum mandatory income thresholds in the bill—130 percent, 150 percent, 185 percent of poverty—were applied without regard to child care costs, the effect would be to force very difficult choices on working poor women whose gross incomes exceed the threshold, but whose incomes, net of child care costs, fall below the threshold. If they continue to work, these women and their children will be ineligible for Medicaid. Unless their employer offers private health insurance coverage, and unless they are able to afford this coverage despite their child care costs, they will be uninsured. On the other hand, if they stop working, or reduce their hours of employment so as to bring their income below the threshold, they will qualify for Medicaid.

In the view of the Committee, the Medicaid eligibility determination process should encourage applicants to work rather than to seek cash assistance. Clearly, child care costs have a dramatic impact on the ability of working poor pregnant women to afford needed health care. To ignore these costs would be to create a significant work disincentive. Accordingly, the Committee bill would require the States, in determining the income eligibility of pregnant women and infants under age 1, to disregard costs for such child care as is necessary for the employment of the pregnant woman or caretaker of the infant. The Committee bill does not impose a limit on the amount of this child care deduction, and neither the Secretary nor the States has any authority to establish an absolute dollar limit on the amount of work-related child care costs that must be disregarded. Neither the Secretary nor the States is authorized to impose such a limit.

The Committee intends that States, in determining income eligibility of pregnant women or infants for Medicaid coverage, disregard all child care costs necessary for employment. The Committee expects that, in determining whether an expense is necessary for employment, the States will take full account of the costs of qualified child care in the woman's neighborhood and at her place of work. The Committee stresses that the child care costs which must be taken into account in determining Medicaid eligibility of pregnant women are not limited to those that are recognized under the AFDC program (Title IV–A).

Both the option relating to income methodology, and the requirement relating to the deduction of child care costs, are effective for determinations (or redeterminations) of eligibility made on or after July 1, 1990, regardless of whether final regulations have been issued. In the case of Texas, the requirement would not apply until September 1, 1991.

(c) Prohibiting Application of a Resource Test.— Under current law, States have the option of applying a resource test in determining Medicaid eligibility of pregnant women and infants. With respect to pregnant women, this test may be no more restrictive than that applied under the Supplemental Security Income (SSI) program; with respect to infants, no more restrictive than that applied under the State's Aid to Families with Dependent Children (AFDC) program.

According to the Children's Defense Fund, as of June, 1989, 43 States (including D.C.) had elected not to apply a resource test in determining the eligibility of pregnant women and infants. (Only California, Colorado, Illinois, Iowa, Missouri, North Dakota, Texas, and Wisconsin still applied resource tests). In its August, 1988, report, the National Commission on Preventing Infant Mortality recommended that assets tests for pregnant women be eliminated. The Committee agrees. The Committee bill would prohibit States, effective July 1, 1990, from imposing any resource standard or methodology in determining eligibility of pregnant women and infants for Medicaid coverage. This prohibition would apply with respect to all pregnant women and infants, whether they are currently covered under a mandatory or an optional eligibility provision. Thus, if a State, before July 1, 1993, elects to cover pregnant women and infants up to 185 percent of the poverty level, it may not apply resource tests to that population.

Resource requirements are basic to means testing for welfare benefits. However, they are fundamentally inconsistent with a public health initiative to reduce infant mortality. The Committee's purpose is not to extend Medicaid benefits to individuals who, due to insufficient means, are considered "deserving." Instead, the purpose is to assure financial access to needed prenatal, maternity, and pediatric care for low-income pregnant women and infants. As a large majority of the States have already recognized, resource tests introduce enormous complexity and substantial cost into the eligibility determination process. They also carry with them a welfare stigma that discourages pregnant women from accessing this coverage. In the view of the Committee, all pregnant women and their infants are deserving; there is no need for a resource test to divide low-income pregnant women and infants into the deserving and the undeserving.

This provision would apply with respect to determinations (or redeterminations) of eligibility for Medicaid occurring on or after July 1, 1990, without regard to whether or not final regulations to carry out such amendments have been promulgated by that date. In the case of Texas, the requirement would not apply before September 1, 1991.

(d) Report and transition on errors in eligibility determinations.— Under current law, States are required to review the accuracy of eligibility determinations. Under this so-called "quality control"

(QC) process, the State selects a monthly sample of cases for review and identifies cases where errors (other than technical errors) have resulted in payments for services on behalf of individuals who were not eligible or whose "spenddown" liability was underestimated. The State's error rate is the ratio of the Medicaid funds spent as a result of the error to the Medicaid funds spent for the entire sample. If this rate exceeds 3 percent, the State is subject to a reduction in Federal matching payments, unless the Secretary waives the disallowance because the State has made a good faith effort to comply. Expenditures for ambulatory prenatal care to pregnant women during a presumptive eligibility period are excluded from the calculation of erroneous payments.

The Committee is concerned that the QC process has had an inadvertent chilling effect on the ability of low-income pregnant women and infants to establish promptly eligibility for Medicaid. As currently structured, the QC process fucuses on penalizing States for extending coverage to individuals who are not eligible. The process does not impose penalties for erroneous denials of coverage to individuals who are in fact eligible. Thus, States have a strong incentive to establish the most stringent, time-consuming eligibility determination and verification procedures. States have no incentive to correct those procedures when they result in the delay or denial of coverage to individuals who are in fact eligible.

In the view of the Committee, payment accuracy is an important goal of the Medicaid program, but it is not the only goal. A fundamental purpose of Medicaid is to improve the health status of the poor by assuring access to needed health care. One of the principal measures of health status is infant mortality. The Committee is concerned that the QC process may be deterring States from making eligibility determinations in a timely and expeditious manner. Unnecessarily lengthy eligibility determination procedures are inconsistent with the program's objective of increasing access by low-income pregnant women and infants to needed prenatal, maternity, and well-child services in a timely manner.

The Committee bill would require the Secretary to report to Congress, by not later than July 1, 1990, on error rates by the States in determining Medicaid eligibility of pregnant women and infants. In addition to information from the current QC system, the report should contain information on the extent to which States erroneously deny or delay eligibility to pregnant women and infants who are in fact eligible for coverage. The report should also include recommendations for reducing the amount of time required by States to make accurate eligibility determinations with respect to these populations. To reduce the adverse incentives of the QC process while the Secretary studies this issue, the Committee bill would exclude from the calculation of error rates any Medicaid expenditures attributable to pregnant women and infants made during the period beginning on July 1, 1989, and ending the first calendar quarter beginning more than 12 months after the Secretary submits the report.

Section 4202—Presumptive eligibility

Under current law, States have the option to offer coverage for ambulatory prenatal care to pregnant women who have been deter-

mined to be presumptively eligible for Medicaid. Generally, the coverage extends through a presumptive eligibility period, which ends on the earlier of (1) the date on which a final eligibility determination is made or (2) 45 days after the determination of presumptive eligibility. If a woman does not file an application for Medicaid within 14 days after being determined presumptively eligible, her coverage terminates at that point.

The purpose of this option is to avoid delays in access of low-income women to needed prenatal care while their formal applications for Medicaid eligibility are being considered. Presumptive eligibility determinations are made by certain providers of outpatient or clinic services, such as Federally-funded community health centers. According to the National Governors' Association, as of January, 1989, 20 States had implemented the presumptive eligibility option.

(a) Extension of presumptive eligibility period.—It is the understanding of the Committee that the rigid timeframe under current law has discouraged some States from adopting the presumptive eligibility option, despite the obvious benefits of making medically necessary outpatient services available to low-income pregnant women during the critical prenatal period while the State processes their formal applications for full Medicaid eligibility. In order to make the presumptive eligibility option more attractive to the States, the Committee bill provides that the presumptive eligibility period ends with (and includes) the earlier of (1) the day on which a final eligibility determination is made or (2) in the case of a woman who does not file an application by the last day of the month following the month during which she is determined to be presumptively eligible, that last day. This modification is effective for ambulatory prenatal services provided on or after July 1, 1990.

This modification would have the following effect. First, the current 45-day limit on the presumptive eligibility period would be eliminated. Thus, if a State took more than 45 days to process a woman's Medicaid application, coverage for ambulatory prenatal care would continue without interruption until the day the State makes a final eligibility determination. Second, a pregnant woman would have at least one month, and as much as two months, during which to file the formal application for Medicaid coverage. Thus, if a woman was determined presumptively eligible on June 15, she would have until July 31 to file her formal Medicaid application. This will avoid the loss of presumptive eligibility solely because a low-income pregnant woman is unable to meet the current 2-week deadline for filing what can be an extremely complicated eligibility form.

(b) Flexibility in application—It is the understanding of the Committee that a number of States have been advised by the Health Care Financing Administration that they must use different application forms for presumptive eligibility determinations and for final Medicaid eligibility determinations. There is no basis for this assertion. The Committee bill clarifies that a State has, and always has had, the option to use the same application form for presumptive eligibility purposes as it uses to determine final Medicaid eligibility for pregnant women.

Section 4203—Optional coverage of prenatal and postpartum home visitation services

Under current law, Federal Medicaid matching funds are available for payments made by States, at their option, to physicians, nurses, and other health professionals, for delivering services in locations other than their offices or clinics. In its August, 1988, report, the National Commission on the Prevention of Infant Mortality recommended the establishment of a "home visitors program" for high-risk pregnant women and new mothers which would educate and work with these women during their pregnancies to promote healthy outcomes by encouraging appropriate behavior and making referrals to needed services.

In order to provide States with a stable source of funding for such programs, the Committee bill would establish a new optional Medicaid benefit: prenatal home visitation services for high-risk pregnant women (as prescribed by a physician) and/or postpartum home visitation services with respect to high-risk infants under 1 (as prescribed by a physician). States would have the option to cover these services during the prenatal period, the post-partum period, or both. States would have the discretion to define "high-risk" for purposes of this benefit and could include in their definition both medical and social risk of an adverse pregnancy or birth outcome. Home visitation services, whether prenatal or postpartum, would have to be prescribed by a physician, but could actually be provided by a nurse, a nurse practitioner, health educator, or other health professional. The scope of the home visitation benefit would be defined by the State, but could include, in addition to medical services, other services designed to improve the outcome of the pregnancy or the health of the infant, including in-home health assessments under the EPSDT program, health education, and parenting training.

This optional benefit would be effective July 1, 1990, regardless of whether the Secretary has issued implementing regulations. The Committee expects that the Secretary, in developing interpretive guidelines or regulations, will make every effort to avoid placing limitations on the availability of Federal Medicaid matching funds that might prevent the States from providing a service that has the potential for improving pregnancy outcomes among low-income women or the health status of their infants.

Section 4204—Payment for obstetrical and pediatric services

Under current law, States have discretion in establishing payment rates and methodologies for physician services under their Medicaid programs. Payments to physicians, like payments to other practitioners, must be consistent with efficiency, economy, and quality of care. By regulation, 42 C.F.R. 447.204, the Secretary has required that payment levels for providers be sufficient to enlist enough providers so that services under the plan are available to beneficiaries at least to the extent that those services are available to the general population.

The Subcommittee on Health and the Environment heard testimony that Medicaid participation of physicians generally, and obstetricians and pediatricians in particular, is inadequate. A physi-

cian's decision to accept Medicaid patients is affected by many factors, including perceived malpractice risk, administrative burdens (prior authorization requirements, paperwork, etc.), discontinuous eligibility, and delays in processing and paying claims. Another important factor is the payment rate itself. As the National Governors' Association testified before the Subcommittee on Health and the Environment on February 8, 1989, "There is no doubt that Medicaid reimbursement rates have not kept pace with average community rates. States have restrained physician fees as one method of controlling program costs. Studies have shown that the fees paid by Medicaid to obstetricians and gynecologists have had an impact on their participation in the program."

Available data provides overwhelming support for the Governors' views. In testimony submitted to the Subcommittee, the Children's Defense Fund calculated that, as of April, 1988, Medicaid fees for a vaginal delivery ranged from a low of 21 percent of the average regional physician charge in New Jersey to a high of 131 percent Massachusetts. Medicaid fees for a Cesarean section ranged from 30 percent of the average regional physician charge in Vermont to 110 percent Massachusetts.

In the view of the Committee, the Medicaid eligibility expansions contained in the Committee bill for poor pregnant women and infants (section 4201) and poor children (section 4211) will not have their intended effect if physicians are not willing to treat Medicaid patients. The Committee recognizes that payment levels are only one determinant of physician participation. However, the Committee believes that, without adequate payment levels, it is simply unrealistic to expect physicians to participate in the program, particularly when so many of them believe that Medicaid patients present a greater liability risk.

(a) Codification of adequate payment level provisions.—The Committee bill would codify, with one clarification, the current regulation, 42 C.F.R. 447.204, requiring adequate payment levels. Specifically, the Committee bill would require that Medicaid payments for all practitioners be sufficient to enlist enough providers so that care and service are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

The Committee bill clarifies that the equal access test is to be applied in relation to the supply of providers in a geographic area. Thus, if a particular geographic area within a State has a smaller number of physicians per thousand insured population than other parts of the State, or than the State as a whole, the Medicaid payments would have to be at a level that ensures that Medicaid beneficiaries in that area have at least the same access to physicians as the rest of the insured population in that area. The Committee bill would not require that Medicaid payment levels be high enough to induce physicians to relocate into this area.

The Committee expects that the Secretary, in determining whether services are available to Medicaid beneficiaries at least to the extent that services are available to the general population, will compare the access of beneficiaries to the access of other individuals in the same geographic area with private or public insurance coverage (whether in the form of indemnity, service, or pre-

paid benefits). It is obvious that Medicaid beneficiaries are likely to have better access to care than individuals without insurance coverage and without the ability to pay for services directly. The question which the Secretary must ask is whether Medicaid beneficiaries have access to provider services that is at least as great as that of others in the area who have third party coverage.

(b) Assuring adequate payment levels for obstetrical and pediatric services.—In the view of the Committee, if infant mortality is to be reduced and child health status improved, it is essential that States comply fully with the adequate payment requirement with respect to obstetrical and pediatric services. The Committee bill therefore requires States, by not later than April 1 of each year, to submit a State Medicaid plan amendment that specifies the payment rates to be used for obstetrical services and for pediatric services during the 12-month period beginning July 1 of that year. These plan amendments may be filed separately or combined. For this purpose, obstetrical services are defined as non-institutional services relating to pregnancy provided by an obstetrician, obstetrician-gynecologist, family practitioner, certified nurse midwife, or certified family nurse practitioner. Similarly, pediatric services are defined as noninstitutional services to children under 18 provided by a pediatrician, family practitioner, or certified pediatric nurse practitioner.

The April 1 submission must include additional data, specified by the Secretary, needed to evaluate the State's compliance with the adequate payment requirement. In order to assure that payments to HMOs and other entities with which the State contracts on a risk basis (whether or not under waiver) provide adequate resources for the delivery of quality obstetrical and pediatric services, the Committee bill requires that the data submitted by the State include information on how payment rates to HMOs and other risk contractors compare with the State's fee-for-service payment rates for obstetrical and pediatric services.

Within 90 days after the submission of a plan amendment by the State relating to obstetrical and/or pediatric services, the Secretary must review the amendment for compliance with the adequate payment requirement and approve or disapprove it. In the event of a disapproval, the State must immediately submit a revised amendment which meets the requirement. The Committee expects that, in reviewing State plan amendments, the Secretary will make certain that payment levels are in fact sufficient to induce physicians to participate in the program so that Medicaid-eligible pregnant women, infants, and children will have access to needed obstetrical and pediatric services.

To enable the Secretary and the States to more accurately gauge compliance with the adequate payment requirement, the Committee bill requires that, beginning with the submission due April 1, 1992, States set forth at least the statewide average payment rates for the second previous year (e.g., July 1, 1990 through June 30, 1991) for obstetrical services. These payment rates must be broken down by procedure, by type of provider (e.g., obstetricians, obstetrician-gynecologists, family practitioners, certified family nurse practitioners, and certified nurse midwives), and by practice area (e.g., metropolitan statistical areas and all other areas). The Committee

bill imposes a parallel reporting requirement beginning in 1992 with respect to pediatric services. Again, statewide average payment rates must to be identified by procedure, by type of provider (pediatrician, family practitioner, and certified pediatric nurse practitioner), and urban and rural practice areas.

The Committee recognizes that access to obstetrical or pediatric services may be particularly problematic in rural areas, and that a State may wish to structure its Medicaid payments so as to encourage physicians who are now practicing in these areas to continue doing so, and to induce those who are not now practicing in these areas to relocate. The Committee bill clarifies that nothing in the Medicaid statute is to be construed to prevent a State from establishing payment levels for obstetrical or pediatric services in rural areas that are higher than those established for these same services in metropolitan statistical areas.

(c) Payment for certain services in certain federally funded health centers.—Under current law, States are required to cover rural health clinic services (and any other ambulatory services offered by rural health clinics), and to set payment levels at 100 percent of the reasonable costs of delivering these services. States also have the option of offering coverage for clinic services; if they elect to do so, they are not required to set payment levels at 100 percent of reasonable cost.

Among the providers of clinic services are community health centers, migrant health centers, and health care for the homeless programs funded under sections 330, 329, and 340 of the Public Health Service (PHS) Act, respectively. There are over 550 of these Federally-funded centers in urban and rural areas throughout the country. In 1987, they delivered primary care services to about 5.7 million people, including 2.5 million children under 18 and 1.6 million women of childbearing age. That year, health center patients accounted for about 10 percent of all births nationally to low-income women.

According to a June, 1989, study prepared for the National Association of Community Health Centers, all but one State has opted to cover clinic services of some kind; however, only 24 of 38 States surveyed pay for clinic services delivered by Federally funded health centers or programs. Of these, only the District of Columbia, Kentucky, North Carolina (subject to a cap), South Carolina, and Tennessee reimburse health centers on a cost basis. (In other States, centers may be paid on the basis of a prospective rate or on a fee basis; States may also treat physicians at a center as a group practice for reimbursement purposes).

The Subcommittee on Health and the Environment heard testimony that, on average, Medicaid payment levels to Federally-funded health centers cover less than 70 percent of the costs incurred by the centers in serving Medicaid patients. The role of the programs funded under sections 399, 330, and 340 of the PHS Act is to deliver comprehensive primary care services to underserved populations or areas without regard to ability to pay. To the extent that the Medicaid program is not covering the cost of treating its own beneficiaries, it is compromising the ability of the centers to meet the primary care needs of those without any public or private coverage whatsoever.

The Committee bill would require States, under their Medicaid programs, to cover ambulatory services offered to pregnant women or children under 18 by a health center or program receiving funds (in whole or in part, directly or by subgrants) under section 329, 330, or 340 of the PHS Act. The Committee intends that the term "ambulatory services" be construed to include any outpatient service which the center is authorized to provide under section 329, 330, or 340 of the PHS Act. The Committee recognizes that, in some States, ambulatory services offered by a health center or program may be broader in scope than outpatient services offered by other classes of providers; nonetheless, the State would still be required to cover the broader range of services when provided by a health center or program. For example, if a center provides home visitation services for high-risk pregnant women or infants, the State would have to pay for those services even if the State does not cover home visitation services furnished by any other class of provider, such as physicians, nurses, or nurse practitioners.

To ensure that Federal PHS Act grant funds are not used to subsidize health center or program services to Medicaid beneficiaries, States would be required to make payment for these services at 100 percent of the costs which are reasonable and related to the cost of furnishing these services. This cost reimbursement requirement applies to all ambulatory services offered by the center or program, not just those included in the current law definition of rural health clinic services. The Committee expects that, in determining reasonableness, the Secretary and the States will use data on the actual costs incurred by health centers or programs in delivering ambulatory care.

These requirements are effective on July 1, 1990, without regard to whether or not the Secretary has promulgated final regulations.

Section 4205—Role in paternity determinations

Under current law, States must require all applicants for Medicaid, as a condition of eligibility, to cooperate with the State in establishing paternity and in obtaining child support. The State may waive this requirement if it determines that the individual has good cause for refusing to cooperate.

The Committee is concerned that application of these requirements to women who are applying only for preganancy-related coverage may discourage many of them from seeking benefits that would give them access to early prenatal care. The Committee notes that the Department's own manuals acknowledge that paternity determinations, which are based on one of several blood tests, cannot be made before an infant is at least 4 months old: "Blood must be drawn in sufficient quantity for the particular test to be performed. . . . This may impose a mandatory delay in a case involving a newborn infant because it is difficult to obtain any significant volume of the baby's blood. Many technicians require that a child be four to six months old and be in good health before they will attempt to obtain a blood sample. . . . Some laboratories will not draw blood for [one type of] testing unless the child is at least 12 months old. For the other tests [for paternity determination], it is generally prudent to avoid venipuncture until the child is 6 months old. An additional advantage in waiting this long after

birth is the assurance that antigens in the blood are fully developed by this age." U.S. Department of Health and Human Services, Office of Child Support Enforcement,"A Guide for Judges in Child Support Enforcement" (1983) at pages 51-52.

Thus, the cooperation requirement is not only a potential barrier to prenatal care for the high-risk, low-income women that would most benefit from it, but it is also a bureaucratic hurdle that yields absolutely no useful information until months after the prenatal period has ended. The Committee bill therefore exempts pregnant women applying for Medicaid on the basis of their pregnancy and low income from the cooperation requirements with respect to establishing paternity and obtaining child support.

Section 4206—Required Medicaid notice and coordination with Special Supplemental Food Program for Women, Infants, and Children (WIC)

The Special Supplemental Food Program for Women, Infants, and Children (WIC), which is not within the jurisdiction of this Committee, serves low-income pregnant women, infants, and children under 5 who are determined by a medical professional to be at nutritional risk and who have incomes at or below 185 percent of the Federal proverty level. Women and children eligible for WIC receive nutrition assistance (including vouchers to purchase iron-fortified cereals, infant formula or milk, eggs, juice, peanut butter), nutrition education, and some health-related services.

The National Commission on the Prevention of Infant Mortality identified WIC as one of the programs to which high-risk pregnant women should have early access. Under the Committee bill, which would raise the income eligibility threshold under Medicaid to that of WIC over the next four years, the logic of coordinating the two programs becomes even more compelling. Under current law, the State's WIC program must include "a plan to coordinate operations under the program with . . . maternal and child health care, and Medicaid programs." While the Medicaid program is currently required to enter into agreements with providers receiving funds under the Title V Maternal and Child Health Block Grant, there is not reciprocal coordination requirement with respect to WIC.

The Committee bill would require States to coordinate their operations under Medicaid with their operations under WIC. In addition, States would be required to notify all women who are pregnant, breast-feeding, or postpartum, and all children below age 5, who are eligible for Medicaid, of the availability of WIC benefits. This notification must occur in a timely manner, either at the time of a determination that a woman is eligible (or presumptively eligible) for Medicaid, or immediately thereafter. The State must also provide for the referral of Medicaid-eligible women and children under 5 to the State agency responsible for administering WIC. This referral could be achieved at the same time as notification. The costs which States incur in carrying out these coordination responsibilities are necessary for the proper and efficient administration of the State Medicaid plan, and as such are subject to Federal matching at a 50 percent rate.

PART B—CHILD HEALTH AMENDMENTS

Section 4211—Phased-In mandatory coverage of children up to 100 percent of poverty level

(a) In General.—Under current law, States are required to offer Medicaid coverage to all children born after September 30, 1983, in families with incomes and resources below State AFDC standards, up to age 7. States are also required, as of July 1, 1990, to cover all infants up to age 1 in families with incomes below 100 percent of the Federal poverty level. In addition, States have the option of extending coverage to all children born after September 30, 1983, in families with incomes below 100 percent of the Federal poverty level, up to age 8. With respect to this poverty level group, States have the option of appplying a resource test; if they do so, the resource standard and methodology may be no more restrictive than that under the State's AFDC program. As indicated in Table 1, as of January, 1989, 21 States had elected to cover children in poverty below ages 2 through 4, and 14 had elected to cover all poor children below ages 5 through 7.

As the Office of Technology Assessment documented in "Healthy Children: Investing in the Future" (1988), some preventive and other health care services for infants and children, notably newborn screening and immunizations, are cost-effective and can improve health status. Medicaid, with its early and periodic screening, diagnostic, and treatment (EPSDT) services benefit, is the major source of financing for preventive health care services for low-income children. Yet, according to the Congressional Research Service, Medicaid in 1986 reached only about half of all children in families with incomes below the poverty level; because of limited private health insurance coverage among the poor, about one third of all poor children were left with no public or private insurance coverage whatsoever ("Medicaid Source Book: Background Data and Analysis" (Committee Print 100-AA), p. 333).

To fill this coverage gap incrementally, the Committee bill would convert the existing option to extend Medicaid coverage to poor children into a mandate. The bill would require States to extend Medicaid coverage to all children born after September 30, 1983, in families with incomes below the Federal poverty level ($10,060 for a family of 4 in 1989), incrementally up to age 18. Under section 4201(c) of the bill, States would not have the option of applying a resource test to this population. This requirement would be effective July 1, 1990, except in Texas, when the requirement would apply on September 1, 1991. As under current law with respect to infants under age 1, this requirement would also apply to a State like Arizona that provides Medicaid coverage under a waiver under section 1115 of the Social Security Act.

The effect of this requirement is to phase in, over the next 12 years, mandatory Medicaid coverage for all poor children under 18. On July 1, 1990, all States would have to cover children born after September 30, 1983, in families with incomes below the proverty level, regardless of whether the family had one parent or two, and regardless of whether the family's resources exceeded the AFDC standard. On that date, the oldest of this cohort would be nearly 6¾ years old. As these children grew older, if their families re-

mained poor, they would continue to be entitled to Medicaid coverage. By the year 2001, all States would be required to cover all poor children under age 18. The Committee notes that States that want to extend coverage more quickly may elect, under the current law "Ribicoff child" option, to cover all children under age 21 whose family incomes and resources do not exceed AFDC levels.

Under the Committee bill, in determining income eligibility for these children, States would be allowed to use a methodology that is less restrictive than that employed under the AFDC program. As under current law, they could not use a methodology for determining income that is more restrictive than that under AFDC. In addition, States would be required to disregard all costs for child care necessary for the employment of the child's parents or other caretaker relative.

(b) Applications using outreach locations.—Under current law, States have the option of accepting and processing applications for Medicaid eligibility at locations other than State or local welfare offices. (This option is in addition to the presumptive eligibility option, under which States designate certain providers to make presumptive determinations of eligibility with respect to pregnant women in order to expedite coverage for prenatal care.) Many States currently station eligibility workers in hospitals, clinics, WIC clinics, and similar locations in order to enroll poor women and children in the program.

The Committee is concerned that, unless poor women and children are able to apply for Medicaid in locations other than welfare offices, many of them will be deterred from obtaining the health care coverage they need in order to receive preventive health services. The Committee bill would therefore require States to provide for the receipt and initial processing of applications for Medicaid coverage by poor pregnant women, infants, and children (whether optional or mandatory) at outreach locations such as hospitals and clinics that provide covered services to these populations. In designating hospitals or clinics for this purpose, States must include both public and private entities.

The Committee bill does not require States to station eligibility workers at each and every hospital, clinic, and WIC program; however, the Committee does intent that, at a minimum, eligibility workers be stationed on a full-time basis in each of the hospitals (such as disproportionate share facilities) and clinics that treat significant numbers of low-income women, infants, and children. These eligibility workers could be employees of the welfare agency, contractors to the agency, or employees of, or contractors to, the hospital, clinic, or other outreach location. As under current law, all costs incurred by the State with respect to the receipt and processing of Medicaid applications at these locations, including the salaries and equipment costs of eligibility workers, would, under the Committee bill, be considered necessary for the proper and efficient administration of the State plan and subject to Federal matching payments at a 50 percent rate.

The Committee is concerned that the lengthy, complex application forms for AFDC eligibility can create a barrier to access for women and children who are not seeking cash assistance, but only Medicaid coverage. Much of the information relevant to eligibility

for cash assistance, such as resources and family composition, are not relevant to the coverage groups mandated under sections 4201(a) and 4211(a). The Committee bill would therefore require States to provide for the use of applications for Medicaid-only coverage at the hospitals, clinics, and other outreach locations that the State designates under the previous requirement.

Under these requirements, the Committee expects the eligibility determination process for low-income pregnant women, infants, and children to work as follows. States would develop application forms for use at designated hospitals, clinics, and other outreach locations. These simplified forms would contain only those information requirements necessary to determine eligibility for Medicaid. This information would include verification of the woman's pregnancy; age of the child (which could be provided through methods other than a formal birth certificate, such as verification from a hospital or from a child's health care provider regarding the child's date of birth); size and income of the family; verification of lawful residence in the U.S.; information concerning third party liability; and, in the case of children only, disclosure of paternity information in circumstances where such information is applicable. States using initial intake applications that included this information would not be required to use separate applications for making final eligibility determinations.

The entire application process could be conducted at the hospitals, clinics, and other outreach locations. If the eligibility worker at the outreach location is a welfare agency employee or contractor, the final eligibility determination could be made at that location. However, even if the eligibility worker is an employee of the hospital or clinic, the pregnant woman or child would not be required to go to the welfare office for a face-to-face interview in order to complete the eligibility determination process. Instead, the simplified application form, along with necessary documentation, would then be forwarded to the welfare office for a final determination.

Section 4212—Extension of Medicaid transition coverage

Under current law, States are required, effective April 1, 1990, to extend Medicaid coverage for 12 months to families who lose AFDC benefits due to earnings, and who continue to report earnings during this period. During the first 6 months of the transition period, States may not impose any premium requirement for this coverage; during the second 6 months, States may, at their option, impose an income-related premium. This requirement is repealed on September 30, 1998.

This Medicaid transitional coverage requirement was one of the provisions of the Family Support Act of 1988 (P.L. 100-460) designed to encourage families to leave welfare and become self-sufficient. Many of these former welfare receipients are employed in low-wage jobs that do not offer health insurance coverage. According to a General Accounting Office study, more than half of former welfare recipients who work are uninsured ("Evaluation of 1981 AFDC Changes: Final Report" (GAO/PEMD-85-4, July, 1985)). The Committee is concerned that, in many cases, 12 months is not suffi-

cient time for a mother to make the transition from welfare to a job that offers health insurance coverage for her and her children.

To further encourage welfare families to work, the Committee bill would allow the States, at their option, to extend the current 12-month transitional coverage period for an additional 12 months (or 3, 6, or 9 months, as the State elects). Thus, a State could offer a working welfare family a total of 24 months of transitional Medicaid coverage (12 mandatory, 12 optional). Under the bill, the structure of the current mandatory benefit would remain unchanged. Thus, States could, at their option, impose the same income-related premium during this optional 12-month period that they are allowed to impose during the 2nd mandatory 6-month period. The Committee bill would also repeal the sunset.

The Committee bill would also make some technical corrections to current law. It clarifies that Medicaid transition coverage terminates at the close of the first month in which the family ceases to include a child, whether or not the child is a dependent child under part A of Title IV, or would be if needy. The Committee bill also clarifies that families who, prior to April 1, 1990, are receiving Medicaid extension coverage under the current law 9-month provision are entitled to continue receiving this extension coverage after that date until their 9-month coverage period expires.

Section 4213—Early and periodic screening, diagnostic, and treatment services

(a) In general.—Under current law, States are required to offer early and periodic screening, diagnostic, and treatment (EPSDT) services to children under age 21. States are required to inform all Medicaid-eligible children of the availability of EPSDT services, to provide (or arrange for the provision of) screening services in all cases when they are requested, and, to arrange for (directly or through referral to appropriate agencies or providers) corrective treatment for which the child health screening indicates a need.

The EPSDT benefit is, in effect, the nation's largest preventive health program for children. Each State must provide, at a minimum, the following EPSDT services: assessments of health, developmental, and nutritional status; unclothed physical examinations; immunizations appropriate for age and health history; appropriate vision, hearing, and laboratory tests; dental screening furnished by direct referrals to dentists, beginning at age 3; and treatment for vision, hearing, and dental services found necessary by the screening. These services are available to children under EPSDT even if they are not available to other Medicaid beneficiaries under the State's plan.

The EPSDT benefit is not currently defined in statute. In the view of the Committee, as Medicaid coverage of poor children expands, both under current law and under the Committee bill, the EPSDT benefit will become even more important to the health status of children in this country. The Committee bill would therefore define the EPSDT benefit in statute to include four distinct elements: (1) screening services, (2) vision services, (3) dental services, and (4) hearing services. Each of these service elements would have its own periodicity schedule that meets reasonable practice standards. These items and services must be covered for children

even if, under the State Medicaid plan, they are not offered to other groups of program beneficiaries.

Under the Committee bill, screening services must, at a minimum, include (1) a comprehensive health and developmental history (including assessment of both physical and mental health development), (2) a comprehensive unclothed physical exam, (3) appropriate immunizations according to age and health history, (4) laboratory tests (including blood lead level assessment appropriate for age and risk factors), and (5) health education (including anticipatory guidance). The Committee emphasizes that anticipatory guidance to the child (or the child's parent or guardian) is a mandatory element of any adequate EPSDT assessment. Anticipatory guidance includes health education and counselling to both parents and children.

Under the Committee bill, vision services must, at a minimum, include diagnosis and treatment for defects in vision, including eyeglasses. Dental services must, at a minimum, include relief of pain and infections, restoration of teeth, and maintenance of dental health. Hearing services must, at a minimum, include diagnosis and treatment for defects in hearing, including the provision of hearing aids. While States may use prior authorization and other utilization controls to ensure that treatment services are medically necessary, these controls must be consistent with the preventive thrust of the EPSDT benefit. For example, States may not limit dental care to emergency services only, *Mitchell* v. *Johnston,* 701 F. 2d 337 (5th Cir. 1983).

The Committee bill also clarifies the periodic nature of EPSDT services. With respect to screening services, the bill requires that they be provided at intervals which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations. The Committee intends that these health examinations be provided at intervals that are no greater than those described for well-child care in the "Guidelines for Health Supervision" (1981) of the American Academy of Pediatrics. The Committee is informed that some States use periodicity schedules for medical examinations to govern the frequency with which children may receive dental examinations. The Committee intends that, among older children, dental examinations occur with greater frequency than is the case with physical examinations.

The Committee bill also requires States to provide screening services at intervals other than those identified in their basic periodicity schedule, when there are indications that it is medically necessary to determine whether a child has a physical or mental illness or condition that may require further assessment, diagnosis, or treatment. These interperiodic screening examinations may occur even in the case of children whose physical, mental, or developmental illnesses or conditions have already been diagnosed, if there are indications that the illness or condition may have become more severe or has changed sufficiently, so that further examination is medically necessary. The Committee emphasizes that the determination of whether an interperiodic screening is medically necessary may be made by a health, developmental, or educational professional who comes into contact with a child outside of the

health care system (e.g., State early intervention or special education programs, Head Start and day care programs, WIC and other nutritional assistance programs). As long as the child is referred to an EPSDT provider, the child would be entitled to an interperiodic health assessment (or dental, vision, or hearing assessment) or treatment services covered under the State plan.

These same considerations apply with respect to vision, dental, and hearing services, all of which must be provided when indicated as medically necessary to determine the existence of suspected illnesses or conditions. For example, assume that a child is screened at age 5 according to a State's periodicity schedule and is found to have no abnormalities. At age six, the child is referred to the school nurse by a teacher who suspects the child of having a vision problem. Under the Committee bill, the child can—and should—be referred at that point to a qualified provider of vision care for full diagnostic and treatment services, and the State must make payment for those services, even though the next regular vision exam under the State's periodicity schedule does not occur until age 7.

While States may, at their option, impose prior authorization requirements on treatment services, the Committee intends that, consistent with the preventive thrust of the EPSDT benefit, both the regular periodic screening services and the interperiodic screening services be provided without prior authorization.

The Committee notes that Medicaid-eligible children are entitled to EPSDT benefits even if they are enrolled in a health maintenance organization, prepaid health plan, or other managed care provider. The Committee expects that States will not contract with a managed care provider unless the provider demonstrates that it has the capacity (whether through its own employees or by contract) to deliver the full array of items and services contained in the EPSDT benefit. The Committee further expects that, in setting payment rates for managed care providers, the States will make available the resources necessary to conduct the required periodic and interperiodic screenings and to provide the required diagnostic and screening services.

The Committee bill clarifies that States are without authority to restrict the classes of qualified providers that may participate in the EPSDT program. Providers that meet the professional qualifications required under State law to provide an EPSDT screening, diagnostic, or treatment service must be permitted to participate in the program even if they deliver services in school settings, and even if they are qualified to deliver only one of the items or services in the EPSDT benefit.

(b) Report on the provision of EPSDT.—In order to assess the effectiveness of State EPSDT programs in reaching eligible children, the Committee bill would require the States to report annually to the Secretary, in a uniform form and manner established by the Secretary, the following information, broken down by age group and by basis of eligibility for Medicaid: (1) the number of children receiving child health screening services; (2) the number of children referred for corrective treatment (the need for which is disclosed by the screening); and (3) the number of children receiving dental services. These reports would be due April 1 of each year (beginning with April 1, 1991) and would apply to services provided

during the Federal fiscal year ending the previous September 30 (beginning with FY 1990).

Section 4214—Extension of payment provisions for medically necessary services in disproportionate share hospitals

(a) Coverage of medically necessary services for children.—Under current law, States may impose reasonable limits on the amount, duration, and scope of covered services. However, effective July 1, 1989, States are prohibited from imposing any fixed durational limit on Medicaid coverage of medically necessary inpatient hospital services provided to infants under age 1 by disproportionate share hospitals. As of January, 1989, according to the National Association of Childrens' Hospitals and Related Institutions, 12 States imposed durational limits on inpatient hospital services for children (Alabama, Alaska, Arkansas, Florida, Kentucky, Louisiana, Mississippi, Missouri, Oregon, Tennessee, Texas, and West Virginia).

The purpose of the current law exception to fixed durational limits is to prohibit States from using arbitrary length of stay limitations (e.g., 20 days per year) to reduce payments for medically necessary services provided by hospitals, including many public and childrens' hospitals, that serve a disproportionate number of low-income patients. The Committee bill would extend this current law prohibition to any fixed durational limits on payment for inpatient services provided to children under age 18 by disproportionate share hospitals. The requirement is effective for inpatient hospital services furnished on or after July 1, 1990.

(b) Assuring adequate payment for inpatient hospital services for children in disproportionate share hospitals.—Under current law, States may reimburse hospitals for inpatient services on a prospective basis. If they choose to do so, States must, effective July 1, 1989, provide for an outlier adjustment in payment amounts for medically necessary inpatient services provided by disproportionate share hospitals involving exceptionally high costs or exceptionally long lengths of stay for infants under 1 year of age. According to the National Association of Children's Hospitals and Related Institutions, as of January, 1989, a total of 44 States pay for inpatient hospital services on a prospective basis; only 17 of these do not make outlier adjustments for high cost or long-stay cases (Alabama, Alaska, California, Colorado, Connecticut, D.C., Florida, Kentucky, Mississippi, Missouri, Nevada, New Hampshire, New Mexico, Oklahoma, Tennessee, Texas, and Washington).

The Committee bill would extend this current law requirement to cases involving children from age 1 up to age 18. States that pay for inpatient hospital services on a prospective basis would be required to submit to the Secretary, no later than April 1, 1990, a State plan amendment that provides for an outlier adjustment in payment amounts for medically necessary inpatient services provided by disproportionate share hospitals after July 1, 1990, involving exceptionally high costs or exceptionally long lengths of stay for children age 1 up to age 18.

Section 4215—Requiring "Section 209(b)" States to provide medical assistance to disabled children receiving SSI benefits

Under current law, States have the option of requiring aged, blind, and disabled individuals receiving Supplemental Security Income benefits to meet eligibility criteria more restrictive than those under SSI in order to qualify for Medicaid. States that elect this "209(b)" option must use eligibility criteria that were in lawful and in effect in that State on January 1, 1972.

While many of these "209(b)" States use more restrictive financial eligibility criteria, the Committee understands that 4 of these States (Connecticut, Minnesota, Missouri, and New Hampshire) exclude from Medicaid coverage disabled children under 18 who receive SSI benefits, because the January, 1972, Aid to the Blind and Disabled Programs did not cover disabled children. Under existing precedent, disabled children may not be excluded from Medicaid coverage if they are also eligible for AFDC, *West* v. *Cole,* 390 F. Supp. 91 (N.D. Miss. 1975). However, in the case of a disabled child not categorically related to AFDC, a "209(b)" State may exclude such a child from Medicaid coverage because eligibility criteria that were in effect in January, 1972, did not recognize disabled children.

The Committee bill would require all "209(b)" States to provide Medicaid to any child under 18 who is receiving (or on whose behalf are being paid) SSI benefits. This will prohibit "209(b)" States from excluding disabled children receiving SSI from Medicaid coverage. This requirement would be effective on July 1, 1990, without regard to whether or not final implementing regulations have been promulgated.

Section 4216—Mandatory continuation of coverage for children otherwise qualified for benefits until redetermination

Under current law, there are several bases on which poor children may qualify for Medicaid. Most children eligible for Medicaid qualify as mandatory categorically needy because they are in families that receive AFDC benefits. Other children who meet the AFDC categorical requirements, but whose families have incomes and resources greater than the AFDC standards, may, by incurring medical expenses, qualify as medically needy. There are also various optional categorically needy groups, such as infants in families with incomes between 100 and 185 percent of the Federal poverty level, or children born after September 30, 1983, in families with incomes below 100 percent of poverty.

The Committee is concerned that the constant turnover in AFDC caseloads may result in the interruption of Medicaid coverage for children who are eligible based on their age and their family's poverty income. Courts have prohibited States from terminating eligibility for Medicaid on one basis without first redetermining an individual's continued eligibility on another basis. See, e.g., *Stenson* v. *Blum,* 476 F. Supp. 1331 (S.D.N.Y. 1979), aff'd, 628 F.2d 1345 (2d Cir. 1980), cert. denied, 449 U.S. 885 (1980); *MAOA* v. *Sharp,* 700 F.2d 749 (1st Cir. 1983).

In order to assure continuity in Medicaid coverage for eligible children, the Committee bill clarifies that States may not discontin-

ue Medicaid coverage to children under 18 until the State has determined that the child is not eligible for Medicaid on any basis. The Committee stresses that the determination as to whether a child is eligible on some other basis must take place before eligibility is terminated; States may not terminate eligibility and then require the child to reapply for benefits. For example, in a case where a child loses AFDC because of a change in income or resources, a State would be required, before terminating the child's Medicaid coverage, to determine whether the child is eligible for coverage on some other mandatory basis (e.g., the coverage group established under section 4211(a) of the Committee bill) or on an optional basis (e.g., if covered under the State plan, medically needy, financially needy, or poverty percentage children).

The Committee bill provides that, in determining erroneous payments for the purpose of "quality control," the Secretary may not include any expenditures attributable to children under 18 who are determined to be ineligible for Medicaid on the basis but whose Medicaid coverage has not been discontinued because a determination on other bases has not been made. The purpose of this provision is to protect the State from any "quality control" penalties for expenditures made on behalf of children under 18 during the period between the determination of ineligibility on one basis and the determination of eligibility or ineligibility on any other basis. The Committee emphasizes that even if a child proves to be ineligible for coverage on any other basis, Medicaid expenditures made on behalf of the child after the initial determination of ineligibility on one basis (but before the determination of ineligibility on any other basis) are not to be included in the calculation of a State's error rates for "quality control" purposes, and a State is not subject to a reduction in Federal matching payments as a result of such expenditures.

Section 4217—Medicaid coverage for foster children

Under current law, States are required to offer Medicaid to children receiving foster care maintenance payments under Title IV-E. In addition, States may also provide Medicaid to foster children under the "Ribicoff child" option, which allows States to extend Medicaid coverage to all children under 21 (or, at State option, under age 20, 19, or 18) whose families do not meet the AFDC categorical requirements but whose family incomes and resources are below State AFDC eligibility levels. Current Federal regulations allow States to limit coverage to reasonable classifications of these financially needy children, such as children in foster homes or private institutions for whom a public agency is assuming a full or partial financial responsibility.

In States electing to cover these financially needy foster children, there are children in foster care who cannot quality for Medicaid because they have small incomes (from a Social Security child's benefit or other sources) in excess of the AFDC eligibility level for a family of one. The Committee bill would allow States, at their option, to extend Medicaid coverage to children under 18 years of age (1) who reside in a foster home, group home, or private institution, (2) for whom a public agency assumes full or partial financial responsibility, and (3) whose income does not exceed 100 percent of

the Federal poverty level. In determining eligibility under this option, States would not be allowed to apply a resource test, and would be allowed to use a methodology for determining income that is less restrictive than the methodology under their Title IV-E programs.

PART C—COMMUNITY AND FACILITY HABILITATION SERVICES AMENDMENTS

Over the last twenty years, dramatic advances have been made in the field of caring for individuals with mental retardation or a related condition such as cerebral palsy or epilepsy. Since 1971, when the Federal government began paying for services to this population under Medicaid in institutions known as intermediate care facilities for the mentally retarded (ICFs/MR), changes in the philosophies of care and the technologies to implement them have led to a much wider range of long-term care options.

On September 30, 1988, the Subcommittee on Health and the Environment heard testimony regarding many people who had benefited from these advances, including the testimony of Sherilin Rowley of Utah, whose 9-year-old daughter has Down's Syndrome:

> My daughter Cydnee is now in an integrated classroom program in our neighborhood elementary school. This program allows her to participate in integrated programming through junior high and high school as well.
>
> As part of her program, she has been hired by a librarian to water plants, to dust books, sort magazines by their dates, and replace returned books to the shelf in alphabetical order. One project was to sort all the National Geographics by date for the past ten years. It didn't occur to the librarian that she might not be able to do it. She just expected her to do it, and she did.
>
> With the paycheck earned from this job, Cydnee can go out to lunch every Friday at the place of her choice as long as it is within her budget. Other skills connected with this job program are grocery shopping with a list and coupons, bus riding and street crossing.
>
> The ripple effect on this integrations that Cydnee is being invited to neighborhood birthday parties, to go ice skating with the entire school, and to go swimming at our neighborhood school. She also played on the community softball team this summer and also participated in other summer recreation programs.
>
> These wonderful effects are the result of mandates that Congress passed for the educating of infants, preschoolers and school-age students. How can we then as a Nation turn our backs on these students who have worked so hard to develop these skills that would allow them to become productive citizens?
>
> Medicaid, as the rules now exist, does not assist her in her continued normal development. They don't allow her to remain in her own home with her own friends in her own community. After having worked with the professionals developing the skills, she needs to live as independent

a life as possible. I find my only placement option if the Medicaid rules aren't changed is a State institution.

As illustrated by Ms. Rowley's testimony, States, with few exceptions, currently do not have the option of using Federal Medicaid funds to pay for health and health-related services to individuals with mental retardation or a related condition who are living in the community, either at home or in a non-institutional residential setting.

The major exception to the institutional ICF/MR benefit is the home and community-based services waiver under section 1915(c) of the Social Security Act. Under this authority, States may use Federal Medicaid funds to provide case management, personal care, habilitation, respite care, and other community-based services to individuals at risk of institutionalization. As of June 30, 1986, 33 States used this waiver authority to provide case management, personal care, habilitation, and respite care services to some 23,000 individuals with mental retardation or related conditions (Medicaid Source Book, p. 388).

In order to obtain a 1915(c) waiver, States must demonstrate to the Secretary that the average per capita expenditures for individuals participating in the waiver will not exceed the average per capita expenditures for those individuals in the absence of the waiver. As interpreted by the Secretary, this budget neutrality requirement has resulted in the imposition of caps on the number of individuals that can participate in a waiver. On September 30, 1988, the Subcommittee on Health and the Environment heard testimony from State Mental Retardation and Developmental Disabilities Agencies that the waiver authority, as administered by the Secretary, creates "powerful fiscal incentives" for the States "to limit waiver services to persons who are relatively expensive to serve in community settings rather than emphasizing low-cost services that are delivered to a wider segment of the potentially eligible service population."

The current benefits structure of the Medicaid program has lead to an institutional bias in spending. In fiscal year 1986, total Federal and State Medicaid spending on services was $41.0 billion; of this amount, $5.1 billion, or 12.4 percent, was spent on ICF/MR services. Total 1915(c) waiver expenditures that year for individuals with mental retardation and a related condition were $220.7 million, or one half of one percent of total Medicaid spending. That same year, State-only, non-Medicaid spending for these individuals was $2.8 billion, with most of this amount spent on community services.

The Committee bill has two major objectives. First, it would create parity between institutional and community services: Federal Medicaid matching funds would be available, at State option, for both services. As under current law, States would continue to have the option of using Federal Medicaid funds to purchase ICF/MR services for these individuals. In addition, the bill would establish a new optional Medicaid benefit, "community habilitation and supportive services," which States could elect to offer to individuals with mental retardation or a related condition in the community. Unlike the current 1915(c) waiver authority, States would not have

to demonstrate budget neutrality to the Secretary, restrict the number of otherwise eligible individuals receiving such services, or limit such services to individuals at risk of institutionalization.

The bill's second major objective is to improve the quality of services paid for by Medicaid, in institutions or community settings, so as to promote the independence, productivity, and integration of individuals with mental retardation or a related condition. With respect to the current ICF/MR benefit, the bill would revise and codify current regulatory requirements for participation in Medicaid, restructure the survey and certification process, and expand State and Federal remedies for enforcing compliance with these requirements.

There is cause for concern about quality in both institutional and community settings. According to the Congressional Research Service, "testimony presented at Congressional hearings in 1985 showed that, despite the upgrading of conditions resulting from ICF/MR standards, abuse and neglect continue to be serious problems at some institutions" (Medicaid Source Book, p. 384). The recent revision of Federal ICF/MR regulations is one attempt to prevent such quality problems and assure that clients are receiving continuous active treatment.

In January of 1989, the Los Angeles Times published the results of an investigation of community services to this population in California. The investigation found a widespread pattern of "lethal neglect, physical and sexual abuse, and financial exploitation" of individuals with mental retardation living in privately run community settings throughout the State:

> From May to July, 1987, residents of a Behavior Research Institute Home in Orinda, California were beaten by a staff member who had a criminal record of arrests for attempted murder and convictions for burglaries, according to a complaint by State Department of Social Services attorneys seeking a revocation of BRI's license.
>
> A woman with mental retardation gave birth to a baby while in the bathroom of the Lois L. Jones Family Home in South-Central Los Angeles in January, 1986. The infant was drowned and left outside in a trash can, according to police and coroners' reports. Licensing inspectors, seeking an emergency closure of the home, also said the memory of the proprietor was so impaired that she could not care for the residents.
>
> A 16-year-old autistic boy in the care of the Horizon House in Long Beach died Aug. 29, 1987, when staff members of the home allegedly delayed getting emergency treatment for the youngster after he began throwing up blood, according to state licensing reports.

(John Hurst, "Private Care for Retarded—A Gamble," Los Angeles Times, January 8, 1989)

From these articles, it is clear that State licensure programs can fail to protect the health and safety of clients, much less assure the provision of quality services. The Committee is adamant that Federal Medicaid dollars are not used to finance the kinds of conditions identified by the Los Angeles Times. The Committee bill would therefore require the Secretary to develop a set of interim minimum requirements concerning the health, safety and welfare

and individual rights of clients receiving the new "community habilitation and supportive services" benefit. These requirements would apply to both the providers of services and the resident settings in which clients receiving such services live. Federal matching funds would not be available for the new benefit until 30 days after the Secretary has issued these interim requirements.

Section 4221—Community habilitation and supportive services as an optional, statewide, service

Under current law, States are not eligible to receive Federal Medicaid matching funds for community-based services to individuals with mental retardation or a related condition, with a few limited exceptions. Under the section 1915(c) waiver authority, States may provide case management, personal care services, habilitation services, and respite care to individuals at risk of ICF/MR placement. States also have the option to offer case management services to particular groups in designated areas within the State. In addition, States have the option of providing personal care services as defined by the Secretary in regulation. Finally, some States have used certain optional service categories—clinic services and rehabilitation services—to offer day habilitation services to this population.

(a) Provision as optional, statewide service.—The Committee bill would allow States, at their option, to cover under their Medicaid programs a new benefit, "community habilitation and supportive services." This benefit would be available on a statewide basis to all Medicaid-eligible individuals with mental retardation or a related condition. Unlike the 1915(c) waiver, this benefit would not be limited to individuals who are at risk of institutionlization, or to individuals who have been discharged from a nursing facility or ICF/MR (redesignated as "habilitation facilities"). Of course, Medicaid-eligible individuals who receive this benefit would also be entitled to whatever medical benefits (e.g., physician, hospital, laboratory and x-ray, drug, etc.) the State offers generally under its Medicaid plan.

(b) Definition of community habilitation and supportive services.—These are services designed to assist individuals with mental retardation or a related condition (1) in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to function successfully in a home or community-based setting, and (2) in participating in community or other activities. The State must provide certain "core" services: case management, respite care, and personal attendant care services. The State may also offer prevocational, education, supported employment, day habilitation and related services, transportation, assistive technologies or devices, and other supportive services.

With respect to the case management services, the Committee bill specifies that they be delivered by entities independent of the providers of other community services to individuals with mental retardation or a related condition. The Committee anticipates that case managers, whether agencies or individuals, will play an important role in assuring the quality of the services received by clients. To assure the effectiveness of the case managers, the Committee bill requires that case management services be provided by en-

tities that (1) do not provide community habilitation and supportive services other than case management, and (2) do not have a direct or indirect ownership or control interest in, or a direct or indirect affiliation or relationship with, a provider of other community habilitation and supportive services. An exception is made for such public entities as State agencies. The Committee bill would not authorize case managers, whether public or private, to select the providers from which a client will receive services.

Federal matching funds are not available for (1) special education and related services otherwise available to the individual through a local education agency, (2) vocational rehabilitation services which otherwise are available to the individual, (3) room and board, and (4) payments made, directly or indirectly, to members of the family of the individual receiving community habilitation and supportive services. For this purpose, room and board is defined as non-personnel costs directly attributable to the purchase of food on behalf of clients, the cost of property, the purchase of household supplies not otherwise used in the provision of covered services, utility expenses, and the costs of facility maintenance, upkeep, and improvement (other than the costs of modifications or adaptations required to assure health and safety of residents or compliance with applicable life safety codes).

(c) Individual with mental retardation or a related condition defined.—Under current law, States have the option of offering ICF/MR services to "the mentally retarded or persons with related conditions." The Secretary has, by regulation, 42 C.F.R. 435.1009, defined "persons with related conditions" as individuals who have a severe, chronic disability that (1) is attributable to cerebral palsy or epilepsy, or to any other condition (other than mental illness) found to be closely related to mental retardation, (2) is manifested before the individual reaches age 22, (3) is likely to continue indefinitely, and (4) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.

Under the Committee bill, individuals eligible for community habilitation and supportive services are individuals who (1) meet the State's Medicaid income and resource eligibility standards and (2) meet the categorical requirement that they are individuals with mental retardation or a related condition. The bill's definition of an individual with a related condition is identical to the Secretary's current regulatory definition of "persons with related conditions." Thus, the category of individuals eligible for community habilitation and supportive services under the Committee bill is identical to the category of individuals eligible under current law for ICF/MR services. However, the bill does not require, and the Committee does not intend, that individuals be at risk of institutional care in order to qualify for community habilitation or supportive services. In general, then, in a State which offers this benefit, individuals with mental retardation or a related condition would be eligible (1) if they are receiving cash assistance under the Supplemental Security Income (SSI) program (except in a "209(b)" State which applies more restrictive income or resource standards), (2) if they qualify as a working, severely impaired individual under 1905(q) of

the Social Security Act, or (3) if they "spend down" into eligibility as a "medically needy" individual in States electing to cover that group.

The Committee recognizes that the bill's definition of "individual with mental retardation or a related condition" does not reach all individuals with developmental disabilities. The Committee also recognizes that the Medicaid income and resource standards under this bill for individuals in the community are (as under current law) more restrictive than those for individuals in an institution; to this extent, the Medicaid program's institutional bias is likely to persist. The only exception is the eligibility policy under the 1915(c) home and community-based services waivers. Current law (and the Committee bill) allows States to use the same special institutional income standard (up to 300 percent of the Supplemental Security Income benefit rate) for their waiver clien as they use (at their option) for their institutional population. Budgetary constraints precluded the Committee from addressing these eligibility issues.

(d) Maintenance of effort.—Under the Committee bill, if a State wishes to offer community habilitation and supportive services under its Medicaid program, it must report to the Secretary, in a format developed or approved by the Secretary, the amount of non-Federal funds obligated by the State (and its localities) for the provision of community habilitation and supportive services for individuals with mental retardation or a related condition during Federal fiscal year 1989. State (or local) expenditures for home and community-based services under a waiver under section 1915(c) of the Social Security Act need not be required. The Committee bill would not authorize the Secretary to require States to report State (or local) expenditures for (1) services to individuals with mental illness who are not individuals with mental retardation or a related condition, (2) vocational rehabilitation or special education services that are excluded from coverage as community habilitation and supportive services, and (3) maternal and child health services that are not community habilitation and supportive services.

The Committee stresses that a State which does not choose to offer this benefit is not required to file such a report. Nor does a State have to file a report at the close of FY 89 in order to keep open its option to cover these services. If a State did not elect to offer this benefit until, say FY 1992, it would not have to file its report regarding expenditures during FY 1989 until the beginning of the quarter in which the benefit was first offered.

In determining the amount of Federal Medicaid matching funds to be paid to a State for community habilitation and supportive services, the Secretary must reduce the total amount expended by a State (and its localities) for such services (other than under a 1915(c) waiver) by the amount of expenditures reported by the State (for itself and its localities) for FY 1989.

The purpose of this requirement is to prevent States from using the option established by the Committee bill to replace State (or local) dollars now being spent on community services for this population with Federal Medicaid dollars. In a discussion of this matter at a hearing before the Subcommittee on Health and the Environment on June 8, 1989, a letter dated June 5, 1989, from the California Department of Developmental Services was introduced into the

record. In arguing that the cost estimates provided by the Congressional Budget Office were "unrealistically low," the letter stated: "California currently spends about $500 million each year from the state's General Fund for programs which we believe meet H.R. 854's definition of 'community habilitation services.' If California opted to include these services in its Medicaid State Plan, we project that the state could receive nearly $130 million in additional Medicaid reimbursements each year."

The maintenance of effort requirement in the Committee bill would prevent such refinancing. Assume that a State (and its localities) spent $500 million on community habilitation and supportive services for individuals with mental retardation or related condition in FY 1989 (excluding the amount it spent under a home and community-based services waiver for this population), and that the State in FY 1991 elected to offer these services under the option established by the Committee bill. In determining the amount of Federal Medicaid matching funds available to the State in connection with its FY 1991 expenditures, the Secretary would first deduct $500 million from the total amount spent by the State (and its localities) on such services for this population in that year (excluding expenditures under a waiver), and would then apply the State's matching rate to any excess. Thus, if the State (and its localities) spent a total of $510 million in FY 1991, and the State's matching rate was 50 percent, the State would receive $5 million in Federal Medicaid matching funds.

(f) Effective date.—The Committee bill would be effective on the later of (1) July 1, 1990, or (2) 30 days after the date on which the Secretary publishes interim regulations to protect the health, safety, and welfare of clients receiving community habilitation and supportive services. The requirements in the Committee bill would not apply to habilitation services furnished under a section 1915(c) home and community-based services waiver in effect before July 1, 1990, until the date the next renewal of such a waiver takes effect.

(g) No abrogation of freedom of choice.—The Committee bill specifies that this section shall not be construed by State or Federal agencies, or by the courts, to abrogate the right of Medicaid-eligible clients to freedom of choice with respect to the providers from whom they can receive covered services. Thus, if a State elects to offer both habilitation facility services and cummunity habilitation and supportive services, then Medicaid-eligible individuals with mental retardation or a related condition who require the level of services in a habilitation facility would have the right to receive services in such a facility even if placement in a community setting would also be appropriate. The Committee intends that the choice be that of the client, not the State.

Similarly, the Committee bill does not authorize a State to restrict a client's choice of provider of community habilitation and supportive services. As under current law, clients would have the right to select from among the qualified providers who elect to participate in the Medicaid program. Although case management is a required element of any community habilitation and supportive services offered by a State, the case managers would not have any authority to designate providers for a client. In the view of the Committee, freedom of choice of provider is fundamental to the

goal of independence, through which clients exercise control and choice over their own lives.

Section 4222—Quality assurance for community habilitation and supportive services

Under current law, States providing home and community-based services covered under a 1915(c) waiver are required to provide assurances to the Secretary that necessary safeguards are in place to protect the health and welfare of beneficiaries. Failure to comply may result in termination of the waiver.

The Committee bill contains a number of provisions that together are designed to assure the quality of community habilitation and supportive services. These services must be provided in a manner consistent with the objectives of expanding opportunities for independence, productivity, and integration into the community. They must be provided in accordance with an individual habilitation plan which is based on a comprehensive functional assessment. The Secretary is directed to develop minimum requirements to protect the health, welfare and safety of clients; these requirements would apply with respect to both the providers of community services and the residential settings where those services are provided. Procedures for monitoring and enforcing these minimum requirements would be established. In addition, States would be required to develop their own programs and standards for assuring the quality of these community services.

(b) Independence, productivity, and integration.—Under the Committee bill, the objectives of community habilitation and supportive services are to expand opportunities for independence, productivity and integration into the community. For this purpose, "independence" means the extent to which individuals with mental retardation or a related condition exert control and choice over their own lives. "Productivity" means engagement by such an individual in income-producing work or work that contributes to a household or community. "Integration into the community" means the use of common facilities, participation in activities, and regulular contact with residents (who are not individuals with mental retardation or a related condition) of the community where such individuals reside.

The Committee notes that these principles of independence, productivity integration into the community are basic goals for all habilitation services, whether offered in the community or in institutions. The Committee bill, in section 4231, incorporates these same objectives into the quality of life requirement for habilitation facilities.

The quality assurance provisions in the Committee bill apply with respect to community habilitation and supportive services provided under 1915(c) waivers, with the following exception. Waivers that were in effect before July 1, 1990, are exempt from these provisions until the later of (1) the date the next renewal of such a waiver takes effect, or (2) the end of the 30-day period after which the Secretary issues the interim requirements for minimum protections.

Under current law, Arizona is providing community-based services to individuals with mental retardation or a related condition

under a section 1115 waiver. The Committee bill provides that, effective July 1, 1990, the quality assurance provisions applicable to community habilitation and supportive services apply to Arizona under its section 1115 waiver program in the same manner as they apply to States that elect to cover these services.

(c) Individual habilitation plans.—Community habilitation and supportive services must be designed and provided according to an individual habilitation plan (IHP), which specifies objectives to meet the client's needs, as identified in the comprehensive functional assessment. The IHP must also include a description of the client's medical care service needs, as identified by the client's physician. The IHP must be prepared by an appropriate interdisciplinary team and be periodically reviewed by this team after each comprehensive functional assessment (or periodic review of such assessment). In developing the IHP, the team must notify, provide for, and encourage the participation of the client, the client's parents (if the client is a minor), the client's legal guardian (if any), and the client's case manager. A parent of an adult client may not participate in developing the IHP if the client objects to that participation.

It is the Committee's belief that a carefully developed IHP will assure proper attention to each person's unique strengths, needs, and circumstances, which will in turn promote quality services. The Committee notes that, if an IHP identifies services community habilitation and supportive services needed by the client, and if those services are covered under the State's Medicaid plan, then the client is entitled to have payment made for those services. However, if the State Medicaid plan does not cover certain community habilitation and supportive services (e.g., transportation services), the client is not entitled to have payment made for those services.

(d) Comprehensive functional assessment.—A comprehensive functional assessment must be prepared before the provision of community habilitation and supportive services to a client. The assessment must identify each client's developmental and behavioral abilities and management needs. The assessment must be conducted and periodically reviewed (at least annually) by an interdisciplinary team. In the case of a client with a seizure disorder, a professional with expertise in the diagnosis and treatment of such disorders must classify the disorder according to the most recent version of the International Classification of Epileptic Seizures. This professional need not necessarily be a member of the interdisciplinary team.

(e) Minimum requirements for services.—Community habilitation and supportive services must meet minimum Federal requirements for the protection of health, safety, and welfare. These include: (1) minimum qualifications for personnel providing services; (2) guidelines for minimum compensation to assure the availability and continuity of qualified personnel to provide services to clients with various levels of impairment; and (3) requirements that providers protect and promote specified clients' rights.

The specified rights include: the right to be free from abuse or restraints (including involuntary seclusion); the right to privacy; the right to confidentiality of records; the right to be treated with

dignity; the right to voice grievances without fear of reprisal; the right to choose the provider of community habilitation and supportive services; and any other right established by the Secretary.

In addition, the Committee bill provides that psychopharmacologic drugs may be administered only (1) on the orders of a physician, (2) as an integral part of a plan (included in the IHP) designed to eliminate or modify the symptoms or behaviors for which the drugs are prescribed, and (3) if, at least annually, an independent, external, trained consultant reviews the appropriateness of the client's drug plan. It is the intent of the Committee that psychopharmacologic drugs not be used in a manner that is inappropriate to the needs of the client or to manage clients for the convenience of providers.

With respect to the right to freedom from involuntary seclusion, the Committee bill does not prohibit the use of "time-out" rooms for less than one hour, subject to review by the interdisciplinary team to ensure the use of the least restrictive and most positive behavior management intervention, and to ensure consistency with the IHP. The Committee recognizes that there is disagreement in the field of mental retardation on the use of this approach, and stresses that it does not endorse the use of "time out" rooms as a standard practice.

(f) Minimum requirements for residential settings.—The Committee bill establishes minimum requirements for residential settings in which one or more community habilitation or supportive services are provided, even though these residential settings are not themselves providers of services. (Residential settings that deliver and receive payment for services are subject to the minimum requirements applicable to providers). The purpose of these minimum requirements is to protect the heath, safety, and welfare of clients receiving community habilitation and supportive services who reside in such group homes, board and care facilities, and other residential settings. For this purpose, a residential setting does not include a setting, such as a client's home, in which fewer than 3 unrelated adults reside.

Under the Committee bill, residential settings must: (1) meet the requirements relating to clients' rights, and administration and other matters, as they apply to habilitation facilities under section 4231, and (2) meet the requirements of the Life Safety Code of the National Fire Protection Association that are applicable and appropriate to the setting, subject to waiver by the Secretary under certain specified circumstances.

In addition, residential settings must disclose persons with ownership or control interests. Individuals may not have an ownership or control interest in a residential facility if they have been excluded from the Medicaid program, or if they have had an ownership or control interest in one or more residential settings that have been found to have repeatedly provided care of substandard quality.

The Committee recognizes that, under this bill, the requirements for residential settings are not as stringent as for habilitation facilities. For example, habilitation facilities are required to provide continuous active treatment; residential settings are not. These differences in regulatory requirements may create an incentive for

ICFs/MR to voluntarily decertify and convert to residential settings. The Committee intends to protect clients in facilities undergoing such conversions from the loss of needed active treatment. The Committee bill provides that, if part or all of a facility converts from a habilitation facility to a residential setting, the facility must continue to provide, or arrange for the provision of, continuous active treatment, to each client who was a resident at the time of conversion and who required active treatment at that time. The requirement applies so long as the client continues to reside in the setting and continues to require active treatment.

Finally, residential settings must document the medical care services received by a client in the client's clinical records. The setting is not itself required to provide or arrange for the provision of these services.

(g) State quality assurance program for services.—Each State that elects to cover community habilitation and supportive services must establish and implement a program for assuring the quality of these services, and for protecting and promoting the rights of clients receiving these services. This quality assurance program must be consistent with the objective of independence, productivity, and integration into the community.

A State quality assurance program must include the following elements, in a manner specified by the State:

(1) A State agency responsible for implementing the program.

(2) Publication of standards relating to the quality of services and to client's rights, consistent with the objectives of independence, productivity and integration into the community.

(3) A system of periodic monitoring (through onsite, unannounced reviews) of compliance with standards, of investigation of complaints, and of public disclosure of the results of such monitoring and investigations. In the view of the Committee, any effective quality assurance program should include an annual assessment of client satisfaction with community habilitation and supportive services, and regular public participation in the quality monitoring process.

(4) A system of enforcement of standards, including specified remedies.

(5) Public participation in the development of the quality assurance program. The Committee expects that States will go beyond formal public hearings and comment periods to consult with and involve clients, parents, guardians, advocates and other interested citizens at every stage of development, implementation, and review of quality assurance programs.

(6) Programs to educate providers, clients, parents, and legal guardians abut the quality assurance program. The Committee intends that these education programs include training and continuing education of direct service staff in residential settings, and education and training programs for client, parent and advocate involvement in quality assurance programs.

A State's quality assurance program may also include incentives to reward providers of community habilitation and supportive services that deliver the highest quality care to clients under this title. These incentives may include public recognition or incentive payments, or both.

Under the Committee bill, the Secretary has no authority to review or approve a State quality assurance program if the program, on its face, meets the stated requirements of this subsection. No Federal matching funds are available with respect to any expenditures, including any quality assurance incentives, made by a State in establishing or carrying out its quality assurance program.

(h) Survey and certification.—The Committee bill requires States to establish and implement a survey and certification process that the Committee intends will assure compliance by providers and residential settings with the minimum requirements to protect to the health, safety, welfare and individual rights of clients receiving community habiliation and supportive services. Under this process, the State would be responsible for certifying, at least annually, the compliance of providers of community habilitation and supportive services, and of residential settings in which such services are provided, with the minimum requirements. In the case of providers or residential settings operated by the State, the Secretary would have this certification responsibility.

The Committee bill provides for two certification methods. In the case of providers (other than residential settings that are providers), certification would be based on performance reviews rather than on-site surveys. In the case of residential settings (whether they are providers or settings in which services are provided), an unannounced on-site survey would have to be conducted at least once every 12 months. Surveys must be conducted on the basis of a protocol developed by the Secretary. To assure the adequacy of State surveys, the Secretary would be required to conduct "look behind" surveys in a sample of settings in each State using the same protocols. Results of the surveys would be available to the public, State Protection and Advocacy Agencies, and State Medicaid Fraud Control Units.

In addition to their survey responsibilities, States would be required, through their survey agencies, to investigate allegations of client neglect and abuse by facility staff. Both the States and the Secretary would be required to maintain adequate staff to investigate complaints of violations of requirements by providers or residential settings. Where the Secretary has reason to question the compliance of a provider or setting, the Committee bill authorizes the Secretary to make an independent survey or review.

The Committee notes that these survey and certification requirements would apply to any State that offers community habilitation and supportive services, whether under the option established by the bill, or under a 1915(c) waiver that is subject to the requirements of the bill.

(i) Enforcement process.—The Committee bill provides for a range of remedies for use by the States and the Secretary to enforce compliance with the minimum requirements. States would be required to establish the following remedies for noncompliance with the requirements by residential settings: (1) denial of payment for new clients; (2) civil money penalties; (3) appointment of temporary management; and (4) emergency authority to close a setting or transfer clients. With respect to providers of services that are not residential settings, civil money penalties would apply. The Secretary would be given independent authority to impose civil money

penalties or, in the case of residential settings, to appoint temporary management. The Committee expects that, as under current law, the Secretary's civil money penalty authority under this bill will be exercised by the Inspector General.

Where noncompliance immediately jeopardizes client health and safety, both the State and the Secretary would be required to take immediate action to remove the jeopardy and to correct the deficiencies through the appointment of temporary management, or to terminate Medicaid participation by the provider or residential setting. Where noncompliance does not immediately jeopardize client health or safety, both the State and the Secretary could apply any of the remedies available to them; however, in any case in which the Secretary did not impose a civil money penalty, the State would be required to impose civil money penalties for each day of noncompliance.

To assure prompt compliance with the minimum requirements, the Committee bill requires States, in the case of a residential setting that has been out of compliance with any of the requirements for 3 months, to deny payment with respect to any clients admitted to the setting after notice to the public.

The costs incurred by States in implementing these remedies, including the costs of temporary management, are subject to Federal matching payments as necessary for the proper administration of the State plan.

The Committee notes that, in establishing minimum "requirements" for providers and for residential settings, the bill does not use the regulatory framework of "conditions" and "standards" that currently applies to ICF/MR services. (Section 4231-4233 of the Committee bill would modify the current law "conditions"/"standards" approach). It is the specific intent of the Committee that, with respect to the provision of community habilitation and supportive services, and residential settings in which such services are provided, the Secretary assure compliance with each element of each minimum "requirement." The Secretary has no authority to redefine these "requirements" as "conditions" or "standards," or as "level A" and "level B" requirements.

(j) Secretarial responsibilities.—The Committee bill directs the Secretary of HHS to publish, by July 1, 1990, as interim regulation that implements the minimum protections for the health, safety, and welfare of clients receiving community habilitation and supportive services. Under the bill, Federal Medicaid payments are not available for these services until 30 days after the publication of these interim regulations. The Committee expects that the Secretary will make every effort to issue these interim regulations by July 1, 1990. To expedite the issuance of these regulations, the Committee bill has not imposed any formal notice or public comment requirements on the Secretary (although the Committee expects that the Secretary will consult with affected parties in the development of these regulations), and has waived the application of requirements under the Paperwork Reduction Act or Executive Order 12291.

These interim regulations must set forth the minimum requirements applicable to providers and residential settings, protocols for surveys of residential settings. The Committee expects the Secre-

tary, in developing survey protocols, to take into account the diversity of residential settings in which community habilitation and supportive services may be provided, and to devise protocols appropriate to this diversity. These interim regulations must also include the following minimum protections, which must be achieved through methods other than reliance on State licensure processes.

In order to avoid a repetition of the problems identified by the January 1989 Los Angeles Times investigation, these minimum protections must assure that (a) individuals receiving such services are protected from neglect, physical and sexual abuse, and financial exploitation; (b) providers and residential settings do not employ, contract with, or otherwise use individuals who have been convicted of child or client abuse, neglect, or mistreatment, or of a felony involving physical harm to an individual, and take all reasonable steps to determine whether applicants for employment have histories indicating involvement in such activities; (c) individuals or entities providing such services are not unjustly enriched as a result of abusive financial arrangements (such as owner leasebacks); and (d) individuals or entities delivering such services to clients, or relatives of such individuals, are not named as beneficiaries of life insurance policies purchased by (or on behalf of) clients.

The Committee bill makes clear that the Secretary is not authorized to develop standards relating to the quality of community habilitation and supportive services beyond the scope of the minimum requirements for the protection of the health, safety, and welfare of clients.

The Secretary may not delegate the responsibility for developing interim or final regulations or minimum requirements or protections, to the States.

The Secretary shall also make available to States, providers, clients and their representatives, technical assistance with respect to the assuring the quality of community habilitation and supportive services, including the development and operation of State quality assurance programs.

By no later than October 1, 1990, the Secretary must provide for the approval of training programs for State and Federal surveyors in conducting surveys for certifying residential settings where community habilitation and supportive services are provided with respect to the minimum Federal standards for health, safety, welfare and individual rights.

The Committee bill requires that, no later than October 1, 1991, the Secretary issue final regulations implementing the minimum requirements to protect the health, safety, and welfare of clients. No Federal Medicaid matching payments may be made after October 1, 1991, for community habilitation and supportive services if the services, or the residential setting in which such services are provided, do not meet the minimum requirements.

Section 4223—Eliminating prior institutionalization requirement under current waiver authority

Under the current 1915(c) home and community-based services waiver, States may, on a budget-neutral basis, provide habilitation services to individuals with mental retardation or a related condi-

tion in designated areas within the State, but only if those individuals have been discharged from a nursing facility or ICF/MR. Effective for waivers approved or renewed on or after enactment, the Committee bill would delete the requirement that waiver beneficiaries must have been discharged from an institution in order to receive habilitation services.

Section 4224—Annual report and evaluation of outcome-oriented instruments and methods

(a) Annual report.—The Secretary would be required to report to the Congress annually on the extent of compliance with the minimum Federal requirements for community habilitation and supportive services, as well as the number and type of enforcement actions taken by States and the Secretary.

(b) Evaluation of outcome-oriented instruments and methods.—The Secretary is required to study the effectiveness of existing outcome-oriented instruments and methods used to evaluate and assure the quality of community habilitation and supportive services, and report to the Congress, by no later than January 1, 1992, recommendations on the use of such instruments and methods (or the development of other instruments and methods).

Subpart 2—Quality assurance for habilitation facility services

Under current law, States have the option of offering services in an intermediate care facility for the mentally retarded (ICF/MR) to Medicaid-eligible persons with mental retardation or related conditions. ICFs/MR are institutions (or distinct parts) which provide health or rehabilitative services, including "active treatment," to individuals with mental retardation or a related condition, and which meet standards prescribed by the Secretary. These standards, or conditions of participation, were recently revised for the first time since 1974 (53 Fed. Reg. 20448, June 3, 1988).

States are responsible for surveying and certifying compliance by ICFs/MR, whether private or State-operated, with the Federal conditions of participation. The Secretary has the authority to validate State survey findings through Federal "look behind" surveys. In the event that a survey finds noncompliance by an ICF/MR with the conditions of participation, only certain remedies are available to the Secretary. If the deficiencies pose an immediate threat to the health and safety of clients, the remedy is termination of all Medicaid payments to the facility. If the deficiencies do not pose an immediate threat to client health and safety, the Secretary may (1) allow the State to implement a correction plan under which all staffing and plant deficiencies are corrected within 6 months while the facility continues to receive Federal Medicaid matching funds; (2) allow the State to implement a reduction plan under which a facility permanently reduces the number of certified beds over a 3-year period while continuing to receive Federal Medicaid matching funds; or (3) terminate the facility's participation in the program.

Currently, 49 States cover ICF/MR services. As of June, 1986, States made Medicaid payments on behalf of 144,000 individuals with mental retardation or a related condition residing in more than 3,400 public and private ICFs/MR. These facilities ranged in size from 4 to 1,300 beds, with the State-operated facilities averag-

ing 327 beds and the private facilities averaging 62 beds. In 1986, Federal and State Medicaid spending on ICF/MR services totalled $5.2 billion, an average of $36,100 per person. Medicaid Source Book at 380, 401.

The Committee bill would retain the current ICF/MR benefit as a State option, renaming ICFs/MR as habilitation facilities. In order to assure the quality and appropriateness of facility services purchased with Federal Medicaid dollars, and to assure that clients in facilities (many of whom are medically fragile individuals with servere or profound retardation) are protected from abuse or neglect, the Committee bill would make a number of changes, which would generally be effective January 1, 1991.

First, the Committee bill would set forth, in statute, the requirements which habilitation facilities must meet in order to participate in the Medicaid program. Second, it would revise the current survey and certification system. Third, it would revise the current correction and reduction plan authorities and establish other intermediate sanctions for both the Secretary and the States. Fourth, it would replace the current utilization review procedures with a preadmission screening and annual review mechanism. Fifth, it would revise and clarify current rules for paying for facility services. Finally, it would require States to make fair and equitable arrangements to protect the interests of employees affected by the closure or reduction of habilitation facilities.

Section 4231—Requirement for habilitation facilities

(a) Specification of facility requirements.—Under the Committee bill, facilities currently described as intermediate care facilities for the mentally retarded (ICFs/MR) would be renamed "habilitation facilities." In order to qualify for Medicaid reimbursement, habilitation facilities would have to be engaged primarily in providing health or habilitation services to individuals with mental retardation or a related conditions, and would have to meet requirements relating to the provision of services, clients' rights, and administration and other matters. These requirements would also apply in States like Arizona, which operate their Medicaid programs under a section 1115 waiver. As under current law, payment would not be made to facilities that are primarily for the care and treatment of mental diseases.

(b) Provision of services.—An habilitation facility would be required to (1) maintain and enhance the quality of life, independence, productivity, and integration into the community of each client; (2) conduct a comprehensive functional assessment of each client promptly upon admission and review this assessment at least annually; (3) provide each client with continuous active treatment in accordance with an individual program plan (IPP) that is based on the functional assessment, and (4) provide professional program services needed to implement the active treatment plan defined in each client's IPP.

The Committee bill retains the current law requirement that habilitation facilities provide continuous active treatment to each client in accordance with an IPP. The continuous active treatment must be coordinated and monitored by a qualified mental retardation professional. Active treatment is defined as services directed

towards (1) the acquisition of behaviors and skills necessary for the client to function with as much self-determination, independence, productivity, and integration into the community as possible, and (2) the prevention or deceleration of regression or loss of current optimal functional status. Active treatment includes aggressive, consistent implementation of a program of specialized and generic training, treatment, and health services. It does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.

States have expressed concern about the scope and interpretation of the requirement of continuous active treatment. In the view of the Committee, continuous active treatment should not be construed to require active programming for every client during every waking moment. On the other hand, the Committee does not intend that Federal Medicaid funds be used to subsidize facilities that do not aggressively and consistently implement a program of training, treatment, and health services for their clients. To assure that State and private habilitation facilities know what is expected of them in this regard, the Committee bill requires the Secretary to establish, by not later than January 1, 1991, an operational definition of continuous active treatment that (1) promotes a consistent assessment by State and Federal surveyors of whether a facility is in compliance and (2) clarifies the manner in which a program of interventions and services is considered to be continuous. This operational definition need not be issued as a regulation; however, the Committee expects that the Secretary, in developing this definition, will consult closely with State officials, clients, parents, facilites, direct care staff, advocates, and other interested parties.

In addition to active treatment, habilitation facilities are responsible for the provision of a broad range of health care services to clients. As under current law, the Committee bill would require habilitation facilities to provide (or arrange for the provision of), through qualified personnel, the following health services: physician services, annual physical examinations, licensed nursing services, comprehensive dental diagnostic and treatment services, routine and emergency drugs and biologicals, and food and nutrition services that assure that each client receives at least 3 meals daily which meet the client's nutritional and special dietary needs. Medical, dental, and other services provided (or arranged by) an habilitation facility must meet professional standards of quality. All health care must be provided under the supervision of a physician.

With respect to staffing, the Committee bill requires the habilitation facilities employ (or arrange for the provision of) sufficient direct care staff to meet the needs of clients at the facility. Facilities may not use a client or volunteers to meet this direct care staff requirement. While the Committee bill would not quantify what a "sufficient" number of direct care staff would be in any given facility, the Secretary would have the authority to do so, and the Committee does not intend to preclude in any way the kinds of staffing requirements that the Secretary has promulgated at 42 C.F.R. section 483.430(c)–(d).

To prevent abuse of clients, the Committee bill would prohibit facilities from using individuals (in the capacity of direct care staff or

otherwise) who have been convicted of child or client abuse, neglect, or mistreatment, or of a felony involving physical harm to an individual. The facility would be required to take all reasonable steps to determine whether applicants for any position at the facility have histories indicating involvement in child or client abuse, neglect, or mistreatment, or have a criminal record involving physical harm to an individual. If an applicant has such a history, the facility could not employ, contract with, or otherwise use the applicant.

The Committee bill provides that psychopharmacologic drugs may be administered only (1) on the orders of a physician, (2) as an integral part of a plan (included in the client's IPP) designed to eliminate or modify the symptoms or behaviors for which the drugs are prescribed, and (3) if, at least annually, an independent, external, trained consultant reviews the appropriateness of the drug plan of each client receiving such drugs. The intent of the Committee is the same with respect to habilitation facilities as it is in the context of community habilitation and supportive services: psychopharmacologic drugs must not be used in a manner that is inappropriate to the needs of the client or to manage clients for the convenience of facility staff.

(c) Clients rights.—Habilitation facilities would be required to protect and promote certain specified rights of each client, including the (1) right to be free from abuse, (2) the right to be free from restraints, (3) the right to privacy, (4) the right to confidentiality of records, (5) the right to accommodation of needs, (6) the right to be treated with dignity, (7) the right to voice grievances without the threat of reprisal, (8) the right to participation in client and family groups and other activities, (9) the right to examine survey results, (10) the right to choose a qualified mental retardation professional or case manager, (11) the right not to be compelled to perform services for the facility, and (12) any other right established by the Secretary. Facilities are required to inform each client, parent (if the client is a minor), or legal guardian, orally and in writing at the time of admission, of the client's legal rights.

The Committee bill identifies the circumstances under which habilitation facilities may involuntarily transfer or discharge a client. A facility must permit each client to remain in the facility and must not transfer or discharge that client unless (1) the transfer or discharge is necessary to meet the client's welfare and the client's welfare can not be met in the facility; (2) the transfer or discharge is appropriate because the client no longer requires continuous active treatment; (3) the safety of individuals in the facility is endangered; (4) the health of individuals in the facility would otherwise be endangered; or (5) the facility ceases to operate, or the transfer or discharge is pursuant to a court order or under a reduction plan approved by the Secretary.

With respect to any transfer or discharge, the Committee bill would require an habilitation facility to provide (1) a final summary of client's status and skills at the time of discharge, (2) recommendations relating to those service needs in the client's new living environment, and (3) sufficient preparation and orientation for the client to ensure safe and orderly transfer from the facility.

While the Committee does not believe that clients who no longer require continuous active treatment should remain, at Medicaid expense, in an habilitation facility, the Committee will not tolerate precipitous, poorly managed transfers or discharges that jeopardize fragile clients. The Committee bill would prohibit habilitation facilities from transferring or discharging clients on the basis of the client's welfare (ground (1)) or the lack of need for active treatment (ground (2)) unless the client's new living environment has been identified and the service needs recommended by the facility in the client's new living environment will be met. The Committee bill would prohibit facilities from transferring or discharging clients on the basis of danger to the safety (ground (3)) or health (ground (4)) of clients or staff in the facility unless adequate arrangements have been made for an alternative placement.

In the Committee's view, one of the essential elements of a quality assurance system in institutional settings is ready access to clients. The Committee bill would require habilitation facilities to permit access to clients by the client's immediate family or other relatives, the client's personal physician or qualified mental retardation professional, and representatives of the Secretary and the State. The Committee bill would also specify the circumstances under which State protection and advocacy agencies would have access to clients or client records for the purpose of carrying out their responsibility to protect the legal and human rights of persons with developmental disabilities.

Under the Committee bill, habilitation facilities would be required to establish and maintain identical policies and practices regarding (1) admission, transfer, and discharge, and (2) the provision of services covered under the State Medicaid plan, to all individuals regardless of source of payment. The purpose of this requirement is to prohibit facilities from discriminating against Medicaid beneficiaries by giving preference in admission or in the provision of services to private pay patients.

In order to protect clients and their families from financial exploitation, the Committee bill would prohibit the following admissions practices: (1) requiring individuals to waive their rights to Medicaid coverage; (2) requiring a third party guarantee of payment as a condition of admission or continued stay; or (3) requesting any payments from an individual, his family, or others, as a condition of admission or continued stay in the facility. In addition, the Committee bill would require facilities, upon written authorization by the client, to manage and account for the client's personal funds.

Administration and Other Matters.—Under the Committee bill, habilitation facilities would be required to meet criteria developed by the Secretary with respect to governing body and management, disaster preparedness, laboratory and radiological services, clinical records, and client and advocate participation. Facilities would have to be licensed under applicable State or local law, meet applicable Life Safety Code standards, maintain an infection control program, and comply with all applicable Federal, State, and local laws and regulations and with accepted professional standards and principles. In addition, habilitation facilities would have to meet other requirements relating to the health and safety of clients and

the physical plant of facilities as the Secretary may prescribe. Life Safety Code standards would not apply to habilitation facilities in the following two circumstances: (1) the Secretary finds that specific provisions of the Code, if rigidly applied, would result in unreasonable hardship on a facility, and that waiver of those provisions would not adversely affect the health and safety of clients or personnel; or (2) the Secretary finds that the fire and safety code in a given State adequately protects clients of, and personnel in, habilitation facilities.

The Committee bill clarifies that, as in the case of nursing facilities participating in Medicaid, the Secretary has the duty and responsibility to assure that requirements which govern the provision of care in habilitation facilities, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of clients. The Committee intends that the ultimate responsibility for assuring the quality of services provided by habilitation facilities to Medicaid beneficiaries rest with the Secretary, and may not be delegated to the States.

These requirements would take effect with respect to habilitation facility services provided on or after January 1, 1991, without regard to whether implementing regulations have been promulgated. The Committee bill makes clear that, prior to this date, nothing in the bill is to be construed to supersede the regulations issued by the Secretary on June 3, 1988, relating to conditions of participation for ICFs/MR.

Section 4232—Survey and certification process

In order to assure that habilitation facilities meet the requirements in this statute, the Committee bill would revise the current survey and certification process. Under current law, States are responsible for surveying and certifying compliance by ICFs/MR with the conditions of participation. The Secretary has the authority to validate State survey findings through Federal "look behind" surveys.

Under the Committee bill, compliance of habilitation facilities with Medicaid requirements would be certified through surveys. The surveys would be based on protocols developed, tested, and validated by the Secretary and would review (1) the quality, appropriateness, and effectiveness of active treatment provided at the facility, and (2) the facility's compliance with all of the requirements of participation. The review of active treatment provided at the facility would be based on a representative sample of clients and IPPs. Surveys would have to be conducted by a multidisciplinary team of professionals who meet minimum qualifications (including conflict of interest prohibitions) established by the Secretary and who have successfully completed a training and testing program approved by the Secretary.

To promote an accurate assessment of an habilitation facility's day-to-day compliance, the annual surveys would have to be conducted without prior notice to the facility. Any individual who notifies, directly or indirectly, a habilitation facility of the time or date on which a survey is scheduled to occur would be subject to a civil money penalty of up to $2,000. States would be required to take all

reasonable steps to avoid giving notice of such surveys through scheduling procedures and conduct of the surveys themselves.

Surveys of habilitation facilities other than those operated by the State would be conducted by the State survey agency. In order to gauge the adequacy of the State surveys, the Secretary would be required to conduct on-site "look behind" surveys of a representative sample of facilities within 2 months of a State survey in a sufficient number to draw inferences about the adequacy of the State surveys. States found to have an inadequate survey and certification performance would be subject to a reduction in Federal matching payments for administrative costs. The Committee bill would also give the Secretary independent authority to conduct a survey of any habilitation facility whenever there is a reason to question compliance.

Under the Committee bill, surveys of State habilitation facilities are to be conducted by the Secretary, not by the States. The Committee is concerned about current policy and practice, under which State survey and certification agencies review the performance of facilities operated by the State mental retardation agency in order to determine whether they should be certified to continue receiving payments from the State Medicaid agency (at rates that have been established by the State). In view of the large numbers of clients residing in State facilities, and the large amounts of Federal Medicaid funds being used to finance services for those clients, the Committee believes that an independent Federal survey is the most efficient and reliable method for certifying the compliance of State facilities with the requirements for participation.

The Committee bill would require States, through their survey agencies, to investigate allegations of client neglect and abuse by facility staff. States would also be required to maintain adequate staff to investigate complaints of violations of requirements by habilitation facilities and to monitor, on-site, a facility's compliance. The results of surveys, including statements of deficiencies and plans of correction, would be available to the public, State Protection and Advocacy Agencies, and State Medicaid Fraud Control Units.

These revisions in the current survey and certification process would take effect January 1, 1991.

Section 4233—Enforcement process

Under current law, if the Secretary, on the basis of a "look behind" survey, finds that an ICF/MR is out of compliance with the conditions of participation, the Secretary has the authority to terminate the facility's participation in the program. If the Secretary elects to terminate, he must notify the State agency and the facility, which is entitled to an administrative hearing and judicial review. If the Secretary finds that the facility's deficiencies do not present an immediate and serious threat to the health and safety of clients, and if the facility seeks an administrative hearing, Medicaid payments continue to be made to the facility until the hearing has been completed and a decision has been issued. If the Secretary finds that the facility's deficiencies present an immediate and serious threat to the health and safety of clients, and if the facility has been notified of its deficiencies and has failed to correct

them, the Secretary must terminate the facility's participation in the program, and Medicaid payments do not continue pending a decision in the administrative hearing.

As an alternative to termination, current law gives the Secretary the authority, until Janaury 1, 1990, to approve correction or reduction plans submitted by the States with respect to ICFs/MR that the Secretary has found, in a "look behind" survey, to have deficiencies that do not pose an immediate threat to the health and safety of residents. Under a correction plan, termination of a facility is postponed for up to 6 months to enable it to correct all staffing and physical plant deficiencies. Under a reduction plan, termination of a facility is postponed for up to 3 years to enable it to reduce its bed capacity or close altogether. During the period that correction or reduction plans are in effect, the deficient facilities continue to receive Medicaid payments.

In the view of the Committee, the current enforcement remedies and procedures are not adequate to assure that clients and taxpayers are protected against the use of Federal Medicaid dollars to subsidize poor quality care in habilitation facilities. Neither the Secretary nor the States have a sufficient range of remedies to deter noncompliance, and facilities know that their financial exposure is minimal so long as they appeal the termination notice and clear up any deficiencies before their appeal comes to a hearing.

In 1987, the General Accounting Office (GAO) reviewed then-existing enforcement procedures with respect to nursing facilities. The GAO found that "when deficiencies do not seriously threaten patient health or safety, there are no effective Federal sanctions to deter noncompliance. Even if the facility is repeatedly out of compliance, it will incur no penalty for not maintaining compliance." The GAO also found that "nursing homes know in advance that they will not be penalized if caught with serious deficiencies as long as they correct them sufficiently to qualify for recertification or stop ongoing decertification action." "Medicare and Medicaid: Stronger Enforcement of Nursing Home Requirements Needed" (July, 1987). In response to the GAO recommendations, this Committee, in the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203), revised the enforcement remedies and procedures applicable to nursing facilities participating in Medicaid.

Although the GAO report concerned ICFs, not ICFs/MR, and although ICFs and ICFs/MR are different types of institutions serving different populations, the Committee believes that the structural enforcement problems identified by GAO exist with regard to ICFs/MR. The Committee bill would therefore revise current enforcement remedies and procedures in order to deter noncompliance with the requirements for participation, to deter repeat violations, and to terminate the participation of substandard facilities. In the view of the Committee, there is no justification for continuing the payment of Federal Medicaid funds to a habilitation facility that does not meet the requirements of participation or that is not operating under an approved correction or reduction plan.

The Committee notes that, in framing the requirements for habilitation facilities in section 4231, the Commitee bill does not use the current regulatory framework of "conditions" of participation. Under current practices, surveyors assess the compliance with a

"standard." If a facility does not meet a majority of the "standards" in a "condition," the facility does not meet the "condition," and it therefore may not be certified for participation in Medicaid. Facilities that meet all of the "conditions" of participation, but are deficient in one or more "standards," may file a corrective plan of action for remedying the deficiencies over a 12 month period. During this period, the facility may continue to receive Medicaid payments.

The effect of this "conditions"/"standards" framework is to downgrade the importance of some critical performance criteria, giving facilities less of an incentive to comply. So long as a facility has an approved plan of correction, it has 12 months to bring itselt back into compliance with any of the "standards" in which it was found deficient, and it is never exposed to any financial penalty for all the days it was deficient.

The current "conditions"/"standards" framework may be justified in a context where the only statutory remedy for noncompliance is termination. However, the Committee does not believe it has merit where, as under the Committee bill, both the Secretary and the States would have at their disposal a range of intermediate sanctions, including civil money penalties, to deter noncompliance. The Committee bill therefore adopts a "requirements" of participation framework, under which a facility receiving Medicaid funds must at all times comply with all "requirements." Failure to meet one of more "requirements" would not necessarily result in termination (assuming no immediate jeopardy to client health or safety). However, it would subject a facility to the possibility of a civil money penalty or other intermediate sanction. The Committee specifically intents that the Secretary discard the existing regulatory practices and conventions associated with the terms "conditions" and "standards," and develop a regulatory approach that clearly articulates and vigorously enforces the "requirements" for participation set forth in the Committee bill.

The Committee notes that, in the Secretary's recent regulations regarding requirements for nursing facilities, 54 Fed. Reg. 5316 (Feb. 2, 1989), "conditions" and standards" were simply re-labelled "level A" and "level B" requirements. The Committee stresses that this approach contravenes the plain langauge and the intent of the Committee bill. Each of the "requirements" identified in the Committee bill has equal weight with respect to whether a facility may be certified to participate in Medicaid and receive Federal matching funds. However, the specific sanction that is to be applied to remedy noncompliance will vary from "requirement" to "requirement." The Committee bill would require both the States and the Secretary to specify criteria to be followed in imposing the remedies established by the bill, including criteria as to how the remedies are to be applied, the amounts of any fines, and the severity of each of the remedies. Repeated or uncorrected deficiencies would be subject to more severe fines. Thus, under the Committee bill, each of the "requirements" would have equal compliance significance. However, because some "requirements" have greater bearing on the health and safety and active treatment of clients than do others, the Committee expects that the sanctions for violating

those "requirements" would be more severe than the sanctions for violating others.

The following example illustrates the difference. Under current regulations, 42 C.F.R. Part 483, client protections are a "condition" of participation which includes the following "standards": protection of client rights; client finances; communication with clients, parents, and guardians; and staff treatment of clients. Under the Committee bill, facilities would have to meet "requirements" relating to clients' rights, including general rights, transfer and discharge rights, access and visitation rights, equal access to quality care, admissions policy, and management of clients funds. While in substance many of the bill's "requirements" are similar or identical to the "standards" in the current regulation, the bill elevates them sustantially in compliance priority for the facility. Under the current regulations, if a facility is deficient in, for example, the "standard" of protection of client rights because clients are not free from unnecessary drugs and physical restraints, but the facility meets all the other "standards" in the "condition" for client protections and meets all the other "conditions" of participation, the facility need only file a plan of correction and implement an approved plan over the next 12 months. The facility is not at risk of any financial penalty for noncompliance during this period. In contrast, under the Committee bill, which requires an habilitation facility to protect and promote the right of a client to be free from any physical restraints or medications imposed for purposes of discipline or convenience of the staff, the facility would be subject to the potential imposition of a civil money penalty or other intermediate sanction for each day during which it is found not in compliance with the "requirement." In this manner, the Committee intends to deter noncompliance and repeated noncompliance, rather than merely correct it.

Under the Committee bill, enforcement remedies and procedures would be established for both the States and the Secretary. States would be required to establish by statute or by regulation at least the following remedies: (1) denial of payment for new admissions; (2) civil money penalties, with interest, for each day a facility is or was out of compliance with a requirement of participation; (3) appointment of temporary management to oversee the operation of the facility and to assure the health and safety of clients; and (4) emergency authority to close the facility or transfer clients. These remedies would have to be in effect as of January 1, 1991.

In the case of facilitiew with deficiencies that immediately jeopardize the health or safety of clients, the Committee bill requires that States either (1) take immediate action to remove the jeopardy and correct the deficiencies through the appointment of temporary management, or (2) terminate the facility's participation in the program. A State's reasonable expenditures for temporary management would be subject to Federal matching payments at the administrative matching rate of 50 percent. In the case of facilities with deficiencies that do not immediately jeopardize the health or safety of its clients, the Committee bill allows the States to (1) impose one or more of the remedies described in the previous paragraph, (2) terminate the facility's participation in the program, or (3) do both.

To eliminate any incentive a facility might perceive not to bring itself into prompt compliance with all of the requirements of participation, the Committee bill expressly authorizes (but does not require) States to impose civil money penalties, with interest, for each day in which a facility was not in compliance with one or more of the requirements of participation. In addition, if a facility has not complied with one or more of the requirements of participation within 3 months after the date it is found to be out of compliance, the Committee bill would require the State to impose civil money penalties and to deny payment for all new admissions.

To deter repeated violations, the Committee bill would require that, in the case of a facility found on 3 consecutive annual surveys not to provide continuous active treatment of adequate quality and effectiveness, the State must, in addition to any other remedies applied, (1) deny payment for new admissions, (2) impose civil money penalties for each day of noncompliance covered under the 3 annual surveys, and (3) monitor the facility until it has demonstrated that it is in compliance with all of the requirements of participation, and that it will remain in compliance with these requirements. The Committee does not intend that this provision be construed to allow very noncomplying facility to have three "strikes" before being sanctioned. Instead, the Committee's intent is to establish an absolute outer limit on the extent to which the program will tolerate noncompliance with the continuous active treatment requirement. the Committee notes that remedy of termination is always available to the State (and the Secretary).

In the case of State habilitation facilities found out of compliance with a requirement of participation, the Committee bill requires that the Secretary apply the remedies established in the law or regulations of that State, except that the Secretary would apply the Federal civil money penalties, not those of the State.

In addition to remedies, the Committee bill would authorize States to establish programs to reward habilitation facilities that provide the highest quality services to clients. The rewards could take the form of public recognition, incentive payments, or both. The cost of any incentive payments or public recognition would be subject to Federal matching payments at the administrative rate of 50 percent.

With respect to the Secretary, the Committee bill would authorize the following remedies: (1) denial of Federal matching payments to the State for payments to a facility after the effective date of a finding on behalf of new admissions or on behalf of all clients; (2) imposition of civil money penalties up to $10,000 for each day of noncompliance; (3) in consultation with the State, appointment of temporary management to oversee the operation of the facility and to assure the health and safety of its clients. It is the intent and expectation of the Committee that the Secretary's civil money penalty authority will be administered by the inspector General, who has the responsibility for administering identical civil money penalty authorities under current law.

In the case of facilities with deficiencies that immediately jeopardize the health or safety of their clients, the Committee bill would require both the Secretary and the States to (1) take immediate action to remove the jeopardy and correct the deficiencies

through temporary management, or (2) terminate the facility's participation in Medicaid. The bill also authorizes both the Secretary and the States to impose additional sanctions in this circumstance, including civil money penalties.

In the case of facilities with deficiencies that do not immediately jeopardize the health and safety of clients, both the Secretary and the States would be authorized to impse any of the remedies established under the Committee bill, or any other remedies they may have under other sources of law. In addition, as an alternative to decertification, the Committee bill would authorize the continuation of Federal Medicaid matching funds for services delivered by the facility that is not in compliance with one or more of the requirements of participation, but only under the terms of a plan of correction or a reduction plan approved by the Secretary. The Secretary would have no other authority for continuing payments to noncomplying facilities.

Under a plan of correction, a facility would have up to 6 months from the effective date of the finding of deficiencies to bring itself back into compliance with all of the requirements of participation. The plan would have to be approved by the Secretary, upon request of the State. if the corrective action is not taken in accordance with the approved plan and timetable, the State would be required to repay the Federal Government any matching payments received for services provided by the facility during the period of noncompliance. The Committee expects that the Secretary, in establishing guidelines for the approval of corrective action plans, will limit to 30 days from receipt of a State request the time allowed to the Department for review and approval of correction plans.

Under a reduction plan, States could continue to receive Federal Medicaid matching payments for up to 36 months from the effective date of the findings of deficiencies for services provided by a noncomplying facility. The reduction plan would require (1) the permanent reduction in the number of certified beds as the facility so as to eliminate the facility's deficiencies, and (2) the provision of services to clients at the facility who will not continue to receive services at the facility after the reduction in bed capacity, including community services. The Committee notes that a State could provide these services through a 1915(c) waiver, through the new optional benefit established under section 4221 of the bill, or through programs and services paid for by the State, localities, or private sources.

In order to approve a State's request for a reduction plan, the Secretary must find that the State (1) has provided for a public hearing on the plan at the affected facility at least 30 days before submission of the plan to the Secretary, (2) has successfully provided community services to clients other than those who would be affected by the reduction, and (3) will make fair and equitable arrangements to protect the interests of affected employees u nder section 4247 of the Committee bill.

In addition, in order to approve the reduction plan the Secretary must find that the plan itself meets the following requirements. First, the plan must (1) identify the clients who will be displaced by the reduction, (2) describe each client's needs for services and provide a timetable for providing such services, (3) provide for continu-

ous active treatment for such clients after discharge under their IPPs, (4) identify the safeguards to protect the health and welfare of such clients upon discharge, including standards to assure quality of the services they will receive in the community, and (5) prepare and orient clients to facilitate either a safe and orderly transfer to another habilitation facility or integration into the community. Each Medicaid-eligible client must be given the option of remaining a client at the facility or being transferred to another habilitation facility at which the client may continue receiving Medicaid-funded services. Finally, the plan must specify the actions to be taken to protect the clients who remain at the facility while the reduction plan is in effect. These actions would at a minimum include maintenance of ratios of qualified staff to clients adequte to protect the health and safety of, and to provide for the continuous active treatment under the client's IPPs.

The Committee bill would require the Secretary to review compliance with the provisions of approved reduction plans at 6-month intervals. If the Secretary finds that the requirements of the plan are not being met, or that the State is not complying with the employee protection requirements, the bill would require the Secretary either (1) to terminate the facility's participation in the program or (2) to disallow, for each month of noncompliance, 5 percent of the Federal Medicaid matching payments which would otherwise be made for services provided at the facility. If the Secretary finds that the facility has not maintained adequate staffing ratios for the remaining clients, the bill would require the Secretary to disallow all Federal matching payments for each month that the facility fails to maintain adequate ratios.

The Committee bill would revise the current reduction plan authority to enable a State to seek a reduction plan not only on the basis of findings made by the Secretary in a "look behind" survey, but also on the basis of findings made by a State survey agency on or after May 1, 1989. As under current law, the current reduction plan authority would be repealed effective January 1, 1990, but correction or reduction plans approved before the date of enactment would continue to operate under their terms and conditions. With respect to the Los Lunas Hospital and Training School in Los Lunas, New Mexico, the State would have 30 days after enactment to file a correction plan, and 65 days after enactment to file a reduction plan, for approval by the Secretary under the requirements of the current law correction and reduction plan authorities.

Section 4234—Effective dates

The new requirements of participation (section 4231) and the revised survey and certification procedures (section 4232) would be effective January 1, 1991, without regard to whether implementing regulations have been promulgated. The enforcement provisions relating to the Secretary's authority would be effective on enactment, without regard to whether implementing regulations have been promulgated. The Secretary's new enforcment authority would apply to existing ICFs/MR, but only with respect to findings of noncompliance made after the date of enactment. The repeal of the current correction and reduction plan authority would be effective

July 1, 1990, but would not apply to plans approved before the date of enactment.

Section 4235—Annual report

The Secretary of HHS would be required to report annually to Congress on the extent of compliance by habilitation facilities and the number of enforcement actions taken.

Subpart 3—Appropriate placement for individuals with mental retardation or a related condition

Section 4241—State preadmission screening and annual client review

Under current law, States must have in effect a preadmission screening program to determine (1) whether individuals with mental retardation or a related condition who seek admission to general nursing facilities require the level of services provided by a nursing facility and (2) whether they require active treatment. States are also required to review, on an annual basis, each nursing facility resident with mental retardation or a related condition to determine (1) whether the individual requires the level of services provided by the nursing facility and (2) whether the individual requires active treatment.

These preadmission screening and annual review requirements do not apply to ICFs/MR. Instead, a physician (or physician assistant or nurse practitioner) must certify, at the time of admission and at least every 12 months thereafter, that an individual needs ICF/MR services. In addition, an interdisciplinary team of health professionals must make a comprehensive medical, social, and psychological evaluation of the need for care prior to admission or authorization for payment.

The current preadmission screening and annual review requirements have three basic purposes: (1) to prevent the inappropriate placement (or continued stay) of individuals with mental retardation or related condition in institutions, (2) to identify the service needs of these individuals, and (3) to preclude the use of Federal Medicaid funds for unnecessary institutional care. In the view of the Committee, these purposes are equally compelling in the context of habilitation facility services. The Committee bill would therefore require that States implement a similar program with respect to habilitation facilities.

Under the bill, States would be required to establish a preadmission screening program for all individuals with mental retardation or a related condition who are admitted to habilitation facilities on or after January 1, 1991. Habilitation facilities would be prohibited from admitting individuals determined not to require the level of services provided by a facility. In addition, States would have to conduct annual reviews of each client in a habilitation facility; all clients residing in such facilities who had not been subject to a preadmission review would have to be reviewed by January 1, 1992. These requirements would be delayed with respect to private pay individuals until the individual becomes eligible for Medicaid. States would be responsible for implementing these requirements

whether or not the Secretary issues final impelementing regulations.

With respect to preadmission screening, the State mental retardation or developmental disability authority must determine, prior to admission, whether the individual requires the level of services provided by an habilitation facility. This determination must be based upon an independent evaluation performed by a person or entity other than a habilitation facility, and must be based upon Federal minimum criteria developed by the Secretary. States must have in effect an appeals process that meets minimum criteria specified by the Secretary to permit individuals who are adversely affected to obtain an impartial review of the determination.

The Committee emphasizes that the preadmission screening determination affects only an individual's eligibility for habilitation facility services. It does not, and is not intended to, restrict an individual's eligibility for whatever community habilitation and supportive services a State may choose to offer, or for any medical or other health services that a State covers under its Medicaid plan.

With respect to annual reviews, the Committee bill would require the State mental retardation or developmental disability authority to conduct a review, at least annually, of (1) whether a client requires the level of services provided by a habilitation facility and (2) whether a client requires community habilitation and supportive services. The review must be based on an independent evaluation performed on site by a person or entity other than the facility, using minimum criteria developed by the Secretary. The evaluation must take into account the client's comprehensive functional assessment. States must have in effect an appeals process that meets minimum criteria specified by the Secretary to permit individuals who are adversely affected to obtain an impartial review of the evaluation.

In the case of clients found not to require the level of services provided by the facility but to require community habilitation and supportive services, the Committee bill would require the State, in consultation with the client's family or legal representative and care-givers, to (1) arrange for the client's safe and orderly discharge, (2) prepare and orient the client for discharge, and (3) provide for (or arrange for the provision of) the required community habilitation and supportive services. To assure these discharges are well-managed and do not harm the client, the Committee bill specifies that they be consistent with the client's transfer and discharge rights under the bill, including the requirement that the service needs of the client will be met in the client's new living environment. The State could meet the bill's requirement that it provide for (or arrange for the provision of) the required community habilitation and supportive services through a 1915(c) waiver, through the new optional benefit authorized by section 4221 of the Committee bill, or through programs and services funded by the State, by localities, or by private sources.

In the case of clients found not to require either the level of services provided by an habilitation facility or community habilitation and supportive services, the State would be required to (1) arrange for the client's safe and orderly discharge (consistent with the cli-

ent's transfer and discharge rights) and (2) prepare and orient the client for discharge.

The Committee bill would not require the Secretary to use a formal rulemaking process, with proposed and final regulations, in developing the minimum criteria for preadmission screening and annual review determinations. However, the Committee expects that the Secretary, in developing these criteria, will consult with the States, parents' groups, and advocates.

Section 4242—Revision of utilization review provisions

Under current law, States must obtain the certification of a physician, at the time of admission and periodically thereafter, that an individual needs ICF/MR services. In addition, an interdisciplinary team of health professionals must make a comprehensive medical, social, and psychological evaluation of the need for care prior to admission or authorization for payment. Finally, each resident of an ICF/MR is subject to an annual onsite inspection of care by an independent professional review team (composed of a physician or nurse and other appropriate personnel) to determine (1) the adequacy of available services, (2) the necessity and desirability of continued placement in the facility, and (3) the feasibility of meeting the individual's health care needs through alternative institutional or noninstitutional services. States that do not meet the physician recertification or inspection of care requirements with respect to ICF/MR clients are subject to reductions in Federal matching funds for ICF/MR services according to a statutory formula.

To eliminate unnecessary duplication, the Committee bill would repeal the existing requirements relating to utilization review, including physician certification and recertification, and inspection of care, as they apply to habilitation facilities. The repeal would take effect when the Secretary determines that a State has begun conducting annual reviews of clients under section 4241 of the bill.

Subpart 4—Payment for community habilitation and supportive services and habilitaiton facility services

Section 4244—Payment for services

(a) Reasonable and adequate payments.—Under current law, States electing to offer ICF/MR services have discretion in establishing payment methodologies and rates. Payments for ICF/MR services (as for other services) must be consistent with efficiency, economy, and quality of care, and must be sufficient to induce enough providers to participate in the program that services are available to beneficiaries at least to the extent that those services are available to the general population. These same rules apply to with respect to personal care services, habilitation services offered under 1915(c) waivers, as well as day habilitation services offered as optional clinic or rehabilitation services.

With respect to institutional services, the Secretary has, by regulation, limited aggregate Medicaid payments for (1) ICF/MR services in each State and (2) services provided by State-operated ICFs/MR in each State, to the estimated amount that would have been paid under Medicare reimbursement principles.

A review by the Congressional Research Service of State reimbursement methodologies for FY 1987 found that 35 States paid for ICF/MR services on a prospective basis, 13 paid on a cost basis, and 1 paid State-operated facilities on a cost basis and private facilities on a prospective basis (2 States did not cover ICF/MR services). CRS noted that, in the case of ICF/MR services, the distinction between prospective and cost systems "may not always be meaningful. Prospective rates may be set at a level sufficient to meet the facility's full anticipated costs. Most ICF/MR services are furnished in State facilities. If the State's Medicaid reimbursement to these facilities is less than their full operating cost, the State will have achieved Medicaid savings only at the expense of another part of the State budget." (Medicaid Source Book, pages 131–133).

In the view of the Committee, one of the key determinants of the quality of care is the amount of payment a provider is receiving for services rendered. The Committee recognizes that reimbursement levels are not the only factor affecting quality. But the provision of quality care, whether in an institutional or community setting, requires resources. If payment rates are set too low, it will be extremely difficult for a provider to deliver services of adequate quality without using excess funds received from other payors, or drawing upon any endowment or operating surplus. Of course, this cross-subsidization is not feasible for providers that do not have endowments or surpluses, or that serve primarily or exclusively Medicaid clients.

Under the Committee bill, States would be required to pay for habilitation facility services through rates which are reasonable and adequate to meet the costs which be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. States are allowed to establish their own methodologies, but those methodologies must not distinguish between State-operated providers and other providers. Thus, if a State's payment methodology applies an inflation index or a cost limit to a private facility, the same index or limit would have to be applied, in the same manner, to the State facilities. The Committee bill does not require that the State pay identical rates to private facilities and State facilities.

The adequacy of Medicaid payment rates is a particular concern in community settings, where low wages and limited benefits can result in high staff turnover that severely compromises the quality and continuity of care available to clients. The Subcommittee on Health and Environment heard testimony from one non-profit community provider that "Our budget is $11 million a year, of which I must raise $3.5 million to keep our doors open. That's supplementing the gap between government funding and actual cost. Incidentally, my direct care staff make $4.25 an hour, and that's not by choice. That's because of the rates we get." It is difficult to minimize staff turnover if Medicaid reimbursement rates do not allow providers to pay their direct care staff more than—or even as much as—these individuals could earn in a fast-food restaurant.

Under the Committee bill, States that elect to offer community habilitation and supportive services must pay rates which are reasonable and adequate to meet the costs of providing services, effi-

ciently and economically, in conformity with applicable State and Federal laws, regulations, and quality and safety standards. These laws and regulations include the guidelines promulgated by the Secretary regarding minimum compensation to assure the availability and continuity of qualified personnel to provide services to clients at various levels of impairment. If payment rates do not meet these requirements, Federal Medicaid matching funds would not be available for community habilitation and supportive services.

The Committee bill does not require States to use a specific methodology in setting payment rates for providers of community habilitation and supportive services. Whatever methodology a State chooses to use, however, must not distinguish between State-operated providers and other providers. States are not required to set identical payment rates for public and private providers.

With respect to both community and facility services, the Committee bill would prohibit States from paying on a capitation or other risk-based basis. The Committee is concerned that risk-based reimbursement, under which providers have an incentive not to deliver services, may not be consistent with the delivery of quality care to such a vulnerable population.

These provisions are effective with respect to community habilitation and supportive services delivered on or after the later of July 1, 1990, or 30 days after publication of interim regulations regarding minimum protections. For habilitation facilities, these provisions apply to services furnished on or after January 1, 1991.

(b) Denial of Federal payments to compensate for civil money penalties.—The Committee bill provides that Federal Medicaid matching funds would not be available for reimbursing the costs of any civil money penalties imposed on either providers of community services or habilitation facilities. Federal Medicaid funds are available for covered services delivered in compliance with program requirements, not for sanctions imposed to remedy noncompliance.

Subpart 5—Employee protections and miscellaneous

Section 4247—Employee protections

Under current law, the Secretary may not approve an ICF/MR reduction plan unless the plan provides for the protection of the interests of affected employees. These protections must include arrangements to preserve employee rights and benefits, training and retraining of affected employees where necessary, redeployment of affected employees to community settings, and maximum efforts to guarantee the employment of such employees.

Over the past two decades, a number of States have moved to reduce the number of residents in large State-operated ICFs/MR. Between 1967 and 1987, the number of individuals with mental retardation in large public facilities declined from 194,650 to 94,565 (Medicaid Source Book, p. 378). Deinstitutionalization affects not only the residents, but also the employees at the facilities involved. The Subcommittee on Health and the Environment heard testimony that in 14 States, about 12,000 State employees who have been displaced from State-run institutions have continued to deliver services to individuals with mental retardation, either in other in-

stitutions, or in community settings, maintaining their State employee status. In some of these States, workers have been redeployed from large State-run institutions to small State-run community settings; in New York alone, some 8,600 State workers have been redeployed since 1975 into over 400 communtiy settings.

The Committee bill would require States to provide that specified fair and equitable arrangements have been made to protect the interests of habilitation facility employees who are affected by a closure or reduction in capacity at that facility. This requirement applies whether or not the closure or reduction in capacity is pursuant to a reduction plan under section 1928(i), and it applies whether or not the facility subject to closure or reduction is operated by the State.

In protecting the interests of affected employees, the State must ensure that the following arrangements have been made:

(1) rights, privileges, and benefits (including continuation of pension rights and benefits) under applicable collective bargaining agreements must be preserved;

(2) collective bargaining rights through any certified representative must be continued;

(3) individual employees must be protected against a wosening of their positions with respect to their employment at the facility during the period of the closure or reduction;

(4) employment of affected employees with at least the same compensation (including benefits) and a comparable level of job responsiblities must be assured, except that this shall not be construed as entitling an affected employee to lifetime employment or as protecting an employee against a discharge for good cause;

(5) paid training or retraining programs must be established for the employment of affected employees in the provision of community services to individuals with mental retardation or a related conditon (whether or not the State has opted, under section 4221 of the Committee bill, to offer community habilitation and supportive services); and

(6) a specified grievance procedure must be provided for affected employees to assure the preceding requirements have been met with respect to such employees.

With respect to requirement (4), in the case of a State-operated facility, the State must offer to affected workers employment, with at least the same compensation (including benefits) and a comparable level of job responsibilities, with a provider of community-based services to individuals with mental retardation, or in a residential setting in which such services are provided. In order to comply with this requirement, a State need not operate the community provider or residential setting; it could, at its option, make arrangements for the placement of affected State employees (with at least the same compensation, including benefits, and a comparable level of job responsibilities) at privately operated providers or settings. The Committee does not intend to require a State which closes or reduces one of its facilities to offer the optional community habilitation and supportive services benefit under section 4221 of the Committee bill. If the affected employee in these circumstances declines the State's offer of employment with a community provid-

er or residential setting, the State, in order to meet requirement (4), may offer the employee a position (with the same compensation, including benefits, and a comparable level of job responsibilities) at another habilitation facility or at another State agency.

With respect to requirement (5), the Committee bill provides that Federal Medicaid matching funds are available at the rate of 50 percent for the reasonable expenses associated with the training and retraining programs for employees affected by the closure or reduction of habilitation facility employees. The Committee intends that the Secretary allow all reasonable costs which the State incurs in training or retraining affected employees to provide quality community habilitation and supportive servies. Federal financial participation would not be available for the costs of training or retraining for skills that are not used in connection with the delivery of communtiy habilitation and supportive services.

With respect to requirement (6) for a grievance procedure, the Committee bill provides for two options. First, the bill outlines a procedure that includes a 60-day informal resolution period, the option of the employee to either binding arbitration or a hearing within 45 days of request, and a decision within 30 days of the hearing or arbitration. Second, in the case of affected employees with certified bargaining representatives, if the State and the representative agree, the parties may use a procedure other than that specified in the bill. The costs of the arbitration proceeeding are to be divided evenly between the affected employee and the State; the cost of the hearing are to be borne solely by the State. Federal Medicaid matching funds are not available for the costs of arbitration proceedings, hearings or alternative grievance procedures.

The requirements in the Committee bill that States make fair and equitable arrangements to protect the interests of affected employees shall not be construed as superseding or abrogating any collective bargaining agreement or any statutory or contractual labor/management negotiating process to the extent that such agreement or process contains protections for individual employees that comply with the requirements of the Committee bill.

These requirements are effective on enactment, regardless of whether the Secretary has issued final regulations to implement these provisions.

Section 4248—Use of State developmental disabilities agency

Under current law, a single State agency designated by the State administers the Medicaid program. Under the Committee bill, States would be allowed to assign to the State developmental disabilities agency specific Medicaid program management functions relating to the provision of services to individuals with mental retardation or a related condition. Federal Medicaid matching funds would be available, at the rate of 50 percent, for the reasonable administrative expenses of the State developmental disabilities agency in carrying out such assigned functions (other than the costs of a State quality assurance program for communtiy habilitation and supportive services under section 1927(g)) in the same manner as they are available for similar expenses of the single State agency.

PART D—FRAIL ELDERLY COMMUNITY CARE AMENDMENTS

Section 4251—Community care as optional, statewide service

Under current law, States use Federal Medicaid matching funds to purchase nursing home care on behalf of low-income elderly in skilled nursing facilities (SNFs) and intermediate care facilities (ICFs). Payments for SNF and ICF services account for approximately 30 percent of all Medicaid spending.

Coverage of non-institutional long-term care services is far more limited. States are required to provide home health services (including part-time nursing, home health aide, and medical supplies and equipment) to individuals entitled to SNF care. About 3 percent of all Medicaid spending goes toward this service. (Medicaid Source Book, p. 35). In addition, the States have the option of covering personal care services, as well as case management services targeted on specific population groups.

There are other services that enable frail elderly who need long-term care to remain in the community, including chore services, respite care, and adult day health. However, Federal Medicaid matching funds are currently available for these non-medical services only under the 1915(c) home and community-based services waiver. Under this authority, States are allowed to provide a range of home and community-based services to individuals who are at risk of institutionalization. However, in order to obtain Federal Medicaid matching funds for these services, a State must demonstrate to the Secretary that the average per capita Medicaid expenditure for services to individuals under the waiver will not exceed the average per capita Medicaid expenditure for services to those individuals in the absence of the waiver. States may target waivers on specific groups (e.g., aged, disabled children, individuals with mental retardation) in specific areas of the State, and may limit the number of otherwise eligible individuals who may enroll. As of February, 1988, 36 States were operating one or more 1915(c) waivers targeted at the aged and disabled (Medicaid Source Book, p. 160).

The budget neutrality requirement in the 1915(c) waiver has proven to be a major impediment to State efforts to provide home and community-based services to the low-income frail elderly. Since the enactment of the waiver authority in 1981, the Subcommittee on Health and the Environment has closely monitored the implementation of the waiver. As a result of concerns expressed by State officials, most notably at a major hearing on this issue held by the Subcommittee on June 25, 1985, the Subcommittee reported a number of revisions in the waiver authority that were enacted in 1986 (section 9502 of COBRA, P.L. 99-272, and section 9411 of OBRA 1986, P.L. 99-509). Despite these and subsequent changes, the budget neutrality requirement remains a major barrier to expansion of home and community-based services. As one State official testified at a hearing before the Subcommittee on June 8, 1989, "HCFA forces our State as well as others which have such waivers through a series of hoops expressly disigned to discourage all but the most persistent."

In view of the Committee, the time has arrived to give the State the option of using Federal Medicaid funds to match State pay-

ments for home and community-based services to the frail elderly without demonstrating budget neutrality to the Federal government. Accordingly, the Committee bill would establish a new optional Medicaid benefit, community care services for functionally disabled elderly individuals. The types of services that a State could offer under this option would be essentially the same as those which a State can now provide under the 1915(c) waiver; however, States would not have to demonstrate budget neutrality as they must under the waiver. To limit expenditures, though, States would be subject to a maintenance of effort requirement and an aggregate ceiling on payment amounts. The bill would retain the current 1915(c) waiver authority, so that States would have the choice of using either the community care benefit or the waiver, or both, or neither.

The Committee stresses that this bill represents a modest, incremental improvement in long-term care coverage for the low-income frail elderly. The benefit is optional, not mandatory. The class of potential beneficiaries is sharply constrained by the bill's definition of functional disability. In addition, beneficiaries would have to meet existing income and resource standards for Medicaid eligibility in the community; these standards are substantially more restrictive than those for either institutionalized individuals or than those for individuals participating in the 1915(c) waivers. To prevent the States from substituting Federal Medicaid funds for State community care dollars, the bill would impose a strict maintenance of effort requirement. Moreover, the bill would limit aggregate payments for these services to an aggregate payment ceiling defined by 30 percent of the rate for Medicare SNF services in the State. In short, the Committee, in framing this new optional benefit, has employed every reasonable cost constraint available to it.

The Committee recognizes that quality is of major concern in the provision of community care services to the frail elderly. The magnitude of the problem was underscored by a February, 1989, General Accounting Office report on board and care facilities, where many potential beneficiaries of community care services reside. Reviewing the records of board and care facilities in 6 States, GAO found that, even though these facilities were licensed by the States, problems persisted year after year, ranging from "very serious situations in which residents have been subjected to physical and sexual abuse, to problems involving persistent insanitary conditions, such as improperly stored food and trash. In some cases board and care residents had been denied heat, were suffering from dehydration, were denied adequate medical care, or had food withheld if they did not work. Situations have also occurred that have contributed to the death of board and care residents. . . . [These] problems are concentrated in homes with low-income residents, especially those living on SSI" "(Board and Care: Insufficient Assurances that Residents' Needs are Identified and Met," GAO/HRD–89–50).

The Committee bill contains a number of safeguards designed to assure that Federal Medicaid funds do not pay for substandard quality care in either a board and care facility or in any other residential settings. Rather than place beneficiaries at risk of the problems documented by GAO, the Committee bill place major responsi-

bility for assuring the quality of community care on the case manager and the beneficiary. In addition, the bill would direct the Secretary to develop minimum requirements for community care and minimum requirements for the residential settings in which community care is provided. These minimum requirements would include protections from neglect, physical and sexual abuse, financial exploitation, inappropriate involuntary restraint, and the provision of services by unqualified personnel. Compliance with these requirements would be monitored by unannounced State surveys using protocols developed by the Secretary. To assure that Federal Medicaid matching funds do not at any point finance substandard quality services, the Committee bill would limit the availability of these funds for community care services until the later of July 1, 1990, or 30 days after the issuance of interim minimum requirements by the Secretary.

(a) Provision as optional, statewide service

Under the Committee bill, States would have the option to provide Medicaid coverage for community care for functionally disabled elderly individuals. This service, like other Medicaid benefits, would have to be offered on a statewide basis. Community care services could only be offered to individuals 65 and over who, on the basis of income and resources, are eligible for Medicaid and who, after a comprehensive functional assessment, are determined to be functionally disabled. Community care services would have to be provided in accordance with an individual community care plan established an periodically revised by a qualified community care case manager.

Federal Medicaid matching funds would be available for this benefit on the later of July 1, 1990, or 30 days after the issuance of interim regulations by the Secretary setting for minimum requirements for providers of community care and residential settings in which such care is delivered.

(b) Community care for functionally disabled elderly individuals

(1) Community care defined.—Community care would include one or more of the following services: (1) homemaker/home health aide services; (2) chore services; (3) personal care services; (4) nursing care services provided by, or under the supervision of, a registered nurse; (5) respite care; (6) training for family members in managing the individual; (7) adult day health services; and (8) other home and community-based services (other than room and board) as the Secretary may approve. In the case of an individual with chronic mental illness, community care could, at State option, include day treatment or other partial hospitalization, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility). The bill does not require that the States electing this option offer "core" services; States covering community care may choose to cover any one or more of the services described above.

Under the Committee bill, nursing care services, if offered under the community care benefit, would not include continuous nursing care services provided on a round-the-clock, 24-hour per day, 7 day-per-week basis; for individuals in need of nursing care of this inten-

sity, the appropriate Medicaid benefit would be nursing facility care). Homemaker/home health aide services, chore services, personal care services, and nursing care services would, if covered, have to be provided in a place of residence used as the individual's home. Federal Medicaid Matching funds would not be available for the costs of room and board.

(2) Functionally disabled elderly individual defined.—Under the Committee bill, to be eligible for this community care benefit, an individual would have to be (1) 65 years of age or older, (2) eligible for Medicaid in the community due to low income and resources (i.e., receiving Supplemental Security Income (SSI) or "spending down" to qualify as "medically needy"), and (3) determined to be "functionally disabled."

The bill would not alter current Medicaid rules for determining income or resource eligibility in the community, with two exceptions, First, States that were providing home and community-based services to the elderly under a 1915(c) waiver at the time they elect to offer optional community care services under the Committee bill would be able to continue coverage of these individuals under the optional community care benefit, even if the incomes or resources of these individuals are greater than permitted under the State's community eligibility standards. The Committee bill would not require States to discontinue their 1915(c) waivers. However, because under current law these waivers allow States to apply less restrictive eligibility criteria used for institutionalized individuals, many 1915(c) waiver beneficiaries, while functionally disabled, would not qualify for the community care benefit with its more restrictive community eligibility criteria. The Committee bill would make these waiver beneficiaries eligible for the community care benefit. However, a State would not be allowed to apply the less restrictive 1915(c) waiver eligibility criteria to functionally disabled elderly individuals who were not participating in the waiver at the time of its termination.

Second, States offering coverage to the "medically needy" would be allowed to use a 6-month projected income period in determining both initial eligibility and the amount of an eligible individual's income to be applied to the cost of care (this would parallel current law with respect to post-eligibility treatment of income for institutionalized individuals, 42 CFR 435.725(f)(1)).

Since January, 1980, the State of Texas has provided personal care services to aged and disabled individuals under a waiver granted by the Secretary under section 1115 of the Social Security Act. This waiver authority was first extended by section 9523(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. 99-272), and again by section 411(k)(9) of the Medicare Catastrophic Coverage Act, Pub. L. 100-360, until January 1, 1990. Currently, 4900 aged and disabled individuals are receiving personal care services in the community under this waiver authority. These individuals meet the community (SSI) resource standard of $2,000, but have incomes between the community income standard (currently $368 per month) and the institutional income standard (currently $715 per month). To enable Texas to continue to divert functionally disabled individuals from nursing home placement, the Committee bill would give Texas the option, upon expiration of its

1115 waiver, to extend personal care services (or any other community care service) to aged or disabled individuals who meet the waiver's test of functional disability and who meet the State's higher institutional income standard. Federal Medicaid matching funds would be available for State expenditures for this population on a permanent basis. The personal care services (and any other community care services) which the State elects to offer under its Medicaid program would be subject to the same minimum requirements set forth in the Committee bill as those community care services offered by other States.

(3) Determinations of functional disability.—As defined in the Committee bill, an individual would be "functionally disabled" if the individual (1) due solely to physical impairment or due solely to mental illness, is unable to perform without substantial assistance from another individual at least two (or, at the option of the State, three or four of the following activities of daily living ("ADLs"): bathing, dressing, toileting, transferring, and eating; or (2) has a primary or secondary diagnosis of Alzheimer's disease.

Thus, under this definition, in order for an individual to be determined to be "functionally disabled", he or she, because of physical impairment, would have to be unable to perform, without substantial assistance from another individual, at least two of the ADLs specified in the bill; *or* he or she, because of mental illness, would have to be unable to perform, without substantial assistance from another individual, at least two of these ADLs; *or* he or she would have to have a primary or secondary diagnosis of Alzheimer's disease. An individual who, because of a combination of physical impairment and mental illness, is unable to perform, without substantial assistance from another individual, at least two of the specified ADLs, is not "functionally disabled" for the purposes of the Committee bill. In this context, "mental illness" is defined in the Committee bill to mean a primary or secondary diagnosis of mental disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition).

The Committee notes that, under this definition, elderly individuals who would be "functionally disabled" due solely to mental illness are treated in precisely the same manner as those who would be "functionally disabled" due solely to physical impairment. In the view of the National Mental Health Association and 10 other national organizations (including the American Psychiatric Association, the American Psychological Association, the Mental Health Law Project, and the National Association of State Mental Health Program Directors), this approach will "be * * * extremely beneficial to persons with mental illnesses". According to these groups, "[i]t will help relieve the pressure on the states to provide community services to individuals discharged or diverted from nursing facilities as a result of the pre-adminssion or resident assessments required under OBRA nursing home reform. The home and community services which can be covered under the new option . . . will also be beneficial to many other elderly persons with mental or physical impairments who are at risk of institutionalization" (June 28, 1989, letter to Members of the Subcommittee on Health and the Environment).

The Committee notes further that the use of "activities of daily living" as well as the actual ADLs specified in the bill) as a measurement for determining functional disability is consistent with the generally accepted views of long-term care experts that ADLs are the most appropriate, most well-developed method for assessing an individual's functional impairments or limitations. Indeed, the Committee understands that processes, procedures, and instruments for determining ADL limitations have been in use for a number of years and that many States are already performing ADL assessments. Therefore, in the view of the Committee, neither the States nor the Secretary (who would have the responsibility for designating one or more functional assessment instruments to be used by the States for making eligibility determinations), should have difficulty in implementing this part of the bill's eligibility requirements.

(4) Assessments of functional disability.—Under the Committee bill, an individual's "functional disability" would be determined on the basis of a comprehensive functional assessment conducted by an interdisciplinary team designated by the State. The assessment would be (1) used to evaluate an individual's ability to perform the 5 ADLs specified in the bill (bathing, dressing, toileting, transferring and eating), (2) based on a uniform minimum data set specified by the Secretary, and (3) conducted using a instrument specified by the State and approved by the Secretary. Any individual who is 65 years of age or older and who is eligible for Medicaid on the basis of income and resources would be able to request such an assessment (or have such a request made on his or her behalf). Neither States nor any interdisciplinary teams designated by the States to conduct these functional assessments would be allowed to charge a fee for these assessments.

With respect to the assessment instrument itself, the Committee bill would require the Secretary, by July 1, 1990, to (1) specify a minimum data set of core elements and common definitions to be used in conducting functional assessments, as well as guidelines for the use of the data set; and (2) identify one or more functional assessment instruments for use by a State in conducting comprehensive functional assessments. To expedite the development of the data set and the assessment instruments, the Committee bill would waive the applicability of the Paperwork Reduction Act and Executive Order 12291 requirements under which the Office of Management and Budget is authorized to review agency reporting forms and information requests. States would have the option of using one of the instruments identified by the Secretary, or of using their own instruments, if those are approved by the Secretary as consistent with the minimum data set of core elements, common definitions, and utilization guidelines.

The Committee intends that the comprehensive functional assessment instrument or instruments developed by the Secretary have the following characteristics. First, when used by a trained observer, the instruments should evaluate the ability of the individual to perform, without substantial assistance, each of the 5 ADLs specified in the bill. At the same time, the instruments must be able to distinguish ADL limitations due solely to physical impairment or due solely to mental illness. Second, when used by another

trained observer on the same individual at the same time, the result of the assessment should be substantially the same as that obtained by the first observer. Finally, although the descriptive portions of the instrument should be designed to be helpful to a qualified community care case manager in planning individual community care plans (ICCPs), they should not allow for either a diagnostic characterization of the individual's functional status. In the Committee's view, such an approach would result in opinions or conclusions about the individual's diagnosis, prognosis, or treatment that may not reflect the individual's current functional status and is, therefore, inappropriate.

With respect to the actual assessments, States would be required to designate interdisciplinary teams to conduct comprehensive functional assessment. Under the Committee bill, States would be allowed to delegate this responsibility to other public or nonprofit private organizations under contract, but only if such organizations have no direct or indirect ownership or control interest in, or affiliation or relationship with, an entity that provides either community care or nursing facility services. States or their subcontractors would be specifically prohibited from charging any fees for an assessment. Their costs for conducting assessments would, however, be eligible for Federal Medicaid matching payments at the regular 50 percent administrative rate.

In conducting each assessment, an interdisciplinary team would be required to (1) identify the individual's functional disabilities (based on the 5 ADLs specified in the Committee bill) and need for community care (based on social, cognitive, and other relevant factors, i.e., whether the individual is living alone or with others); and (2) determine, on the basis of the assessment, whether the individual is "functionally disabled." The results of these assessments would be used in establishing, reviewing, and revising ICCPs for those individuals determined to be eligible for community care.

Under the Committee bill, each functionally disabled elderly individual who receives community care would be required to have his or her comprehensive functional assessment reviewed and revised at least once every 12 months. In addition, each elderly individual who is determined not to be functionally disabled (and, therefore, ineligible for services) would be entitled to appeal any adverse decision relating to such a determination. States electing to provide Medicaid coverage for community care for functionally disabled elderly individuals would be required to establish a process by which such an appeal could be made.

(5) Individual community care plan (ICCP).—Once an individual is determined to be functionally disabled and eligible for community care, the Committee bill would require that a written plan of care—an individual community care plan (ICCP)—be developed and periodically reviewed and revised by a qualified community care case manager. The ICCP would have to be based upon the individual's most recent comprehensive functional assessment and a face-to-face visit with the individual in his or her residence. The purpose of this visit requirement is to assure that the case manager is familiar with the current living arrangements of the individual and the implication of those arrangements for the ability to provide quality community care services to the individual. Func-

tionally disabled individuals who disagree with the ICCP that is developed for him or her would have the right to appeal that determination under an appeal process which States would be required to establish.

The ICCP would specify the community care to be provided to each functionally disabled elderly individual. Although the ICCP could specify services that the State has not elected to cover under its Medicaid program, the individual would be entitled to have payment made only for community care that is within the amount, duration, and scope specified under the State's Medicaid program. For example, an ICCP may call for the provision of respite care. However, if the State Medicaid program covers only homemaker, chore, and personal care services, the individual is not entitled to Medicaid payment for respite care services.

Under the Committee bill, the ICCP would have to reflect the individual's needs and preferences, consistent with the amount, scope, and duration limitations on community care services under the State's Medicaid program. The Committee bill would not give the individual final authority with respect to the content of the ICCP; that must remain with the case manager, who would be accountable for the adequacy of the plan. However, it is the intent of the Committee that the ICCPs be developed by the case manager with maximum input from, and involvement of, the beneficiary, so that the plans accurately reflect each beneficiary's unique needs and preferences, and so that each beneficiary understands his or her rights and responsibilities under the ICCP.

In this connection, the Committee bill would require that each ICCP, to the extent feasible, allow for and promote the direction and oversight of community care by the beneficiary. In the view of the Committee, one element essential to assuring quality in community care services is the ability of beneficiaries to negotiate agreements with providers that will maximize each beneficiary's functioning, self-determination, and physical security, while recognizing any limitations on the capacities of providers or coverage under the State Medicaid program. Thus, the Committee bill would entitle functionally disabled individuals to choose the providers from whom they will receive community care services.

While the State could designate an individual's case manager, neither the State nor the case manager would have the authority to limit beneficiary freedom of choice among qualified providers. A beneficiary would have the right to select any provider of community care, whether an agency or an individual, that meets the bill's requirements for participation. The Committee bill makes clear that the State would not be authorized to permit payment for community care to be made through a qualified community care case manager; the State would have to pay the provider directly so tht the case manager could not exert indirect control over the beneficiary's choice of provider. The intent of the Committee is to assure that individuals receiving community care services have the ability to select and, to the extent feasible, direct their providers. The Committee anticipates that beneficiaries would monitor the care they are receiving under their ICCPs and, in cases where the beneficiary believes the provider is not meeting its responsibilities, to

resolve the matter directly with the provider, seek assistance from the case manager, or find another provider.

The ICCP would be limited in scope. Under the Committee bill, case managers through the ICCPs could not direct the provision of Medicaid services other than community care, such as personal care services, rehabilitative services, or nursing facility services. Similarly, the Committee bill would be authorize the case manager or the ICCP to exercise any control over the delivery of any home health or other long-term care services covered under Medicare or paid for by the individual from his or her own funds.

Under the Committee bill, ICCPs would have to be established, reviewed, and revised by qualified community care case managers meeting the following criteria. First, a qualified case manager must be a public or private nonprofit organization. Private nonprofit organizations may be qualified as a community care case manager, however, only if they have no direct or indirect ownership or control interest in, or affiliation or relationship with, an entity that provides either community care or nursing facility services. Second, a qualified case manager must have experience in establishing, reviewing, and revising comprehensive functional assessments and in providing case management services to the elderly. The Committee intends that such experinece involve the development of assessments and the provision of case management services for individuals in need of the type of community care services specified in the bill. Third, a qualified case manager must have procedures for assuring the quality of services it provides and must meet qualify standards established by the Secretary, including standards designed to assure that case managers are competent and that beneficiaries are protected against financial exploitation by case managers.

In addition to developing and revising the actual content of ICCPs, qualified case managers would be responsible for (1) assuring that community care services covered under the State Medicaid plan and specified in an ICCP are actually being provided; and (2) visiting each individual receiving such services in his or her residence at least once every 90 days. These requirements are designed to assure both program accountability and quality of care. Thus, the Committee intends that case managers determine that all the covered community care services specified in an ICCP are actually delivered at the time and date so designated and make inquiries about the quality of the services provided. Moreover, the Committee intends that case managers actually meet with the individual to whom community care services is being provided to make assessments about the individual's health status and continued need for community care services (whether or not specified in the individual's ICCP). The Committee further expects case managers to monitor for any signs of abuse, neglect, financial exploitation, inappropriate involuntary restraint, or substandard quality of services by a community care provider or in a community care setting in which community care are delivered.

(c) Ceiling on payment amounts and mainteannce of effort.—To remain within the constraints established by the FY 90 Budget Resolution, the Committee bill contains two provisions that would limit Federal Medicaid payments to States electing to offer commu-

nity care to the functionally disabled elderly. The first is an aggregate ceiling on Federal Medicaid payments linked to payments for skilled nursing facilities (SNFs) under Medicare. The second is a requirement that States electing this option maintain their current fiscal effort in providing community care services to the frail elderly. The Committee intends to monitor the implementation of these provisions to ascertain whether adjustments are needed.

(1) Ceiling on payment amounts.—Under the Committee bill, Federal Medicaid matching payments to a State for community care provided in any calendar quarter could not exceed 30 percent of the product of the following: (1) the average number of individuals receiving community care in the quarter, (2) the average per diem rate of payment for Medicare SNF services in that State for the quarter, and (3) the number of days in a quarter. Thus, in a State in which Medicare pays SNFs at an average rate of $80 per day, the maximum Federal Medicaid matching payments a State could receive for providing community care to an average of 1000 functionally disabled elderly individuals in a quarter would be $2.16 million ($0.30 \times 1000$ beneficiaries $\times \$80 \times 90$ days). This aggregate payment ceiling would apply regardless of the State's Medicaid matching rate.

(2) Maintenance of effort.—Under the Committee bill, if a State wishes to offer Medicaid coverage for community care to functionally disabled elderly individuals, it must report to the Secretary, in a format developed or approved by the Secretary, the amount of non-Federal funds obligated by the State (and its localities) for the provision of community care to functionally disabled elderly individuals in Federal fiscal year 1989. State (and local) expenditures for home and community-based services under a section 1915(c) waiver would not be subject to this reporting requirement.

The Committee bill would require the Secretary, in determining the amount of Federal Medicaid matching funds to be paid to a State for community care, to reduce the total amount expended by a State (and its localities) for such services by the amount of expenditures reported by the State (for itself and its localities) for FY 1989. The purpose of this requirement is to prevent States from using the option established by the Committee bill to replace State (or local) dollars now being spent on community care for this population with Federal Medicaid dollars.

The Committee stresses that a State which does not choose to offer the community care benefit is not required to file such a report. A State is not required to file a report at the close of FY 1989 in order to retain its option to cover these services. For example, if a State does not opt to offer the community care benefit until FY 1992, it would not have to file its report regarding expenditures for FY 1989 until the beginning of the quarter in which the benefit is first offered.

The Committee also notes that the only State and local expenditures subject to reporting are expenditures for community care as defined in the bill to functionally disabled elderly individuals as defined in the bill. Spending under a 1915(c) waiver would not have to be reported. Spending for community care for elderly individuals who are not functionally disabled as defined in the bill would not have to be reported. Spending for services that are not community

care as defined in the bill, even if provided to functionally disabled elderly individuals, would not have to be reported.

The following example illustrates how the Committee bill would prevent refinancing of current State or local expenditures. Assume that a State (and its localities) spent $500 million on community care for functionally disabled elderly individuals in FY 1989 and that the State elects to offer the community care benefit in FY 1991. In determining the amount of Federal Medicaid matching funds available to the State in connection with its FY 1991 expenditures, the Secretary would first deduct $500 million from the total amount which the State reports it (and its localities) spent for community care for this population in FY 1991 (excluding spending under a 1915(c) waiver). The Secretary would then apply the State's Medicaid matching rate to any excess. Thus, if the State (and its localities) spent a total of $510 million in FY 1991, and the State's matching rate was 50 percent, the State would receive $5 million in Federal Medicaid matching funds. (This $5 million would also be subject to the ceiling on payment amounts established by the bill).

(d) Minimum requirements for community care.—As noted above, the Committee views quality of care as a major concern in the provision of community care services to the functionally disabled elderly. Many of these services are delivered to the elderly in their own homes or in the homes of their families with whom they live, often making it difficult to monitor the quality of care that is provided. In many instances, they are also delivered in residential settings, such as board and care facilities, which are not required to meet any Federal quality standards and, indeed, are not even required to be licensed in a number of States. Charges of substandard care, neglect, abuse, and misappropriation of funds are neither uncommon nor, in many cases, unfounded.

In order to help assure that functionally disabled elderly individuals receive—and that Federal Medicaid dollars pay for—only quality community care services, the Committee bill would mandate the Secretary to establish quality care requirements for both community care and "community care settings" (settings in which community care services are provided). Interim requirements would have to be published in July 1, 1990; final requirements, October 1, 1991. The Secretary would be prohibited from delegating this responsibility to the States. States would, however, be permitted to establish more stringent standards with respect to quality requirements applicable to community care providers or to "community care settings."

(1) Minimum requirements for community care providers.—The Committee bill would require the Secretary to establish Federal minimum quality requirements which would include (1) minimum competency qualifications for personnel providing community care; (2) guidelines for minimum compensation to assure the availability of competent personnel and to reduce the rate of turnover among such personnel; and (3) a specification of patients' rights (including the rights to free choice regarding services and treatment; to freedom from restraint; to privacy; to confidentiality of records; and to voice grievances). In addition, community care sevices would have to be provided in compliance with requirements developed by the Secretary designed to assure, through methods other than reliance

on State licensure, that functionally disabled elderly receiving community care services are protected from neglect, physical and sexual abuse, financial exploitation, inappropriate involuntary restraint, and the provision of services by unqualified personnel.

Since many of the community care services provided for under the Committee bill are often delivered by individuals who are not licensed health professionals, the Committee intends that the Secretary establish Federal personnel competency qualifications that will ensure that such individuals are competent to provide whatever community care services they are expected to provide. For example, a home health aide who is, as part of his or her duties, requirements to help move an individual out of bed and into the bathroom, should be competent at this task before he or she is allowed to provide this type of care. Similarly, an aide who is required to bathe an individual as part of his or her duties should be competent to perform this task before being permitted to provide this service to the functionally disabled elderly. For services such as these, the Committee expects the Secretary to set standards by which an individuals's competency can be established and determined.

Because the individuals who provide community care services are usually less skilled in training, they are, in general, paid at only the minimum wage level. In addition, they are often required to perform work that is less attractive than other job opportunities for the same pay. As a result, current personnel are difficult retain and new workers are difficult to recruit. The Committee is informed that turnover rates are high and, as a result, there is little continuity of care.

In the Committee's view, the most appropriate way to address this problem is for the Secretary to establish guidelines regarding minimum compensation for individuals who provide community care. The Committee intends that such guidelines take into account the nature of the services to be provided (vis-a-vis other less skilled employment opportunities) as well as the level of functional disability of the individuals who are eligible to receive community care services. In addition, the Committee intends that such guidelines consider the growing need for this type of caregiver and the importance of continuity in the provision of services.

In addition to these minimum quality requirements, community care services would have to be provided in accordance with the requirements established by the Secretary designed to assure—through methods other than State licensure—that functionally disabled elderly individuals are protected against abuse, neglect, financial exploitation, inappropriate involuntary restraint, and the provision of health care services by individuals who are not competent. The need to go beyond compliance with State licensure requirements is documented in the GAO's recent study on board and care facilities, "Board and Care: Insufficient Assurances That Residents' Needs Are Identified and Met," in which investigators cite example after example of residents being abused and neglected, and receiving inadequate care in licensed facilities. In the Committee's view, additional measures—such as competency evaluation requirements—must be taken by the Secretary to assure that func-

tionally disabled elderly individuals are not subjected to these practices.

(2) Minimum requirements for "Community Care Settings".— Under the Committee bill, "community care settings" would be defined as settings, in which community care is provided, that are either non-residential (e.g., facilities in which adult day health services are delivered) or residential (e.g., foster homes, board and care facilities, and other group living arangements) in which more than two unrelated adults reside. (Nursing facilities would not be considered "comunity care settings" since the Medicaid statute already contains requirements for participation applicable to them.) "Community care settings" could not have, as persons with an ownership or control interest, any individuals who have operated facilities that have been found repeatedly to be substandard. Residential settings in which community care services are not provided to Medicaid-eligible residents would not be subject to these minimum requirements.

Since 1976, when Congress enacted the so-called "Keys Amendment" to the Social Security Act (which permitted Supplemental Security Income (SSI) payments to be made to individuals in small publicly-supported community residences), the number of elderly living in "community care settings" such as board and care homes, has grown considerably. Although the actual figure cannot be determined (because of the substantial number of unlicensed facilities), the recent GAO report, "Board and Care: Insufficient Assurances That Residents' Needs Are Identified and Met," cities a estimate of over 260,000 board and care beds in approximately 10,000 facilities designated for serving the elderly. Many of the elderly living in these facilities would undoubtedly qualify for community care under the Committee's bill.

As discussed above, the need for minimum requirements for community care settings such as board and care homes is well-documented in this GAO study. In one State visited, for example, GAO investigators noted that during one 3-month period in 1987, 357 cases of abuse were reported, of which 180 were confirmed by State officials. In 73 percent of the confirmed cases, the abusers were employees of the board and care facilities. In another State, officials found that residents were forced to work in one board and care facility on a farm, and were subjected to physical abuse by the operators. And in still other States, inspectors found continuous violations regarding trash, improperly dispensed medications, lack of heat, absence of pest control, and insufficient food.

Similar conditions were also cited in a March 1989 report, "Board and Care Homes In America; A National Tragedy," prepared by the House Select Committee on Aging's Subcommittee on Health and Long-Term Care (Comm. Rept. 101–711). That study reviewed the quality of care in board and care facilities over the last ten years. Although GAO investigators were unable to obtain a great deal of information about unlicensed facilities, given the conditions described in the GAO and the Health and Long-Term Care Subcommittee's reports, the Committee agrees with the GAO conclusion that "undoubtedly, serious problems also exist in unlicensed homes".

The Committee bill would not establish a program for directly regulating board and care facilities or similar residential settings. However, the Committee insists that Federal Medicaid funds not be spent for services provided in settings that do not assure that residents are not subject to neglect, abuse, financial exploitation, or other harm. Otherwise, the Medicaid program would, in effect, be indirectly subsidizing substandard living arrangements. This the Committee refuses to do.

Accordingly, the Committee bill would establish a number of minimum requirements for community care settings in which community care is provided. Such requirements would include (1) specified residents' rights, including rights of incompetent residents, access and visitation rights, protection of resident funds, and restrictions on the use of physical or chemical restraints or psychopharmacologic drugs; (2) applicable licensing and life safety code standards; and (3) applicable sanitary and infection control standards. In addition to these requirements, these settings would have to meet requirements developed by the Secretary designed to assure, through methods other than reliance on State licensure, that the functionally disabled elderly receiving community care services are protected from neglect, physical and sexual abuse, financial exploitation, inappropriate involuntary restraint, and the provision of services by unqualified personnel.

The Committee stresses that, in establishing minimum "requirements" for providers and for community care settings, the bill would not use the regulatory framework of "conditions" and "standards" that currently applies to SNF and ICF services. (The nursing home reform provisions of the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100-203, established "requirements" for participation by nursing facilities in Medicaid, effective October 1, 1990). It is the specific intent of the Committee that, with respect to the provision of community care or the settings in which such care is provided, the Secretary assure compliance with each element of each minimum "requirement." The Secretary has no authority to redefine these "requirements" and "conditions" or "standards," or as "level A" and "level B" requirements.

(e) Survey and certification process.— In order to assure compliance by providers and settings with the Federal minimum requirements regarding the health, safety, welfare, and individual rights of functionally disabled elderly individuals receiving community care services, the Committee bill would require States to establish and implement a survey and certification process. Under this process, the State would be responsible for certifying, at least annually, the compliance of providers of community care services, and of "community care settings" in which such services are delivered, with the minimum requirements. In the case of providers and "community care settings" operated by the State, the Secretary would have this certification responsibility.

The Committee bill would provide for two certification methods. With respect to community care providers (other than "community care settings" that are providers), certification would be based upon on a periodic performance reviews, rather than on-site surveys. With respect to "community care settings" (whether they are providers or settings in which community care is provided), certifi-

cation would be based upon an unannounced, on-site survey using a protocol developed by the Secretary. To assure the adequancy of State surveys, the Secretary would be required to conduct "look behind" surveys in a sample of settings in each State using the same protocols. Results of all provider reviews and "community care setting" surveys would be available to the public and to State Medicaid Fraud Control Units.

In addition to their provider review and "community care setting" survey responsibilities, States would be required, through their survey agencies, to investigate allegations of individual neglect and abuse and misappropriation of personal property by personnel providing community care services, and allegations of individual neglect and abuse in "community care settings". If a State finds that a provider has delivered community care of substandard quality, or that a "community care setting" is substandard, the State would have to make a reasonable effort to notify family members and other individuals receiving community care services by that provider or in that setting. Both the States and the Secretary would be required to maintain adequate staff to investigate complaints of violations of requirements by providers or by "community care settings". Where the Secretary has reason to question the compliance of a provider or a "community care setting" with these requirements, the Committee bill would authorize the Secretary to make an independent review or survey.

The Committee notes that these survey and certification requirements would not apply to any State that does not elect to offer Medicaid coverage for community care services for functionally disabled elderly individuals. In addition, they would not apply with respect to services provided under a section 1915(c) waiver.

The Secretary would be required to develop protocols and methods for use by State surveyors in evaluating and assuring the quality of "community care settings." Survey protocols and methods relating to the interim requirements would have to be issued by July 1, 1990. Survey protocols and methods relating to the final requirements would have to be published by October 1, 1991. Effective January 1, 1992, no Federal Medicaid matching funds would be available to pay for community care provided to beneficiaries residing in "community care settings" that have not been subject to a State survey using the final version of the portocols and methods.

(f) Enforcement.—With respect to providers of community care, the Committee bill would provide for the use of two remedies by both the States and the Secretary to enforce the requirements of the bill: (1) termination of participation in the program, and (2) civil money penalties. States would be required to establish, by statute or regulation, a civil money penalty assessed and collected, with interest, for each day in which the provider is or was out of compliance with a requirement. The States would be responsible for enforcement in the case of providers other than those which they operate; the Secretary would be responsible for enforcement with respect to State providers. The Secretary would be given independent authority to impose civil money penalties of up to $10,000 for each day of noncompliance by either a State or private provider. The Committee expects that, as under current law, the Secre-

tary's civil money penalty authority under this bill will be exercised by the Inspector General.

Where noncompliance by a provider immediately jeopardizes the health or safety of beneficiaries, the Committee bill would require both the State and the Secretary to either (1) take immediate action to remove the jeopardy and to correct deficiencies through the appointment of temporary management or (2) terminate Medicaid participation by the provider. The same requirement would apply with respect to "community care settings."

Where noncompliance by a provider does not immediately jeopardize beneficiary health or safety, the Committee bill would authorize the State and the Secretary to apply any of the remedies available to them under State or Federal law, including civil money penalties. Both the State and the Secretary would have to develop criteria under which the penalties would become incrementally more severe for repeated or uncorrected deficiencies. Civil money penalties would not be applicable to "community care settings" that are not providers, since these settings do not directly receive Medicaid reimbursements. Instead, as described in section (g), the Committee bill would simply deny Federal Medicaid matching funds for community care delivered to individuals residing in substandard or noncomplying "community care settings" (subject to a one-time 3-month grace period).

(g) Payment for community care.—The Committee bill would require that States pay for the community care services they elect to offer at rates which are reasonable and adequate to meet the costs of providing care, efficiently and economically, in conformity with applicable State and Federal laws, regulations, and quality and safety standards. The Committee notes that the applicable laws include the guidelines which the Secretary is required to promulgate regarding mimimum compensation for community care providers. The Committee stresses that payment rates must be adequate to assure that the individuals who are provided hands-on community care are competent to perform the tasks expected of them under the ICCP and are willing to deliver such services for a reasonable period of time before moving on to other employment.

Under the Committee bill, Federal Medicaid matching funds would not be available for the costs of a civil money penalty imposed by the State or the Secretary for noncompliance with the requirements of this bill or Medicaid program integrity provisions. Federal Medicaid matching funds would also be denied for legal expenses incurred by a provider in defending an action for a civil money penalty or exclusion from the program if there is no reasonable legal ground for the provider's case. In the Committee's view, Federal Medicaid funds should not be used to subsidize litigation which does not raise reasonable objections but is primarily designed to delay the imposition of remedies so that the provider can continue receiving Medicaid payments.

To ensure that Federal Medicaid matching funds do not pay for substandard quality care, the Committee bill would prohibit Federal financial participation in the following circumstances. First, payment could not be made for community care that does not meet the minimum requirements developed by the Secretary, including protections from neglect, physical and sexual abuse, financial exploita-

tion, inappropriate involuntary restraint, and incompetent providers.

Second, payment could not be made for community care that is provided in community care settings that (1) are found by a survey to be substandard or (2) do not meet one or more of the minimum requirements developed by the Secretary. The residents of a community care setting found to be substandard or out of compliance with the minimum requirements would be allowed to continue receiving Medicaid coverage for community care for up to 3 months while the setting eliminates its deficiencies. This opportunity to correct would apply only once with respect to each setting. Thereafter, payments for community care would not be made on behalf of residents in these settings from the day the settings are found to be substandard or not comply with the minimum requirements.

Under the Committee bill, Federal Medicaid matching funds would not be available for community care provided to a functionally disabled elderly individual by a member of the individual's family. In the Committee's view, it would create difficulty in monitoring and assuring the quality of services in circumstances where the community care provider is a relative of the beneficiary.

(h) Effective dates.—The community care option would be effective on the later of (1) July 1, 1990, or (2) 30 days after the publication of interim regulations by the Secretary setting forth minimum requirements for community care providers and community care settings. The Secretary would be required to issue final regulations implementing the requirements for providers and community care settings by October 1, 1991. To expedite the publication of these interim and final regulations, the Committee bill would waive application of the Paperwork Reduction Act and Executive Order 12291. Effective upon their publication, the Secretary's interim and final requirements would apply to community care provided to the elderly by Arizona and any other State operating under a waiver granted by the Secretary under section 1115 of the Social Security Act.

PART E—HOSPICE COVERAGE

Section 4261—Mandating hospice coverage

(a) In general.—Under current law, States may, at their option, offer hospice care to terminally ill individuals who elect these services in lieu of hospital, nursing facility, or other services. Hospices provide palliative treatment (i.e., care intended to comfort, not cure) to terminally ill patients, generally in their own homes. Hospice services include physicians' services, nursing care, medical social services under the direction of a physician, home health aide and homemaker services, medical supplies, bereavement counseling, and short-term inpatient care for pain control and symptom management. Except in the case of patients with AIDS, payment for short-term inpatient services is subject to an aggregate limit. To participate, hospice programs must make services available on a 24-hour basis and meet other Medicare standards. According to the National Governors' Association, as of March 1989, 20 States offered hospice coverage under their Medicaid programs: Arizona, California, Connecticut, Delaware, Florida, Hawaii, Idaho, Illinois, Kentucky, Massachusetts, Michigan, Minnesota, Nebraska, New

York, North Carolina, North Dakota, Rhode Island, Texas, Vermont, and Wisconsin.

The Committee notes that hospice care is a benefit available to all terminally ill Medicare beneficiaries, regardless of the State in which they reside. In the view of the Committee, the hospice care benefit should also be available to low-income, terminally ill individuals who are not elderly or disabled Medicare beneficiaries, regardless of the State in which they reside. The Committee recognizes that hospice services may frequently be sought by low-income persons with AIDS, few of whom are eligible for Medicare. The Committee bill would therefore require all States to offer hospice coverage under their Medicaid programs. The requirement would take effect July 1, 1990, without regard to whether final implementing regulations have been issued.

(b) Payment.—Under current law, States that elect to offer coverage for hospice care must pay for such services in the same amounts, and with the same methodology, as used under Medicare Part A. In the case of a terminally ill Medicaid-eligible beneficiary whose home is a nursing facility or intermediate care facility for the mentally retarded, the State may pay a separate rate to the hospice program in order to take into account the room and board furnished by the facility. The Medicaid statute defines room and board for this purpose to include the performance of personal care services, such as assistance in activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervising and assisting in the use of durable medical equipment and prescribed therapies.

It has come to the attention of the Committee that the Medicare hospice care rates may not adequately reflect the costs of caring for some classes of terminally ill patients, such as AIDS patients. The Committee bill would therefore allow States, at their option, to set their hospice payment rates in amounts higher than the Medicare rates. As under current law, States would not be allowed to set rates lower than the Medicare rates, and would be required to use the Medicare methodology in establishing rates.

The Committee is also informed that a number of States pay hospices substantially less for room and board than they pay to nursing facilities in which the hospice patients live. Once a resident of a nursing facility has elected hospice care, the State may no longer pay the nursing facility. Instead, the State pays the hospice, and the hospice enters into a written agreement with the facility, under which the hospice takes responsibility for the professional management of the patient and the facility provides room and board. The facility receives payment for room and board from the hospice. If the amount paid by the State to the hospice for room and board is lower than the facility's room and board rates, the hospice must make up the difference. If the room and board payment to the hospice is 30 or 40 percent lower than the nursing facility rate, as has been reported to the Committee, it is obviously very difficult for a hospice to accept a nursing facility resident as a patient. In order to eliminate any financial disincentive hospices might face to accept Medicaid patients living in nursing facilities, the Committee bill would require that States, in these circumstances, pay the hospice an additional amount equal to at least 95 percent of the rate

that would have been paid by the State to that facility for the Medicaid beneficiary.

(c) Clarifying effect of hospice election.—Under current law, terminally ill Medicaid beneficiaries who elect hospice care must waive payment for services, such as hospital and nursing facility services, that are defined by the Secretary under Medicare as related to the treatment of the individual's condition with respect to which a diagnosis of terminal illness has been made or that are duplicative of hospice care. Medicare, under its hospice benefit, does not cover many of the non-skilled services that States cover under Medicaid, including personal care services. This attendant care and other personal care is essential to enabling terminally ill Medicaid beneficiaries who have no family or friends to remain at home. The Committee is concerned that, if the current statutory language is interpreted to require a beneficiary to waive payment for personal care services, the practical effect will be to deny them access to hospice benefits at home, since the hospice rate under Medicare does not include a component for the cost of personal care services. The Committee bill would therefore clarify that, in electing hospice care, a Medicaid beneficiary waives payment for services determined by the Secretary for which payment may otherwise be made under Medicare. Thus, a beneficiary would not be required to waive payment for personal care services, attendant care, and other services covered under the State's Medicaid program but not under Medicare.

PART F—MISCELLANEOUS

Section 4271—Amendments relating to nursing home reform

(a) Moratorium on implementation of February 2, 1989, regulation.—On February 2, 1989, HCFA issued final regulations with a comment period which specified new and revised requirements long-term facilities must meet in order to receive Federal funds for the services they provide to their residents (54 Fed. Reg. 5316). Such facilities include skilled nursing facilities (SNFs) under Medicaid, and SNFs, and intermediate care facilities (ICFs) and effective October 1, 1990, nursing facilities under Medicaid. The February 2nd final regulations followed the publication of a notice for proposed rule making (NPRM) for conditions of participation for Medicare and Medicaid long-term care facilities on October 16, 1987 (52 Fed. Reg. 338582). That NPRM was released prior to the passage of the nursing home reform legislation authorized by this Committee and included in the Omnibus Reconciliation Act of 1987 (OBRA '87) (P.L. 100-203).

Despite the intervening enactment of OBRA '87, HCFA has not published a new NPRM on participation requirements for Medicare and Medicaid long-term care facilities. It has chosen instead to issue the February 1989 final regulations. According to the agency, such regulations are designed to implement the provisions of the October 1987 NPRM as well as those sections of the OBRA '87 legislation that HCFA has determined to be "self-executing".

Among the OBRA '87 requirements that are addressed in the February 2nd regulations are those relating to residents' rights; admission, transfer, and discharge rights; resident behavior and facili-

ty practices; quality of life; resident assessments; services for residents; infection control; physical environment; and administration. Under OBRA '87, these requirements are to take affect on October 1, 1990. The February 1989 final regulations mandate, however, that many of these requirements become effective August 1, 1989, sixteen months prior to the deadline set in OBRA '87. A HCFA rule published on July 14, 1989, delays the final regulations' effective date until January 1, 1990 (54 Fed. Reg. 29717). Nonetheless, as currently structured, the February 2nd final regulations will be put into place—with no opportunity for public comment or for agency adjustments—well before the law's October 1, 1990, effective date.

In the view of the Committee, the implementation of these regulations is premature and should be postponed. Indeed, even HCFA acknowledges that a delay "would be beneficial to all affected parties" (54 Fed. Reg. 29718). Thus, the Committee bill postpones until October 1, 1990, the implementation of HCFA's February 2, 1989 final regulations. During the interim period, the Committee would encourage HCFA to review these regulations and, where appropriate, to revise and reissue them with an opportunity for public comment, in accordance with both OBRA '87 and with the comments that HCFA has already received since the regulations' publication last February.

With respect to the content of the February 2, 1989 final regulations, the Committee takes issue with HCFA's claim in the preamble that "OBRA '87 was written with both the recommendations of the IoM and *our [October 16, 1987] NPRM as a model*" (emphasis supplied). For the record, the Committee wishes to inform the agency that the only blueprint for congressional action on nursing home reform legislation in 1987 was the congressionally mandated Institute of Medicine study, "Improving the Quality of Care in Nursing Homes." (Note that legislation on Medicaid nursing home reform was first introduced on May 5, 1987 [H.R. 2270], some five months prior to the publication of the October 1987 NPRM. Similar legislation relating to Medicaid nursing home reform was introduced on June 24, 1987 [H.R. 2770], four months ahead of the NPRM). Thus, the Committee never intended—and does not intend now—that HCFA use its October 1987 NPRM as the basis for developing and implementing OBRA '87.

(b) Nurse aide training.—Under current law, effective January 1, 1990, all nurse aides used by nursing facilities participating in Medicaid must (i) have completed, within four months, a training and competency evaluation program approved by the State; and (ii) be competent to provide nursing-related services.

OBRA '87 required the Secretary to establish requirements for State nurse aide training and competency evaluation programs and State nurse aide competency evaluation programs by September 1, 1988. Pending the publication of regulations establishing such requirements, HCFA has issued a guidance document, effective May 12, 1989 (HCFA Transmittal No. 62, Sections 2504-2512 (April 1989), which sets out approval criteria for the States. This delay has resulted, in some instances, in States postponing either the development of appropriate training and evaluation programs or the approval of qualified training and evaluation programs that are al-

ready in operation. It has resulted, too, in confusion among the States, nurse aides, and the nursing home industry.

In response to these concerns, the Committee bill contains a number of provisions designed to clarify the structure and operation of the OBRA '87 nurse aide training and competency evaluation requirements.

(1) Delay in requirements.—In order to ensure that State nurse aide training and competency evaluation programs and State nurse aide competency evaluation programs are effectively qualified, approved, and put into place, the Committee bill delays from January 1, 1990, until October 1, 1990, the date by which nurse aides must complete a competency evaluation program and be determined to be competent to provide nursing-related services.

The Committee notes, however, that a number of States have already begun to implement the nurse aide training and competency evaluation provisions of OBRA '87 and would encourage such States to continue those activities. It would also encourage all other States to begin implementation of these requirements as soon as possible. The Committee further notes that the enhanced Medicaid matching rate for nurse aid training and competency evaluation programs provided for under OBRA '87 continues through the third quarter of FY 1990, or until July 1, 1990. The October 1, 1990 delay for which the Committee bill provides does not change the conditions for, or the expiration date of, this enhanced matching rate.

No compliance actions before effective date of guidelines.—In light of the confusion that has resulted from HCFA's delay in publishing regulations relating to nurse aide training and competency evaluation programs and to nurse aide competency evaluation programs, the Committee bill prohibits the Secretary from taking any compliance action against any State that has a made a good faith effort, prior to May 12, 1989 (the effective date of HCFA's interpretative guidelines), to comply with these OBRA '87 requirements. Such efforts would include a State's approval (prior to May 12, 1989) of a nurse aide training and competency evaluation program which the State had reasonably believed, at the time it made its certification, was in compliance with the OBRA '87 requirements. however, for periods occurring after May 12, 1989 and until HHS nurse aide training regulations are effective, the Committee intends for States to meet fully, the requirements of the statute, as specified in HCFA's May 1989 guidance document (as periodically updated).

In providing for this good faith exception, the Committee emphasizes that the Secretary's past failure to implement the OBRA '87 nurse aide training and competency evaluation provisions through regulation, while, regrettable, should not be construed to undermine the validity of the requirements specified in HCFA's May 12, 1989 interpretative guidelines. OBRA '87 did not mandate that the Secretary issue such regulations and explicity did not predicate implementation of the nurse aide training and competency evaluation requirements upon the issue of final regulations.

(3) Publication of proposed regulations.—The Committee bill requires the Secretary to promulgate proposed regulations to implement OBRA '87 nurse aide training and competency evaluation re-

quirements within 90 days of enactment of this Act. The Committee intends for such proposed regulations to include among its requirements the items and issues discussed throughout section 4271(b).

Because nurse aides provide most of the "hands-on" care to nursing faclity residents, the nurse aide training requirements were—and continue to be—one of the cornerstones of OBRA '87. Accordingly, HCFA's missed deadlines for taking interim steps towards full implementation of these requirements have become of particular concern to the Committee as October 1, 1990 (the date on which the entire nursing home reform law becomes effective) quickly approaches. Effective as of that date, States will be able to waive the statute's minimum nurse staffing requirements (with respect to both registered nurses and licensed practical nurses) in all nursing facilities, and in turn, to leave residents under the exclusive care of nurse aides.

The Committee stresses that, while it expects the Secretary to issue proposed regulations in a timely manner, the failure of the Secretary to issue proposed (or final) regulations, as required under the Committee bill, does not, and is not to be construed to, delay the applicability of the statutory requirements relating to nurse aide training and competency evaluation. Under current law, these requirements are effective January 1, 1990 (and under section 4271(b)(1), above, October 1, 1990), without regard to whether final implementing regulations have been published. If such requirements were conditioned on the Secretary's taking specific actions, the Secretary would have the ability to forestall—in violation of the intent of OBRA '87—the implementation of these critical protections against the provision of substandard care. The Secretary was not given this power in OBRA '87 and the Committee declines to give it to him now.

(4) Clarification of grace period for nurse aide training of individuals.—Under current law, effective January 1, 1990, a nursing facility participating in Medicaid may not use (on a full-time, temporary, per diem, or other basis) any individual as a nurse aide for more than a four-month period unless the individual has completed an approved nurse aide training program and is determined to be competent to provide nursing related services.

As discussed in section 4271(b)(1), above, under the Committee bill, the January 1, 1990 effective date would be postponed until October 1, 1990.

This section of the bill simply clarifies what Congress had originally intended in enacting the OBRA '87 requirements relating to the use of nurse aides: no individual may work as a nurse aide for more than 90 days at any point in his or her career without having completed an approved nurse aide training and competency evaluation program and without having demonstrated competency to provide nursing and nursing-related services. This requirement applies whether such an individual is an employee of a nursing facility or is a per diem worker form an agency pool. For example, an individual may perform nurse aide work as an employee of nursing facility "A" for 70 days, then quit and obtain employment at nursing facility "B". Under the Committee's bill, it is now clear that this individual could be used as a nurse aide at facility "B" (or any

other nursing facility) for only 20 days without having completed an approved training and competency evaluation program and without having demonstrated competency to provide services. Similarly, if an individual is employed by an agency (or as an independent contractor) and works 15 days at nursing facility "A", 15 days at nursing facility "B", 15 days at nursing facility "C", and 45 days at nursing facility "D", such individual may not be used as a nurse aide by any other nursing facility until he or she has completed an approved training and competency evaluation program and has demonstrated competency.

The Committee bill includes this clarification not only to explain its purpose in enacting the OBRA '87 requirements regarding the use of nurse aides, but also to stress its intent that the 90-day exemption from the training and competency evaluation requirements is only a grace period, not a "loophole" for circumventing the law.

(5) Requirements for training and evaluation programs.—Under current law, effective January 1, 1989, States are required to specify those approved nurse aide training and competency evaluation programs and, approved nurse aide competency evaluation programs, that meet the minimum requirements for those programs as set forth in OBRA '87. For nurse aide training and competency evaluation programs, these requirements relate to covered subject matter; the minimum number of training hours; training; instructor qualifications; and the procedures for determining competency. For nurse aide competency evaluation programs, these requirements relate to the covered subject matter and the procedures for determining competency.

It has come to the attention of the Committee that several States have approved—or plan to approve—programs which include elements that OBRA '87 never intended to be a part of the training and evaluation process. In the Committee's view, these elements act as obstacles both to the retention of currently employed nurse aides and to the recruitment of new candidates. Of particular concern are those programs which impose charges or fees for textbooks and other related course material, and those programs which require that the competency of nurse aides be determined solely on the basis of a written examination or which require nurse aides to travel unreasonable distances in order be evaluated. The Committee bill includes a number of provisions designed to clarify the intent of OBRA '87 with regard to these practices.

With respect to charges for textbooks or related course material or for the competency evaluation itself, the Committee bill requires that approved training and evaluation programs specifically prohibit the imposition of such charges on nurse aides. It is well known that nurse aides are among the nursing home industry's lowest paid workers, with wages at or near the minimum wage. In the Committee's view, the imposition of any charges relating to training and competency evaluation on these employees would be a real hardship for them. This action would also discourage other individuals to seek work as a nurse aide. Such a result would be both contrary to the intent of Congress and to the best interests of nursing home residents who need nurse aide services.

With respect to competency determinations, the Committee bill requires that approved training and competency evaluation programs provide for procedures which allow nurse aides, at their option, (i) to establish competency through procedures or methods other than the passing of a written examination; and (ii) to have the competency evaluation conducted at the nursing facility at which they are (or will be) employed (unless such facility is not in compliance with the OBRA '87 mandates).

In the Committee's view, even well-trained, experienced nurse aides, by virtue of either their educational background or their usual nursing facility responsibilities, may be intimidated or threatened by the idea of being "tested" through the use of a written examination. Moreover, the Committee believes that, considering the tasks that nurse aides generally perform, there are other, perhaps more appropriate and less formal ways of evaluating nurse aide competency. Indeed, the Conference Report that accompanied OBRA '87 (H. Rept. 100–495) noted that the word "testing" was struck from the agreement and replaced with the words "competency evaluation" in order "to emphasize that [training and competency evaluation] programs *shall* include manual and oral evaluation" (emphasis added) (p. 678). The Committee agrees and affirms the position taken in the OBRA '87 Conference Report (as quoted above). Thus, the Committee stresses again, as it did in 1987, its intent that nurse aides be evaluated under methods or procedures that are the most comfortable, the most appropriate, and the most reasonable for them.

In response to these views, the Committee believes HCFA should be taking appropriate action (through its interpretive guidelines and forthcoming regulations) to ensure that both manual and oral metods of competency evaluation—at a minimum—are available to nurse aides. In the Committee's view, too, States should not approve any training and competency evaluation program in which such methods are not affected. Under the Committee's bill, it is clear they cannot do so. It is also clear that individual nurse aides—and not the State and not the nursing facilities—have the right to choose for themselves, within reason, the process or procedures by which they are to be evaluated. Thus, the Committee does not intend that a request from a nurse aide working in Pennsylvania to have a competency evaluation performed in California, be granted. It does intend, however, that there be several methods of competency evaluation available to nurse aides and that each individual nurse aide be able to choose among them or any other reasonable competency evaluation procedures.

In requiring that approved programs permit nurse aides to have their competency evaluation conducted at the nursing facility at which they are or will be employed, the Committee again believes that it is simply clarifying the intent of OBRA '87, that is, nurse aides should be evaluated for competency in a manner that is the most reasonable and least burdensome for the aides themselves. In the Committee's view, this standard does not include training and competency evaluation program requirements which demand that nurse aides travel significant distances for their competency evaluation. Nor does it include any other program requirement, such as travel mandate, that would involve relatively great expense (in

relation to nurse aides' income) to nurse aides who wish to be evaluated.

The Committee bill makes it clear, therefore, that individual nurse aides have the right to be evaluated in the nursing facility at which they are or will be employed. An aide is not entitled to exercise this right, however, if he or she is used or is to be used in a nursing facility that has been determined to be out of compliance with OBRA '87 requirements within the previous two years. In such instances, the Committee intends that aides who express a preference, be evaluated at the most convenient, alternative location available.

This section of the Committee bill also corrects an inconsistency in the minimum requirements for approved training and competency evaluation programs and approved competency evaluation programs with regard to the subject matters they are to cover. The Committee bill simply clarifies that both such programs must include skills relating to the care of the cognitively impaired residents.

(6) Delay and transition in 75-hour training program requirements.—Under current law, approved nurse aide training and competency evaluation programs must, among other requirements, provide for a minimum of 75 hours of initial training. As noted above, current law also provides that, effective January 1, 1990, all nurse aides used by nursing facilities participate in Medicaid must (i) have completed such an approved training and competency evaluation program within four months; and (ii) be competent to provide nursing related services. The Committee bill considers this requirement to be met with respect to nurse aides, who as of July 1, 1989, have completed a training and evaluation program of at least 60 hours and have received up to 15 hours of supervised practical training or regular in-service education.

(7) Clarification of State responsibility to determine competency.—Under OBRA '87, States are specifically required to make determinations about the competency of individual nurse aides to provide nursing related services. OBRA '87 also specifically prohibits States from delegating this responsibility to a nursing facility. It has come to the attention of the Committee, however, that some States may be circumventing this prohibition by entering into subcontracts with nursing facilities (or entities related to nursing facilities) to carry out the States' responsibility to make nurse aide competency determinations. Under the Committee bill, such subcontracts (or any other legal device designed to relieve a State directly or indirectly of its duty to conduct nurse aide competency evaluations), are specifically prohibited.

(8) Clarification of temporary enhanced Federal financial participation for nurse aide training by nursing facilities.—Under OBRA '87, Federal Medicaid matching funds are available for State expenditures with respect to nurse aide training and competency evaluation programs, and competency evaluation programs, regardless of whether the programs are conducted in or outside of nursing facilities, and regardless of the skill of the personnel involved in such programs. During the period July 1, 1988, to July 1, 1990, the matching rate on these expenditures is the lesser of (i) 90 per-

cent or (ii) the State's regular matching rate plus 25 percentage points.

The Committee bill clarifies that the expenditures subject to Federal matching at the enhanced matching rate during the July 1, 1988, to July 1, 1990, period include the costs for nurse aides to complete competency evaluation programs, regardless of whether the programs are conducted in or outside of nursing facilities. Effective July 1, 1990, expenditures attributable to nurse aide training and competency evaluation programs, and competency evaluation programs, are subject to a 50 percent matching rate.

Under current law, as a general rule, Medicaid funds are available only for expenditures attributable to Medicaid beneficiaries. One exception is the start-up expenditures for nurse aide training and competency evaluation. The Committee bill clarifies that the Secretary may not take into account, or allocate amounts expended for nurse aide training and competency evaluation on the basis of the proportion of nursing facility residents entitled to Medicare or Medicaid. This prohibition applies with respect to expenditures for activities under nurse aide training and competency evaluation programs, and competency evaluation programs, prior to October 1, 1990. Therefore, the Committee expects that the costs of nurse aide training and competency evaluation, subject to Federal matching payments, will be allocated on the basis of the proportion of residents eligible for Medicare and Medicaid.

(9) Effective dates.—The Committee bill provides that, except for those changes made under section 4271(b)(5) above, all of the amendments made with respect to the OBRA '87 nurse aide training and competency evaluation requirements are to take effect as if they were included in the enactment of OBRA '87. With respect to the amendments made under 4271(b)(5) (relating to requirements for training and evaluation programs), the bill provides that those modifications are to apply to nurse aide training and competency evaluation programs, and to nurse aide competency evaluation programs, offered on or after 90 days after the enactment of this Act.

(c) Preadmission screening and annual resident review.—The preadmission screening and resident review (PASSAR) process established under OBRA 1987 has two components: (1) preadmission screening; and (2) annual resident review. It is intended to prevent the inappropriate placement of individuals with mental illness or mental retardation in nursing facilities. It is also intended to ensure that Federal funds are not used to pay for inappropriate nursing facility care.

Under current law, prior to admission to a nursing facility, States are required to screen, all individuals (including those eligible for Medicare and those using private, personal funds or private long-term care insurance) with mental illness or mental retardation to determine whether they require the level of services provided by a nursing facility. Effective January 1, 1989, nursing facilities participating in Medicaid may not admit any individual with mental illness or mental retardation who has been determined by the State not to require such care.

Current law also requires States to review, on an annual basis, all residents (including those eligible for Medicare and those using private, personal funds or private long-term care insurance) with

mental illness or mental retardation to determine whether nursing facility placement continues to be appropriate. The first round of these annual reviews must be completed by April 1, 1990. Individuals who have resided in nursing facilities for less than 30 months and who do not require nursing facility care must be discharged in an orderly manner. The Secretary has been authorized to approve, prior to April 1, 1989, State alternative disposition plans (ADPs) for the implementation of this requirement. It is the Committee's understanding that HCFA has approved the ADPs of 47 States.

The law exempts individuals with a primary diagnosis of dementia (including Alzheimer's disease or a related disorder) from both components of the PASSAR process.

OBRA 1987 directed the Secretary to issue, by not later than October 1, 1988, minimum criteria for States to use in making PASSAR determinations. Pending final regulations, HCFA issued a series of draft guidelines, culminating in interim guidelines, effective May 26, 1989 (HCFA Transmittal No. 42, Sec. 4250–4253 (May 1989)) for States to use in implementing this requirement. In some instances, this delay has resulted in confusion and difficulty in implementing the PASSAR requirements.

In response to these concerns, the Committee bill contains a number of provisions designed to clarify the structure and operation of the PASSAR requirements. The Committee emphasizes, however, that while the bill makes some adjustments in the OBRA 1987 requirements, it has not changed or in any way modified, its view on the need for these provisions. Indeed, the Committee reaffirms its position that these requirements are fundamental for the protection of individuals with mental illness or mental retardation against inappropriate institutionalization.

The Committee notes further that, despite the delays in the Secretary's issuance of Federal criteria for State PASSAR determinations, the implementation of the OBRA 1987 PASSAR requirements is already well underway in the States. The National Mental Health Association, on behalf of itself and seven other national organizations (including the National Association of State Mental Health Program Directors and the National Association of State Mental Retardation Program Directors) has informed the Committee that many individuals have already been through the screening process, and that States are addressing the need for alternative community-based services for those found not to need nursing facility care. These organizations conclude that "the PASSAR process is vitally important for people with mental retardation and related conditions and with mental illness" (June 27, 1989 letter to Subcommittee Chairman Henry A. Waxman). The Committee agrees and does not intend, through the provisions related to the OBRA 1987 PASSAR requirements discussed below, to disrupt, delay, or interfere with this implementation process in any way.

(1) No compliance actions before effective date of guidelines.—As noted above, OBRA 1987 directed the Secretary to issue, by not later than October 1, 1988, minimum criteria for States to use in making PASSAR determinations. In light of the confusion that has resulted from HCFA's delay in publishing these criteria, the Committee bill prohibits the Secretary from taking any compliance action against any State that has made a good faith effort, prior to

May 26, 1989 (the effective date of HCFA's interpretative guidelines), to comply with these requirements of OBRA 1987. However, for periods occurring after May 26, 1989 and until final PASSAR regulations are effective, the Committee intends for States to meet fully, the requirements of the statute, as specified in HCFA's guidance document (as periodically updated).

In providing for this good faith exception, the Committee emphasizes that the Secretary's past failure to implement the OBRA 1987 PASSAR provisions through regulation, while regrettable, should not be construed to undermine the validity of the requirements specified in HCFA's May 26, 1989 interpretative guidelines. OBRA 1987 did not mandate that the Secretary issue regulations and explicitly did not predicate implementation of the PASSAR requirements upon the issuance of final regulations.

(2) Publication of proposed regulations.—The Committee bill requires the Secretary to promulgate proposed regulations to implement the OBRA 1987 PASSAR requirements within 90 days of the enactment of this Act. The Committee intends that such proposed regulations include among their requirements the items and issues discussed throughout section 4271(c).

The Committee stresses that, while the Committee expects the Secretary to issue proposed regulations in a timely manner, the failure of the Secretary to issue proposed (or final) PASSAR regulations, as required under the Committee bill, does not, and is not to be construed to, delay the applicability of the statutory requirements relating to preadmission screening or annual resident review. As under current law, these requirements are effective January 1, 1989, without regard to whether final implementing regulations have been published. If such requirements were conditioned on the Secretary's taking specific actions, the Secretary would have the ability to forestall—in violation of the intent of OBRA 1987—the implementation of these critical protections against the inappropriate institutionalization of individuals with mental illness or mental retardation. The Secretary was not given this power in OBRA 1987 and the Committee declines to give it to him now.

(3) Clarification with respect to admissions and readmission from a hospital.—Under current law, all individuals with mental illness or mental retardation (with the exception of (i) those persons with a primary diagnosis of dementia (including Alzheimer's disease or a related disorder) and (ii) those persons who have resided in a nursing facility for 30 months are longer) are subject to the PASSAR requirements. Since the preadmission screening requirements were put into place on January 1, 1989, however, the Committee has learned that, in some instances, the screening process is being inappropriately applied. Thus, the Committee bill clarifies two exceptions to the preadmission screening component of the PASSAR program. No changes are made, however to the annual resident review component.

The first exception clarifies that nursing facility residents (that is, those individuals who have already been admitted to a nursing facility) who are being readmitted to the nursing facility after a hospital stay are not subject to the preadmission screening requirements. Since these individuals have already been admitted to a nursing facility (and, in appropriate cases, have already met the

applicable preadmission screening requirements), it was never intended for them to undergo a second screening upon their readmission to the nursing facility. The Committee bill makes this explicit in the law.

The second exception applies to individuals who seek admission to a nursing facility directly from a hospital and who are expected to remain in the facility only briefly. Under this exemption, an individual (i) who is admitted to a nursing facility directly from a hospital after receiving acute inpatient care at the hospital; (ii) who requires nursing facility services for the condition for which he or she received care in the hospital; and (iii) whose attending physician has certified, before admission to the nursing facility, that he or she is likely to require less than 30 days of nursing facility services, is not subject to the preadmission screening requirements. Such an individual must meet all three of these conditions in order to be eligible for the exemption. Thus, for example, an individual who has been hospitalized with a stroke; who seeks admission, directly from the hospital, to a nursing facility for facility services required for treating the effects of the stroke; and who is certified by his or her physician to need no more than 30 days of facility care for such services, is not required to undergo preadmission screening under the Committee's bill. However, should this individual have a mental illness or mental retardation and remain in the nursing facility beyond 30 days, he or she is still subject to PASSAR's annual resident review process.

(4) Charges applicable in cases of certain Medicaid-eligible individuals.—Under current law, providers participating in Medicaid, including nursing facilities, must accept payment made by the State on behalf of eligible beneficiaries as payment in full. The only exception to this is that providers may collect nominal cost-sharing obligations which the State is allowed to impose on certain classes of beneficiaries; however, eligible residents in nursing facilities who are required to apply most of their income to the cost of care are not subject to cost-sharing. The purpose of this mandatory assignment requirement is to protect low-income individuals from excess provider charges.

There are circumstances in which, under current law, a State may not actually be making payments to a nursing home on behalf of a resident who is eligible for Medicaid. For example, a nursing home resident may be receiving Veterans' Administration aid and attendance payments. In a State which covers institutionalized individuals with incomes below 300 percent of the SSI benefits level, these payments are not taken into account in determining initial eligibility for Medicaid. However, these payments are considered in determining, post-eligibility, the amount of an individual's monthly income that is available to be applied to the cost of care.

Assume a State which sets its 300 percent eligibility threshold at $1,104 per month and which pays for nursing facility care at $1,165 per month (an ICF rate of $38.83 per day). If a resident has a monthly income of $1,250, of which $150 is Veterans' aid and attendance benefits, then the resident will be eligible for Medicaid ($1,100 is lower than the $1,104 income threshold), but the State will not actually make any payment ($1,250, less a $30 personal needs allowance, leaves $1,220, which exceeds the cost of care to

the State of $1,165). It is the understanding of the Committee that, in such circumstances, nursing facilities have charged these residents at "private pay" rates which are significantly higher than the Medicaid payment levels, even though these residents are Medicaid eligible.

The Committee bill clarifies that, in such cases, nursing facilities may not charge more than the rate which the State has established under its Medicaid plan. The Committee bill prohibits a nursing facility participating in Medicaid from imposing charges for Medicaid-eligible individuals for covered services that exceed the payment amounts established by the State for those services. This prohibition specifically applies in situations where the State is not making any payment to a nursing facility on behalf of a Medicaid-eligible resident because the individual's post-eligibility income exceeds the payment amounts established under the State's Medicaid plan.

(5) Delay in application to private pay residents.—Under current law, both components of the PASSAR requirements—the preadmission screening and the annual resident review—apply to all individuals with mental illness or mental retardation who seek admission to a nursing facility, regardless of their source of payment for services. The Committee bill delays the application of each of these requirements with regard to so-called "private pay" individuals (that is, those individuals who, at the time of their admission, are not entitled to Medicaid services) until they establish eligibility for Medicaid. If a "private pay" individual never qualifies for Medicaid, these requirements would not apply.

With respect to the application of the preadmission screening requirements, the Committee bill postpones the timing of the screening for a "private pay" individual with mental illness or mental retardation from the point at which he or she seeks admission to a nursing facility until the point at which he or she establishes Medicaid eligibility for nursing facility services. At that juncture, as the Committee bill provides, such individual must undergo, within a 24-hour period, a preadmission screening (just like any other non-"private pay" person would have to do in order to be admitted to a nursing facility). If as a result of the screening, it is determined that the individual does not require nursing facility services, the individual cannot remain in, or be admitted to, the facility.

With respect to the application of the annual resident review requirements, the Committee bill also postpones the timing of the review for a "private pay" individual with mental illness or mental retardation until the point at which the individual establishes Medicaid eligibility for nursing facility services. Once the individual becomes Medicaid eligible, he or she is subject to a resident review at least once a year. Again, should it be determined on the basis of such review that the individual does not require nursing facility services, the current annual resident review requirements are to be applied and the individual must be discharged from the nursing facility (unless he or she has resided in the facility for 30 months or more).

The Committee emphasizes that its bill delays the application of OBRA '87's PASSAR requirements to "private pay" residents until they become eligible for Medicaid. It does not, however, exempt

them from these requirements altogether (unless they have primary diagnosis of dementia (including Alzheimer's disease or a related disorder). Thus, the Committee reaffirms its conviction that individuals with mental illness or mental retardation who do not require nursing facility services should not reside in nursing facilities. This principle applies whether an individual is Medicaid eligible or not.

The purpose of the OBRA '87 PASSAR requirements is to assure that an independent determination is made of an individual's need for institutional placement. The Committee bill simply postpones this determination until the point at which the individual becomes eligible for Medicaid. Thus, unless a State has its own preadmission screening and resident review requirements, individuals would be free to spend their own resources on nursing facility care. However, upon qualifying for Medicaid, an individual is subject to the program's interest in appropriate placement and appropriate expenditures of funds, and must, therefore, undergo the PASSAR process.

In light of these modifications to the PASSAR requirements, the Committee does not believe it is appropriate to impose sanctions on those States which have failed, since January 1, 1989 (the date on which PASSAR's preadmission screening component went into effect), to screen "private pay" individuals for admission to a nursing facility participating in Medicaid. Accordingly, the Committee bill prohibits the Secretary from taking such actions under these circumstances. The Secretary must, however, impose and continue to impose sanctions on those States which have failed to demonstrate (to the satisfactory of the Secretary) that they have made a good faith effort to comply, between January 1 and May 26, 1989 (the date on which HCFA's PASSAR interpretative guidelines went into effect), with all other PASSAR requirements (see section 4271(c)(1), above).

The Committee is aware that a number of States have developed their own preadmission screening programs that require a review of all persons who seek admission to a nursing facility participating in Medicaid—regardless of their source of payment. The Committee, in including the provisions described above, has no intention of disrupting or interfering with the operation of such programs or of changing such programs' standards for admitting or retaining or making payment for, residents of nursing facilities participating in Medicaid. Thus, the Committee bill expressly states that these changes to the PASSAR provisions of OBRA '87 are not to be construed as prohibiting States from developing and conducting preadmission screening programs which screen and periodically review all applicants and residents including those that are "private pay."

(6) Denial of payments for certain residents not requiring nursing facility services.—Under current Medicaid law, no Federal matching payments may be made for covered services which are not medically necessary. Such services include those provided by a nursing facility.

One exception to this principle was established in OBRA '87. It provides that individuals with mental illness or mental retardation who have resided in a nursing facility for 30 months or more may

elect to remain in such facility even though they do not require nursing facility services. Under these circumstances, a State cannot be denied Federal matching payments for reimbursement to nursing facilities for any services provided to these individuals.

The Committee bill simply clarifies that (with the exception of those residents who meet the requirements of the 30-month rule described above), no Federal Medicaid matching funds are available for nursing facility care furnished to any individual who does not require the level of services provided by a nursing facility.

The Committee recognizes that, under current law, some persons who are eligible for Medicaid are not subject to the OBRA '87 preadmission and annual resident review determinations which indicate whether individuals require the level of services provided by a nursing facility. The Committee expects, however, that with respect to these individuals, States will use other utilization review methods designed to assure that Federal Medicaid matching funds are not paying for nursing facility services that are not required.

(7) No delegation of authority to conduct screening and reviews.—Under OBRA '87, State mental health and mental retardation authorities are required to conduct both components of the PASSAR process and to make independent determinations about the nursing facility requirements of individuals with mental illness or mental retardation. Although OBRA '87 did not specifically prohibit the States from delegating these responsibilities to nursing facilities themselves, it was never the law's intention to allow facilities to be able to conduct these activities. Since nursing facilities have a direct interest in the eligibility determinations that are to be made for those individuals subject to the PASSAR requirements, there is a potential conflict of interest in permitting them to make these determinations. Thus, it was the Committee's view in 1987—as it is today—to prohibit nursing facilities (or any of their related entities) to participate, in any way, in the PASSAR process.

It has come to the attention of the Committee, however, that some State mental health and mental retardation agencies (or other appropriate State authorities) may be circumventing the intent of OBRA '87 that PASSAR determinations be made independent of a nursing facility by entering into subcontracts with nursing facilities (or related entities) to carry out the State's responsibility to conduct preadmission screenings and annual resident reviews, and to make determinations about individuals' nursing facility requirements based upon these screenings or reviews. Under the Committee bill, such subcontracts (or any other legal device designed to relieve a State directly or indirectly of its duty to perform the PASSAR requirements), are specifically prohibited.

(8) Annual reports.—Current law authorizes the Secretary to approve, prior to April 1, 1989, State alternative deposition plans (ADPs) designed to relocate nursing facility residents determined, under PASSAR's annual resident review component, to require "specialized services" (see section 4271(c)(11), below), but not to require the level of services provided by a nursing facility. Such plans have been approved by the Secretary for some 47 States. Under the Committtee bill, each of these States is required to report to the Secretary, on an annual basis, on the number and disposition of the nursing facility residents covered under the State

ADP. In addition, the Committee intends that the Secretary require States with ADPs in effect to provide information on the age of each individual covered under a State's ADP, the type or types of "specialized services" required by each such individual, and the type of facility or community setting to which each such individual has been (or will be) relocated.

Current law also requires that the Secretary report to Congress, on an annual basis, on the extent of nursing facility compliance with the requirements of OBRA '87 and on the number and type of Federal and State enforcement actions taken under the law. The Committee bill provides that the Secretary's annual report also include a summary of the State information (as specified above) on approved ADPs.

(9) Revision of alternative disposition plans.—Current law does not provide for any revisions in a State's ADP once it has been approved by the Secretary. Under the Committee bill, subject to the approval of the Secretary, a State with an approved ADP is authorized to revise or amend, before October 1, 1990, its approved ADP. The Secretary may approve such a revision or amendment, however, only if the revised agreement provides that all residents covered under the agreement who do not require nursing facility services, are discharged from the facility no later than April 1, 1994 (five years after the initial deadline for filing ADPs). Thus, this provision of the Committee bill gives States the opportunity to revise their approved ADPs in light of the information resulting from the first set of annual resident reviews.

(10) Definition of mentally ill.—In establishing the requirements for those individuals who are subject to the PASSAR process, OBRA '87 defined "mentally ill" individuals to include those "with a primary or secondary diagnosis of mental disorder (as defined in the Diagnostic and Statistical Manual of Mental disorders, 3rd edition [DMS III])" and to exclude those with a "primary diagnosis of dementia (including Alzheimer's disease or a related disorder)." At the time this definition was developed and adopted by the Congress, there was general agreement that a reference to DSM-III was the most appropriate most widely recognized way to identify the population at risk of inappropriate institutionalization.

Because of its very breadth, however, much confusion has arisen over the implementation of definition of the term "mentally ill". To avoid any further difficulties, the Committee bill modifies the definition of mental illness from "a primary or secondary diagnosis of mental disorder (as defined in DSM-III)" to a "serious mental illness as defined by the Secretary". In developing this definition, however, the Committee intends that the Secretary refer to the term "serious mental llness" as that term is defined and used in the Community Support Program operated under the National Institute of Mental Health.

The Committee notes that in making this modification, there is no intention to include any changes to that part of the OBRA '87 definition of mental illness which excludes individuals with "a primary diagnosis of dementia (including Alzheimer's disease or a related disorder)". Such individuals remain exempt from both aspects of the PASSAR process.

(11) Substitution of "specialized services" for "active treatment".—Under OBRA '87, State mental health and mental retardation authorities are not only required to determine if an individual with mental illness or mental retardation requires the level of services provided by a nursing facility; such authorities are also required to determine if these individuals require "active treatment" for these conditions. OBRA '87 defined the term "active treatment" to have the meaning formulated by the Secretary. The law specifically excluded from this definition of "active treatment," however, those services within the scope of services that a nursing facility must provide or arrange for its residents under the OBRA '87 requirements relating to the provision of services and activities.

In response to some confusion that has arisen over the development of an appropriate definition of this term, the Committee bill clarifies, that for the purposes of meeting the OBRA '87 PASSAR requirements, the term "active treatment" does not necessarily have the same meaning as it does for the purposes of meeting the Medicaid requirements for intermediate care facilities for the mentally retarded (ICF/MR). Thus, the Committee bill substitutes the term "specialized services" for the term "active treatment". As under current law, the term "specialized services" is to be defined by Secretary. And like current law, the Secretary cannot define "specialized services" to include those services within the scope of services that a nursing facility must provide or arrange for its residents under the OBRA '87 requirements relating to the provision of services and activities.

(12) Effective dates.—The Committee bill provides that, with some exceptions to section 4271(c), all of the amendments with respect to the OBRA '87 PASSAR requirements are to take effect as if they were included in the enactment of OBRA '87. With respect to the amendments made under section 4271(c)(4) (relating to charges applicable in cases of certain Medicaid-eligible individuals); section 4271(c)(5) (relating to delay in application to private pay residents); section 4271(c)(7) (relating to no delegation of authority to conduct screening and reviews); section 4271(c)(9) (relating to revision of alternative disposition plans); and section 4271(c)(11) (relating to substitution of "specialized services" for "active treatment"), the bill provides that those modifications are to take effect on the date of the enactment of this Act, without regard to whether or not regulations to implement these modifications have been promulgated by the Secretary.

(d) Other amendments

(1) Assurance of appropriate payment amounts.—As this Committee recognized in the report to accompany the House Budget Committee's 1987 Budget Reconciliation Amendments, quality nursing home care is not free (H. Rept. 100–391, p. 463). The Committee anticipated then—as it does today—that a number of the reforms contained within OBRA '87 will entail additional costs of operation for nursing facilities participating in Medicaid.

In order to assure that Medicaid State payment rates allow for these additional costs, OBRA '87 requires that, for those Medicaid nursing facilities in compliance with the law, such rates must take into account the costs of meeting the statute's requirements relat-

ing to the provision of services, residents' rights, and administration. To ensure that State Medicaid payments actually take these costs into consideration, OBRA '87 also requires that each State submit to the Secretary (by April 1, 1990), a State plan amendment to provide for an appropriate adjustment in payment amounts for nursing facility services furnished on or after October 1, 1990. The Secretary is required to review and approve or disapprove each such amendment by September 30, 1989. The failure of the Secretary to approve an amendment, however, does not relieve either the State or any nursing facility of the obligation to comply with requirements of OBRA '87.

The Committee bill clarifies that State Medicaid plan amendments must include a detailed description of the State methodology used in determining the appropriate adjustment in the payment amounts for nursing facility services. In addition, the bill specifies that these costs include the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

(2) Disclosure of information of quality assessment and assurance committees.—Under OBRA '87, nursing facilities must establish and maintain a quality assessment and assurance committee designed (i) to identify quality assessment and assurance issues and (ii) to develop and implement appropriate plans of action to correct those quality deficiencies which have been identified. The Committee bill clarifies that the internal records of these committees are subject to disclosure only for the purpose of determining whether or not such a committee is meeting its statutory obligations, and, consequently, of determining whether a nursing facility is in compliance with this OBRA '87 requirement.

(3) Period for resident assessment.—OBRA '87 requires that a nursing facility conduct a standardized, reproducible assessment of each resident's functional capacity which describes the resident's capability to perform daily life functions as well as any significant impairments in the resident's functional capacity. Such an assessment is to be performed no later than four days after the resident's admission. The Committee bill extends this period to 14 days.

(4) Clarification of responsibility for services for mentally ill and mentally retarded residents.—Under current law, a nursing facility must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care. In the case of residents with mental illness or mental retardation, however, the provision of, or the arrangement for, some of these services (such as "specialized services" as discussed in section 4271(c)(11), above) may be the responsibility or obligation of the State, not of the nursing facility. The Committee bill simply clarifies the lines of responsibility for those residents with mental illness or mental retardation. Thus, for those treatments or services which are required by an individual with mental illness or mental retardation and which the State does not provide or arrange for (or is not required to provide or make arrangements for), the nursing facility itself must provide (or arrange for the provision of) such services.

(5) Residents' rights to refuse intra-facility transfers to move the resident to a Medicare-qualified portion.—Under the Medicare Cat-

astrophic Coverage Act of 1988 (P.L. 100-360), since January 1, 1989, Medicare coverage for a stay in a skilled nursing facility (SNF) has been expanded to up to 150 days in a calendar year. As a result of this expansion, many Medicaid-eligible nursing facility residents are now also eligible for Medicare SNF services (such residents are often referred to as being "dually-eligible"). In virtually every State, the Medicare reimbursement rate for these services is higher than the State reimbursement rate for similar nursing facility services covered under Medicaid. Consequently, nursing facilities now have an incentive to transfer or relocate their "dually-eligible" residents from their Medicaid-certified beds (for which facilities receive fewer dollars) to their Medicare-certified beds (for which facilities receive more dollars). State Medicaid agencies also have an incentive to encourage nursing facilities to follow this practice since it allows Federal Medicare dollars to be substituted for State and Federal Medicaid funds.

Under current law, however, residents can be transferred or discharged within a nursing facility" * * * only for medical reasons or for his welfare or that of other patients or for non-payment of his stay * * * and is given reasonable advance notice to ensure orderly transfer or discharge and such actions are documented in his medical record" (42 C.F.R. 405.1121(k)(4)). Under this rule, the involuntary transfer of "dually-eligible" residents for the sole purpose of taking advantage of the expanded Medicare SNF benefit is clearly prohibited. Nonetheless, over the past few months, the Committee has received disturbing reports about a number of nursing facilities that are involuntarily transferring their "dually-eligible" residents from their Medicaid-certified beds to their Medicare-certified beds in order to receive a higher Medicare reimbursement rate. These reports further indicate that involuntary transfers of this type have led to confusion, depression, and loneliness among the residents affected.

HCFA has received similar reports and complaints and has recently made its position on this matter clear. In a June 12, 1989 letter to all nursing home administrators (whose facilities are certified under either Medicare or Medicaid, or under both programs), HCFA stated:

> It is clear that an individual cannot be moved except for medical reasons or non-payment. With respect to non-payment under Medicare or Medicaid, you should be aware that an individual cannot simply be moved from either a Medicare bed or from a Medicaid bed because the individual is no longer eligible for the benefit unless you provide them proper notification of their rights under the applicable statute.
>
> Furthermore, a person cannot be required to move from his/her bed into a Medicare certified bed simply to take advantage of the Medicare benefit. Although Medicaid is required under certain circumstances to seek payment for services from other parties, it is not required to mandate transfer of an individual from one place to another to obtain these payments.

HCFA went on in its letter to acknowledge—as this Committee does now—the reimbursement dilemma that has arisen in response to the expanded Medicare SNF benefit: a resident must occupy a Medicare-certified bed in order for a facility to receive Medicare payment, but in order to occupy such a bed, a resident may have to be moved, in violation of current law. To avoid this conflict (as well as to begin to implement the OBRA '87 requirement which mandates the elimination of the distinction between the two different types of Medicaid-certified beds), HCFA suggests in its letter that facilities consider having all their beds "dually-certified" at the SNF level. The Committee concurs in this view. In the intervening time, however, the Committee expects the Secretary to continue to enforce current law regarding residents' transfer rights as specified in 42 C.F.R. 405.1121(k)(4), quoted above.

Nonetheless, to ensure that these rights are protected under OBRA '87, the Committee bill establishes the right of a resident to refuse a transfer to another room within the facility if a purpose of the transfer is to relocate the resident from a non-Medicare-certified portion of the facility to a Medicare-certified portion of the facility. The Committee stresses that the relocation of a resident to a Medicare-certified portion of the facility need not be the sole purpose for the transfer to trigger the resident's right; the relocation for the higher Medicare payment need only be one of the reasons for the move.

If a resident refuses such a transfer, the Committee bill further provides that neither the resident's eligibility for Medicaid nor the State's entitlement to Medicaid Federal matching payments is affected. Thus, a resident who refuses such a transfer may, under the Committee's bill, remain in his or her current bed location and continue to be eligible for Medicaid services. If that bed is (or ever becomes) Medicare-certified or "dually-certified," however, the nursing facility would be able to receive the Medicare reimbursement rate for the services provided.

(6) Resident access to clinical records.—OBRA '87 established a number of "residents' rights" that nursing facilities must meet in order to be in compliance with the requirements of the law. Among these is the right to confidentiality of personal and clinical records. The Committee bill adds to this provision the right of residents to have prompt access, upon request, to their current clinical records. Such request need not be in writing.

(7) Inclusion of State notice of rights in facility notice of rights.—Among the "residents' rights" established under OBRA '87 is the requirement that nursing facilities make available to each resident, upon reasonable request, a written statement of the resident's legal rights during his or her stay at the facility and of the requirements and procedures for establishing Medicaid eligibility. The Committee bill adds to this provision a requirement that a nursing facility's statement include any written notice, prepared by the State under the requirements of OBRA '87, of the rights and obligations of residents (and their spouses) under the Medicaid program.

(8) Removal of duplicative requirement for qualifications of nursing facility administrators.—Current Medicaid law provides that a State Medicaid plan must include a program which meets specified requirements for the licensing of nursing facility administrators.

Under OBRA '87, however, nursing facility administrators are not required to be licensed; instead they are required to meet standards set by the Secretary. The Committee bill repeals, effective October 1, 1990, the current Medicaid provisions relating to nursing facility administrators.

(9) Clarification on findings of neglect.—Under OBRA '87, States are required (through their agencies responsible for surveys and certifications of nursing facilities) to review, investigate, and make findings with respect to allegations of neglect or abuse of a resident, or of misappropriation of a resident's property, which are brought against a nurse aide or other individual used by a nursing facility to provide services to such a resident. States are also required to notify the appropriate State authority if a nurse aide or other individual is found to have neglected or abused a resident or to have misappropriated resident property in a nursing facility.

Under the Committee bill, however, a State is prohibited from making a finding that an individual has neglected a resident if the individual can demonstrate that such neglect was caused by factors beyond his or her control. Thus, under this standard, a nurse aide (or other individuals used to provide services to residents) cannot be found to have "neglected" a resident if, for example, he or she can demonstrate that the reason a meal went undelivered was because no food was available, rather than because of an unwillingness to deliver the meal. Similarly, a nurse aide cannot be found to have "neglected" a resident if he or she can demonstrate that, at the time a resident needed to be turned in bed, he or she was required to provide, because of a shortage of personnel, more urgent health-related services to other residents.

In the Committee's view, nurse aides and other individuals who provide nursing facility services to residents should not be used as "scapegoats" for those who may have either the responsibility or capability of preventing or correcting the deficiencies that have resulted in charges of resident neglect. Thus, the purpose of this standard is to help ensure that such individuals are not held responsible for actions and activities (such as a shortage of staff, or a shortage of supplies such as dressings, linens, and food) which such individuals can demonstrate are beyond their control.

(10) Timing of public disclosure of survey results.—Under OBRA '87, each State and the Secretary must make available to the public, information relating to all surveys and certifications (including statements of deficiencies and plans of correction) respecting nursing facilities. The Committee's bill clarifies that the results of such surveys must be made available to the public within 14 calendar days of the time they are made available to the nursing facilities that have been surveyed.

(11) Clarification of applicability of enforcement rules to dually-certified facilities.—In order to coordinate the Federal and State enforcement efforts established under OBRA '87 to maximize nursing facility compliance with the requirements for Medicaid participation, current law requires that specified rules, designed to delineate which such efforts take priority under what circumstances, be followed. These rules describe the conditions under which the Secretary's or a State's compliance action will take precedence, as well

as the circumstances under which the Secretary's or a State's recommendation for sanctions will be applied.

OBRA '87 also established enforcement procedures that are to be applied with respect to skilled nursing facilities participating in Medicare.

OBRA '87 did not, however, address specifically, the procedures and process by which enforcement actions are to be taken against nursing facilities that are certified to participate in both Medicaid and Medicare (such facilities are often referred to being "dually-certified"). To clarify what enforcement rules are to be used in these circumstances, the Committee bill requires that the OBRA '87 enforcement requirements relating to nursing facilities participating in Medicaid also apply to facilities participating in both Medicaid and Medicare.

(12) Clarification of Federal matching rate for survey and certification activities.—To assist States in meeting the costs of implementing the new nursing facility survey and certification requirements established under OBRA '87, that law provided for an increase in the Federal matching rate for State survey and certification activities, beginning with FY 1990. The Committee bill clarifies that until that time (October 1, 1990), the Federal Medicaid matching rate for these activities is the current 75 percent.

(13) Miscellaneous technical corrections.—The Committee bills makes a number of miscellaneous technical corrections to OBRA '87.

(14) Effective dates.—The Committee bill provides that, except for the provisions relating to sections 4271(d)(8) and 4271(d)(11), all of the additional amendments made to the OBRA '87 nursing home reform requirements are to take effect as if they were included in the enactment of OBRA '87. With respect to the amendments made under section 4271(d)(8) (relating to removal of duplicative requirement for qualifications of nursing facility administrators), the bill provides that such modifications are to take effective October 1, 1990. With respect to the amendments made under section 4271(d)(11) (relating to clarification of applicability of enforcement rules to "dually-certified" facilities), the bill provides that such modifications are to take effect on the date of the enactment of this Act.

Section 4272—Medicare buy-in provisions

(a) Medicare buy-in for premiums of certain working disabled.—Under current law, States are required to extend Medicaid coverage to certain working disabled individuals who (1) were eligible for benefits under both Supplemental Security Income (SSI) and Medicaid, (2) due to earnings lost eligibility for SSI, (3) continue to meet the SSI resource test, (4) do not have earnings sufficient to make up for the loss of SSI, Medicaid, and attendant care services, and (5) would be seriously inhibited from continuing employment in the absence of Medicaid benefits. These qualified severely impaired individuals are entitled to full Medicaid benefits so long as they continue to work and meet these requirements.

Under section 10112 of this bill, as reported by the Committee on Ways and Means, Social Security Disability Insurance (SSDI) beneficiaries would be allowed to purchase Medicare coverage after

they have worked a full 48 months and have exhausted their extended period of Medicare eligibility. The Committee bills would require States to pay the Medicare Part A and Part B premiums (but not deductibles or coinsurance) on behalf of these qualified working and disabled individuals if they are not otherwise eligible for Medicaid and if their income (as determined using SSI methodologies) does not exceed 200 percent of the Federal poverty level ($11,960 for a single individual in 1989). These qualified working and disabled individuals would not be subject to a resource test. States would have the option to impose a sliding scale premium (in reasonable increments, as determined by the Secretary) on those qualified working and disabled individuals whose incomes exceed 150 percent of the poverty level. This requirement is effective July 1, 1990.

(b) Technical corrections to Medicare buy-in for the elderly.—Under current law, States are required to pay the premiums, deductibles, and coinsurance for elderly and disabled Medicare beneficiaries with incomes at or below 100 percent of the Federal poverty level ($5,980 for an individual, $8,020 for a family of 2 in 1989) and resources that do not exceed twice the SSI level ($4,000 for an individual, $6,000 for a couple in 1989). This requirement is being phased in over 4 years; in most States, the 1989 minimum income threshold is 85 percent of poverty ($5,083 for an individual, $6817 for a family of 2 in 1989). The purpose of the medicare buy-in requirement is to protect the low-income elderly and disabled against increasingly burdensome Medicare cost-sharing obligations.

(1) Temporary retroactive benefits caused by delay in implementation.—The Medicare buy-in protections were effective January 1, 1989. However, according to a March, 1989, report commissioned by the Villers Foundation, only 11 States implemented coverage in January, and only 34 States had implemented coverage by March. In addition, 3 States were reported to be "undecided" as to when to implement. The Committee finds these results deeply disturbing, since those who bear the consequences of these lackadaisical compliance efforts are the low income elderly and disabled. The Committee expects that this sorry performance, for which both HCFA and the States share responsibility, will not be repeated.

Under the Committee bill, States would have the option to make low-income Medicare beneficiaries whole for the losses resulting from delays in implementation of the buy-in protections. If, during the period January through September, 1989, an individual was determined to be a qualified Medicare beneficiary, the State may elect to provide buy-in coverage to the individual for any month during that period, if the individual would have been eligible in that month as a qualified Medicare beneficiary. For example, if a State did not begin taking applications for Medicare buy-in until July, 1989, and an individual was determined to be qualified Medicare beneficiary in that month (and would, given the opportunity to apply, have been a qualified Medicare beneficiary during all of 1989), the State may pay the Medicare premiums, deductibles, and coinsurance for that individual for the months from January through June, 1989, and receive Federal Medicaid matching funds for those costs.

(2) Clarification with respect to "section 209(b)" States.—Under current law, qualified Medicare beneficiaries are, like Medicare beneficiaries, defined as a national class, with uniform eligibility criteria. The income standard is specified as a percentage of the Federal poverty level. The resource standard is set at twice the SSI level. Both income and resources are determined using SSI methodologies or, at State option, less restrictive methodologies. These criteria apply in all States, including "209(b)" States, which apply eligibility standards to aged, blind, or disabled individuals more restrictive than those under SSI in determining eligibility for Medicaid.

HCFA has taken the view that "if you are a 209(b) State, you may apply your more restrictive income methodologies in determining eligibility under this provision. You may also use your more restrictive resource standards and methodologies in determining eligibility under this provision." "State Medicaid Manual Transmittal #31" (December, 1988). This interpretation of the statute is in error, and the Committee bill would so clarify. "209(b)" States may not (and have never had the authority to) use their more restrictive income methodologies or their more restrictive resource standards or methodologies in determining eligiblity for qualified Medicare beneficiaries.

Section 4273—State matching payments through voluntary contributions and taxes

(a) Voluntary contributions.—Under current regulations, 42 C.F.R. 433.45, States are allowed to use as State expenditures, for purposes of receiving Federal Medicaid matching payments, funds donated from private sources that (1) are transferred to the State Medicaid agency and are under that agency's administrative control, and (2) do not revert to the donor's facility or use unless the donor is a non-profit organization and the Medicaid agency, of its own volition, decides to use the donor's facility. In testimony submitted for the record at a hearing of the Subcommittee on Health and the Environment on June 8, 1989, HCFA stated its intent to undertake a regulatory initiative to limit the use of donations as the State share of Medicaid. Section 8431 of the Technical and Miscellaneous Revenue Act of 1988 (P.L. 100-647), imposed a moratorium on the issuance of any final regulation changing the treatment of voluntary contributions used by States to receive Federal Medicaid matching funds; this moratorium expired on May 1, 1989.

In Tennessee, the Volunteer State, funds donated by nonprofit hospitals have enabled the State to extend Medicaid coverage to low-income pregnant women and infants with incomes up to 100 percent of the Federal poverty level, to increase the scope of the inpatient hospital benefit for all Medicaid eligibles from 14 to 20 days, and to provide a payment adjustment to disproportionate share hospitals. The Committee notes with approval the recent decision of the Departmental Appeals Board upholding Tennessee's donated funds policy and rejecting the efforts of HCFA to disallow Federal Medicaid matching funds to the State for its use of these funds. *Tennessee Department of Health and Environment,* DAB No. 1047 (May 4, 1989).

In view of the Committee, the use of donated funds by Tennessee and other States to pay the State share for expansion of Medicaid eligiblity or services, or for increased reimbursement to disporportionate share hospitals, is entirely appropriate. Applied in this manner, donated funds promote the basic objective of the Medicaid program—to make quality health care accessible to the poor. In order to facilitate such arrangements, the Committee bill would allow States to use private funds donated by hospitals to the State, and subject to its unrestricted control, as State expenditures for purposes of receiving Federal Medicaid matching funds. The State's authority to use donated funds to claim Federal matching funds would be subject to the following limitations: (1) the aggregate amount of donations in any Federal fiscal year could not exceed 10 percent of the State's share of aggregate Medicaid expenditures in that State for that year, and (2) the aggregate amount of donations made by (or on behalf of, or with respect to) any particular hospital in an annual cost reporting period could not exceed 10 percent of the hospital's gross revenue (excluding any Federal funds under Medicaid, Medicare or the Title V Maternal and Child Health Block Grant). The Committee bill is effective for funds donated on or after May 1, 1989.

Under the Committee bill, hospitals may benefit from a donation of funds. For example, if a hospital primarily serves children, and a State uses the funds voluntarily contributed by the hospital and other hospitals to expand Medicaid eligiblity for poor children, and some of the newly-eligible children use the hospital's services, the fact that the hospital has received Medicaid reimbursement for services rendered to these children does not invalidate the hospital's contributions as a permissible donation. Or, for example, if a hospital is a Medicaid disproportionate share hospital, and a State uses funds voluntarily contributed by that hospital and other disproportionate share hospitals to expand Medicaid eligibility and to comply with the statutory requirement that it make a payment adjustment to disproportionate share hospitals, the fact that the hospital, like other disproportionate share hospitals, receives an increase in its reimbursement for the Medicaid patients it serves does not disqualify its contributions as donations.

However, under the Committee bill, if the amount of the benefit to the hospital is directly related, in timing and amount, to the timing and amount of the transfer, the transfer would not be considered a donation. For example, if a hospital is the only facility in a given reimbursement category under the State's Medicaid plan, and the State uses the funds transferred by the hospital to increase the reimbursement rate solely to that hospital's category, and the amount by which the rate increases is directly related to the amount of the funds transferred by the hospital, the transfer of funds could not be treated as a donation.

The Committee emphasizes that, in order to qualify as State expenditures for Federal Medicaid matching purposes, the donations must be voluntary, and, once made, must be under the unrestricted control of the State. It is not the intent of the Committee bill to legitimize donations that are made under circumstances that are inherently coercive and abusive. For example, a State that provides preferential treatment and increased interim funding in order to

induce fund transfers from hospitals, and then uses those funds as the State share for a substantial backlog of pending claims from those hospitals, would not meet the requirements of the Committee bill. A fact situation of this nature was described by the Departmental Appeal Board in *West Virginia Dept. of Human Services,* DAB No. 956 (1988), rev'd, *Lipscomb* v. *Sullivan,* C.A. 2: 87-0333 (S.D.W.V., June 18, 1989).

The Committee further notes that the Texas Department of Human Services has placed 140 staff at over 60 hospitals and clinics throughout the state to process applications for Medicaid. For purposes of Federal financial participation, the facilities pay the State's share of the administrative costs of this staff, an amount estimated by the State at about $1.3 million for FY 1989. In the case of private facilities, for purposes of the Committee bill, these payments for State staff would constitute funds donated by hospitals to, and subject to the unrestricted control of, the State. Texas could continue its current practice of claiming Federal Medicaid matching funds for these expenditures.

(b) State tax contributions.—The Medicaid statute does not specify the revenue sources from which States may finance their expenditures under the Medicaid program. Income taxes, sales taxes, excise taxes, and property taxes are revenue sources used by many States.

Some States, such as Florida, Tennessee, and Texas, also impose taxes or other mandatory assessments (such as licensure fees) on health care providers or classes of providers (e.g., all hospitals, only disporportionate share hospitals, only district or university hospitals). In some instances, these taxes or other assessments are applied at a uniform rate among providers. In other cases, they are structured to "level the playing field" among providers by imposing a relatively higher burden on facilities which provide relatively lower amounts of indigent care. In some cases, these taxes and assessments are permanent. In other instances, these taxes are temporary, as when Maine in 1988 imposed a one-time excise tax on hospitals to initiate eligiblity expansions for pregnant women and infants and the elderly and disabled. Revenues from these provider-specific taxes or other assessments have been used to fund State indigent care programs, to fund expansions in Medicaid eligiblity or services, or to free up revenues from other sources for the funding of such programs or expansions.

In testimony submitted for the record at a hearing of the Subcommittee on Health and the Environment on June 8, 1989, HCFA stated its intent to undertake a regulatory initiative to limit the use of provider-specific taxes as the State share of Medicaid spending. A moratorium on the issuance of any final regulation changing the treatment of provider-specific taxes used by States to receive Federal Medicaid matching funds, contained in section 8431 of the Technical and Miscellaneous Revenue Act of 1988 (P.L. 100-647), expired on May 1, 1989. In the view of the Committee, HCFA does not have, and never had, the authority to dictate to the States what tax or mandatory assessment mechanisms they may use in order to raise revenues that will pay for State Medicaid expenditures.

It is evident that States need revenues in order to implement expansions in their Medicaid programs such as those required by sections 4201 and 4211 of the bill. The Committee believes that the use of provider-specific taxes or other mandatory assessments is an appropriate method for States to finance the expansion of Medicaid eligibility or services for the poor. The Committee bill would therefore clarify that nothing in the Medicaid statute may be construed to authorize the Secretary to deny or limit payments to a State for Medicaid expenditures attributable to taxes, whether or not of general applicability, imposed with respect to the provision of items or services. The Committee specifically intends that, for this purpose, the term "taxes" include licensure fees and any other mandatory assessments that a State may elect to impose on health care providers.

Section 4274—Disproportionate share hospitals

Under current law, States are required, in making payment for inpatient hospital services, to take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs. In response to widespread noncompliance with this requirement, section 4112 of the Omnibus Budget Reconciliation Act of 1987 (P.L. 100–203) set forth minimum criteria for defining disproportionate share hospitals and for payment adjustments States are required to make. In computing payment adjustments for disproportionate share hospitals, States may use (1) the Medicare disproportionate share adjustment percentage, or (2) an alternate methodology that provides for an additional payment amount or increased percentage payment. This requirement is being phased in over a three year period and will be fully implemented by July 1, 1990.

A survey conducted by the Intergovernmental Health Policy Project in February, 1989, for the National Association of Public Hospitals found that (1) only 6 states (California, Florida, Louisiana, Michigan, New York, and Tennessee) account for nearly two-thirds of total Medicaid spending for disproportionate share payments; (2) a total of 14 States have proposed no better than de minimis payment adjustments (some as low as $1.00 per day); (3) average payments per hospital range from a high of $2.6 million in Louisiana to $0 in several States); and (4) less than half of the State plan amendments submitted to comply with the OBRA 1987 requirements have been approved by HCFA. The Committee is seriously concerned by the delays in implementation of the disproportionate share hospital requirements and, in particular, by the inadequate payment adjustments that persist in some States. The Committee expects HCFA to scrutinize State reimbursement policies toward disproportionate share hospitals and assure that all of the States are in compliance with the statutory requirements and that reimbursement rates more adequately reflect hospital costs. The Committee will continue to monitor closely the implementation of this requirement and, if necessary, will consider the imposition of a uniform national standard for the payment adjustment.

(a) Clarification of Medicaid disproportionate share adjustment calculation.—The Committee bill would clarify that, for purposes of calculating a hospital's Medicaid inpatient utilization rate, an inpa-

tient day includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere. The intent of the Committee is to make clear that States must include all Medicaid inpatient days, including a hospital's nursery, psychiatric, and administrative Medicaid patient days, in calculating a hospital's Medicaid inpatient utilization rate for purposes of determining eligibility for, and the amount of, payment adjustments to Medicaid disproportionate share hospitals. The provision would take effect on July 1, 1990.

(b) Federal financial participation for Medicaid capital payments.—The Committee bill would clarify that the Secretary is, and has since 1981 been, without authority to limit the amount of payment adjustments, including pass-through payments for capital costs, that may be made under a State's Medicaid plan to disproportionate share hospitals. It is the intent of the Committee that States such as California which elect to make capital pass-through payments to disproportionate share hospitals qualify for Federal financial participation in connection with these expenditures.

(c) Special rule for New Jersey uncompensated care trust fund.—Current law establishes a special rule by which two States, New York and Texas, can comply with the requirement that payments for inpatient hospital services take into account the situation of disproportionate share hospitals. The Committee bill would establish a special rule for the New Jersey Uncompensated Care Trust Fund. The bill identifies New Jersey as a State with a Medicaid plan that, as of January 1, 1987, provided for payment adjustment based on a statewide pooling arrangement involving all acute care hospitals which provides for reimbursement of the total amount of uncompensated care delivered by each participating hospital. Under the bill, New Jersey would be in compliance if the aggregate amount of the payment adjustments under its Medicaid plan for disproportionate share hospitals is not less than the aggregate amount of such adjustments otherwise required to be made under the Medicaid statute. The provision is effective as though enacted in OBRA '87.

Section 4275—Provisions relating to demonstration of effectiveness of Minnesota family investment plan

Section 10265 of this bill, as reported by the Committee on Ways and Means, would authorize a demonstration of the Minnesota Family Investment Plan. The Committee bill would provide that, if the Secretary approves this demonstration, Federal Medicaid matching payments would be available for the costs of services and administration for families participating in the demonstration. To ensure budget neutrality, the bill limits the aggregate amount of the Federal matching payments to the amount that would have been made for participating families in the absence of the demonstration. The State would be required to (1) provide Medicaid benefits to all families participating in the project, (2) provide Medicaid 12-month transitional coverage to all families whose participation is terminated due to increased income from employment, and (3) provide Medicaid 12-month extension coverage to all families

whose participation is terminated due to the collection or increased collection of child support. The Committee bill does not authorize the Secretary to waive any requirement of Title XIX in connection with this demonstration, and the Committee does not intend that the demonstration result in the reduction of eligibility or coverage under current law to Medicaid beneficiaries in Minnesota.

Section 4276—Miscellaneous provisions

(a) Fraud and abuse technical amendments

(1) Treatment of loss of right to renew license.—Under current law, the Secretary is permitted to exclude from Medicare and State health care programs, including Medicaid, individuals and entities whose license to practice has been revoked, suspended, or "otherwise lost." The Committee is informed that, in reviewing State licensure board actions to determine whether exclusion is appropriate, the Inspector General has found a number of cases in which a board has revoked the "license" of a physician whose actual license had already expired, or in which a board has revoked the right of a physician to renew a license which has expired. The Committee bill would clarify that the loss of a right to apply for or renew a license to provide health care is tantamount to losing the license itself and may serve as the basis for exclusion from Medicare and State health care programs.

(2) Clarification with respect to emergency treatment.—Under current law, payments may not be made under Medicare or State health care programs (including Medicaid) for items or services (other than an emergency item or service) furnished by individuals or entities excluded from participation in the programs during the period of the exclusion. The purpose of the exception for emergency items or services is to assure that program beneficiaries have immediate access to emergency care when needed, even if the nearest physician has been excluded from the program. The Committee is informed that the Inspector General has identified cases in which excluded physicians are practicing on a full-time basis as "emergency physicians" in hospital emergency rooms and continuing to receive payments under Medicare and Medicaid for the services they routinely provide there. In the view of the Committee, this behavior is designed to circumvent the intent of the prohibition on payments to excluded practitioners and represents a clear abuse of the emergency item or service exception. The Committee bill would therefore clarify that payments may not be made to excluded physicians or other individuals or entities for items or services furnished in an emergency room of a hospital.

(b) Psychiatric Hospitals

(1) Clarification of coverage of inpatient psychiatric hospital services.—Under current law, States may offer Medicaid coverage for inpatient psychiatric hospital services for individuals under 21. These are defined by statute as inpatient services which are provided in an intitution (or distinct part thereof) which is a psychiatric hospital as defined in section 1861(f) of the Social Security Act. Current regulations, 42 C.F.R. 441.151(b) also allow the provision of such services in nonhospital settings. They recognize services pro-

vided by a psychiatric facility or an inpatient program in a psychiatric facility, either of which is accredited by the Joint Commission on Accreditation of Hospitals. The Committee bill would clarify that inpatient psychiatric hospital services may be provided in either a psychiatric hospital or in another inpatient setting that the Secretary has specified in regulations. This provision is effective as though enacted in the Deficit Reduction Act of 1984 (Pub. L. 98-369), when the statute was inadvertently amended in a manner seemingly inconsistent with current HCFA regulations and policy.

(2) Intermediate sanctions for psychiatric hospitals.—Under current law, psychiatric hospitals that are not in compliance with the conditions of participation are subject to termination from the Medicaid program. Neither the State nor the Secretary has authority to impose intermediate sanctions in such circumstances.

Under the Committee bill, termination would remain the only sanction available to a State if the State determines that a psychiatric hospital's deficiencies immediately jeopardize the health and safety of its patients. However, if the deficiencies do not immediately jeopardize patient health or safety, the State would have a choice of terminating participation by the hospital or denying Medicaid payment for patients admitted after the date of the findings. The Secretary would be authorized to continue Federal Medicaid matching payments for services at the noncomplying facility for a period of up to 6 months from the date of the findings, but only if (1) the State elects not to terminate the facility's participation, (2) the State submits a plan and timetable for corrective action and the Secretary approves the plan, and (3) the State agrees to repay any Federal Government funds paid to the facility if corrective action is not taken in accordance with the approved plan and timetable. Under the Committee bill, the State would be required to deny Medicaid payments for all new admissions if the facility remains out of compliance for 3 months from the date of the findings, whether or not the facility is operating under a corrective action plan. If the hospital remains out of compliance for 6 months from the date of the findings, no Federal Medicaid matching payments would be available for services provided by the facility until the State determines that the hospital is in compliance.

(c) Clarification of application of 133 percent income limit to medically needy.—Under current law, States may extend Medicaid coverage to individuals who meet the categorical requirements for eligibility (i.e., they are aged, blind, disabled, or members of a family with dependent children), but who are not receiving cash assistance under AFDC or SSI because they do not meet the income or resource standards. Individuals qualify for coverage as medically needy when their incomes, less incurred medical expenses, meet the State's medically needy income level (MNIL). The State may not set its MNIL higher than 133⅓ perent of the payment standard for an AFDC family of comparable size. HCFA has erroneously attempted to apply the 133⅓ percent ceiling to optional categorically needy groups who are not receiving cash assistance. The Committee bill would clarify that the 133⅓ percent limit applies, and has always applied, solely to determinations of eligibility with respect to medically needy individuals.

Under current law, States, in determining income and resource eligibility for certain eligibility groups consisting of aged, blind, or disabled individuals, may not use methodologies that are more restrictive, and may use methodologies that are less restrictive, than the methodology used under the Supplemental Security Income (SSI) program. This provision, by its own terms, applies to aged, blind, or disabled individuals in "section 209(b)" States that have opted to use eligibility criteria (in their January, 1972 State plans) more restrictive than those under SSI. These States may still set eligibility standards lower than those under SSI, but may not use methodologies that are more restrictive than those under SSI.

The Committee bill would further clarify that "209(b)" States may not use income or resource methodologies in determining eligibility for aged, blind, or disabled individuals that are more restrictive than those under SSI. Under current law, a methodology is considered "no more restrictive" if, using the methodology, additional individuals may be eligible for Medicaid and no individuals who are otherwise eligible are made ineligible. For example, under current law, in determining a disabled child's eligibility for SSI benefits, the Social Security Disability Income (SSDI) benefits of the father are not attributed to the child. A "209(b)" State could not count the father's SSDI benefits in determining whether the SSI-eligible child qualifies for Medicaid, because this methodology would result in the denial of Medicaid eligibility to the child.

(d) Health maintenance organizations (HMOs)

(1) Waiver of 75 percent rule for public entities.—Under current law, no Federal Medicaid matching payments may be made for services provided by entities contracting with States on a prepaid capitation or other risk basis if 75 percent or more of the enrollees are Medicaid or Medicare beneficiaries. The Secretary may modify or waive this requirement in the case of an HMO that is a public entity if (1) special circumstances warrant the modification or waiver and (2) the HMO has taken and is taking reasonable efforts to enroll individuals who are not eligible for Medicaid or Medicare. The Committee bill would delete the requirement that the Secretary find special circumstances warrant the modification or waiver.

(2) Extending special treatment to Medicare competitive medical plans (CMPs).—Under current law, States have the option to guarantee to certain HMOs a minimum enrollment period of up to 6 months for Medicaid beneficiaries who lose eligibility for benefits during the period. The Committee bill would add Medicare CMPs to the types of HMOs to which States may extend this minimum enrollment protection. In addition, States may currently deny Medicaid beneficiaries their right to disenroll from certain HMOs without cause for up to 6 months. The Committee bill would include Medicare CMPs among the types of HMOs into which Medicaid beneficiaries could be "locked" for up to 6 months.

(3) Automatic 1-month reenrollment for short periods of ineligibility.—Under current law, if a Medicaid beneficiary who is enrolled in an HMO loses eligibility due to a short-term change in income or resources, upon reestablishing eligibility the individual is not automatically reenrolled in the HMO. Given the high turnover rates in the Medicaid caseloads in many States, this creates a sub-

stantial disincentive for HMOs to enroll Medicaid beneficiaries. The Committee bill would therefore allow States, at their option, to reenroll individuals who lose and quickly reestablish eligibility in the following circumstances: (1) the individual must be enrolled as Medicaid beneficiary in an HMO; (2) the individual must lose eligibility for Medicaid while enrolled; (3) the individual must reestablish eligibility for Medicaid in the first onth or the second month after losing eligibility; and (4) the individual must be reenrolled (if the State elects this option) in the same HMO. The Committee bill is intended to minimize the administrative disruption to HMOs resulting from the involuntary loss of eligibility by Medicaid beneficiaries. It is not intended to lock beneficiaries into HMOs. Upon reenrollment, the individual would have the same right to disenroll without cause upon one months' notice applied before the loss of eligibility.

(4) Elimination of provisional qualification for HMOs.—The Committee bill would strike an obsolete authority for States to make a provisional determination as to whether an HMO is Federally qualified.

(e) Personal care services.—Under current law, States have the option of offering Medicaid coverage for any medical or remedial care specified by the Secretary. By regulation, the Secretary has specified personal care services in a beneficiary's home, defined as services prescribed by a physician in accordance with the beneficiary's plan of treatment and provided by an individual who is qualified to provide the services, supervised by a registered nurse, and not a member of the beneficiary's family. It has come to the attention of the Committee that HCFA is attempting to limit the scope of personal care services to services delivered within the beneficiary's home.

HCFA's interpretation would preclude a State, in the case of a ventilator-dependent beneficiary who requires periodic suctioning, from using Medicaid funds to pay for the services of an attendant whenever that beneficiary is outside of his home. The effect is to severely limit the beneficiary's ability to live a normal life and, in some cases, to live in the community at all. In the view of the Committee, the HCFA interpretation is inconsistent with one of the broad purposes of the Medicaid program, to encourage the independence and integration into the community of low-income elderly and disabled individuals.

The Committee bill would therefore establish an optional benefit, personal care services, and define it to mean services (1) prescribed by a physician for an individual in accordance with a plan of treatment, (2) provided by a person who is qualified to provide such services and is not a member of the individual's family, (3) supervised by a registered nurse, and (4) furnished in a home or other location. Personal care services would not include services furnished to an inpatient or resident of a hospital or nursing facility. The Committee bill would take effect on enactment and would apply to personal care services furnished before enactment under 42 C.F.R. 44.170(f). The Committee's intent is to nullify HCFA's interpretation of current regulations that personal care services must be performed solely in the beneficiary's home, as well as to clarify

that HCFA may not impose such a restriction on the personal care services benefit in the future.

The Committee observes that, under section 4251 of the Committee bill, States would have the option to offer community care to functionally disabled elderly individuals. Community care would include a number of different services, one of which is personal care services. The Committee emphasizes that personal care services offered by States under the option defined by this provision of the bill ((c) section 4276(e)) would not be subject to the same requirements that would apply to personal care services offered by States under the community care option. For example, under the community care option, services are limited to functionally disabled elderly individuals. Under the free-standing option, personal care services could be offered to both elderly and non-elderly individuals, whether functionally disabled or not. The same observation applies with respect to personal attendant care, one of the "core" elements of the optional community habilitation and supportive services benefit that would be established by section 4221 of the Committee bill. The requirements applicable to personal attendant care under section 4221 would not apply to personal care services under this section.

(f) Supervision of health care of residents of nursing facilities by nurse practitioners and clinical nurse specialists acting in collaboration with physicians.—Under current law, skilled nursing facilities (SNFs) participating in Medicaid must have a policy that the health care of every resident is under the supervision of a physician, and that the physician visit the patient at least once every 30 days during the first 90 days after admission, and no less frequently than once every 60 days thereafter. Intermediate care facilities (ICFs) participating in Medicaid must ensure that the health care of each resident is under the continuing supervision of a physician, and that the physician see the resident whenever necessary, but at least once every 60 days, unless the physician decides that visits of that frequency are unnecessary and records the reasons for that decision. These physician visit requirements are independent of the physician certification requirements applicable to all Medicaid-eligible residents in SNFs or ICFs.

Under the nursing home reform provisions contained in the Omnibus Budget Reconciliation Act of 1987 (P.L. 100–203), effective October 1, 1990, nursing facilities must require that the health care of every resident be provided under the supervision of a physician. As under current law, this supervision would include periodic visits to each resident. Under current law, States may pay for care provided by licensed practitioners, including nurse practitioners and clinical nurse specialists, within the scope of their practice as defined by State law. The Committee bill would give States the option of paying nurse practitioners or clinical nurse specialists working in collaboration with a physician to conduct these periodic visits to nursing facility residents, but only if the practitioner or specialist is not an employee of the facility in which the beneficiary resides. The Committee does not intend to restrict in any way the right of residents to choose a personal attending physician, or the freedom of Medicaid beneficiaries to choose a nurse practitioner or clinical nurse specialist. This option is effective October 1, 1990, without

regard to whether final implementing regulations have been promulgated.

(g) Codification of coverage of rehabilitation services.—Under current law, States may offer Medicaid coverage for other diagnostic, screening, preventive, and rehabilitative services. By regulation, 42 C.F.R. 440.130(d), the Secretary has defined rehabilitative services to include any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level. The Committee is informed that currently 14 States have elected, under this optional service, to provide mental health rehabilitation services to individuals with severe and long-term mental illnesses (Arkansas, Florida, Idaho, Maine, New Hampshire, New York, North Carolina, Ohio, Oregon, Rhode Island, South Carolina, South Dakota, Vermont, and Wisconsin). The Committee bill would codify the current regulation, effective on enactment.

(h) Institutions for mental diseases

(1) Study.—Under current law, the Federal Medicaid matching funds are not available for services to individuals under the age of 65 who are patients in an institution for mental diseases (IMD). The statute defines an IMD as a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of individuals with mental diseases. The Secretary in regulation, 42 C.F.R. 435.1009, has provided that classification on an institution as an IMD is determined by its "overall character." Under guidelines developed by HCFA, one of the tests for identifying a facility as an IMD is whether more than 50 percent of all the patients in the facility have mental diseases requiring inpatient treatment. For a single facility, under a common administration, containing a number of different units serving patients with different needs and each with a separate license, a central issue is whether to include the beds of all the patients when determining the facility meets the 50 percent test. Changes in the way that mental health care is delivered have left a number of "mixed purpose" facilities unclear as to their IMD status, and the way in which it is determined.

The Committee bill would require the Secretary to conduct a study of the implementation of the exclusion of coverage for services to individuals under 65 residing in IMDs. On the basis of this study, the Secretary would be required to submit to Congress a report that includes any recommendations for modification in the current Medicaid provisions, regulations, guidelines, and practices that may be appropriate to accommodate changes that may have occurred in the delivery of psychiatric and other mental health services on an inpatient basis since the IMD exclusion was enacted in 1972. The report is due by October 1, 1990.

(2) Moratorium on treatment of certain facilities.—The Committee bill would provide that any determination by the Secretary that Kent Community Hospital Complex or Saginaw Community Hospital (both in Michigan) is an IMD shall not take effect until 180 days after Congress receives the report described above.

(3) Subacute psychiatric facilities.—Under current law, States may offer Medicaid coverage for inpatient psychiatric hospital services to individuals under age 21, and for services in IMDs for individuals 65 and over. The Committee bill would direct the Secretary to conduct a study of the costs and benefits of providing Medicaid services in public subacute psychiatric facilities which provide services to psychiatric patients who would otherwise require acute hospitalization. The study must examine, with respect to individuals under 21 and over 64, (1) the relative difference in the cost of providing services in subacute psychiatric facilities and acute inpatient psychiatric facilities, (2) the effect of subacute psychiatric facilities in preventing hospitalization in acute psychiatric facilities, and (3) the impact of subacute psychiatric facilities on the accessibility and quality of psychiatric services. The report must be submitted to the Congress by October 1, 1990. The Committee expects that, in connection with this report, the Secretary will study the cost-effectiveness, accessibility, and quality of services at the East Valley Pavilion of the Santa Clara Valley Medical Center in San Jose, California.

(i) Timely payment under waivers of freedom of choice of hospital services.—Under current law, States must have claims payment procedures that ensure that 90 percent of the clean claims (i.e., those not requiring further information or substantiation) submitted by physicians and other health care practitioners are paid within 30 days of receipt, and that 99 percent of such claims are paid within 90 days receipt. Current law also entitles Medicaid beneficiaries to freedom of choice among providers electing to participate in the program. However, the Secretary is authorized to waive certain requirements, including the freedom of choice protection, to enable a State to restrict the provider from whom a Medicaid beneficiary can obtain services (other than in emergency circumstances) to providers who comply with reimbursement, quality, and utilization standards under the State plan.

The Committee is informed that three States (California, Illinois, and Washington) are currently operating under this 1915(b)(4) waiver authority to contract with hospitals on a selective basis. The Committee bill would require that, in the case of 1915(b)(4) waivers, the timely payment requirements currently applicable to health care practitioners also apply to those providers, including hospitals, that are subject to selective contracting or other restrictions. This requirement would be effective on the first calendar quarter beginning more than 30 days after enactment, and would apply to existing 1915(b)(4) waivers as well as to future waivers.

(j) Home and community-based services waivers

Under current law, the Secretary is authorized to grant waivers to enable States to offer Medicaid coverage for home and community-based services to individuals who, but for such services, would require the level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded (ICF/MR).

(1) Clarifying definition of room and board.—Under current law, home or community-based services for which payment is authorized by either section 1915(c) or 1915(d) of the Social Security Act do not include room and board. The Committee bill would clarify

that room and board does not include the portion of costs for rent and food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of the caregiver, would require admission to a hospital, nursing facility, or ICF/MR. This clarification would be effective for services provided on or after enactment.

(2) Treatment of persons with mental retardation or a related condition in a decertified facility.—Under current law, the Secretary may only grant a 1915(c) waiver if the State demonstrates that the average per capita Medicaid expenditure for individuals participating in the waiver in a fiscal year does not exceed 100 percent of the average per capita expenditure the State estimates would have been made for these individuals during that year in the absence of the waiver. The Committee bill would provide that, in the case of waivers that apply to individuals with mental retardation or a related condition who reside in ICFS/MR terminated from participation in Medicaid, States may determine the average per capita expenditures that would have been made for these individuals as though the facility continued to participate in the Medicaid program. The intent of the Committee is to facilitate State efforts to provide home and community-based services to individuals with mental retardation or a related condition who are displaced from an ICF/MR.

(3) Scope of respite care.—Under current law, respite care is one of the home or cummunity-based services that a State may offer through a 1915(c) waiver. The Committee bill would clarify that the Secretary may not restrict the number of hours or days of respite care in any period that a State may provide under a waiver, except insofar as the State would violate the waiver authority's overall budget neutrality requirements. In the view of the Committee, States should have complete discretion to define the scope of the respite care they choose to offer under a 1915(c) waiver, so long as they comply with the general waiver limits relating to average per capita expenditures for all home or community-based services.

(4) Permitting adjustment in estimates to take into account preadmission screening requirements.—Under current law, States are required to screen, prior to admission to nursing facilities participating in Medicaid, all individuals with mental retardation or a related condition. The State must determine whether the individual requires the level of services provided by the nursing facility or by an ICF/MR, and whether the individual requires active treatment. If the individual is determined not to require the level of services provided by a nursing facility, the facility is prohibited from admitting the individual. These preadmission screening requirements took effect on January 1, 1989. Under the Committee bill, the Secretary would be directed to allow States with 1915(C) waivers for individuals with mental retardation or a related condition to adjust their estimates of average per capita expenditures to take into account increases in expenditures for, or utilization of, ICFs/MR resulting from the implementation of the preadmission screening requirements.

(k) Spousal impoverishment

The Medicare Catastrophic Coverage Act (P.L. 100-360) established minimum requirements for the income and resources a spouse remaining in the community is allowed to keep when her spouse resides in a nursing facility at Medicaid expense. This requirement is effective for individuals institutionalized on or after September 30, 1989.

(1) Equal treatment of transfers by community spouse before institutionalization.—Under current law, States are required to delay Medicaid eligibility in the case of institutionalized individuals who dispose of resources for less than fair market value during the 30-month period prior to application for benefits. Certain transfers are protected, including transfers by the institutionalized individual to a community spouse, but only so long as the community spouse does not dispose of the resources to a person other than the spouse for less than fair market value. The Committee bill would clarify that, for purposes of the prohibitions on transfers of assets, transfers by a spouse of an institutionalized individual would be subject to the same treatment as transfers by the institutionalized individual. For example, if, prior to the institutionalization of her spouse, and within 30 months of the institutionalized spouse's application for Medicaid, a spouse were to withdraw savings from a joint acount, place them in her own account, and then give them to a child who is not a minor or disabled, the institutionalized spouse would be subject to a delay in eligibility for Medicaid coverage.

(2) Clarifying application to "Section 209(b)" States.—The Committee bill would further clarify that the rules and procedures relating to income and resources set forth in section 1924 of the Social Security Act apply in each and every State participating in Medicaid, including "209(b)" States. (These are States that apply more restrictive standards to aged, blind, and disabled SSI recipients for purposes of determining Medicaid eligibility). The Committee stresses that "209(b)" States may not comply with the requirements of sction 1924 by applying their own resource or income standards or methodologies to institutionalized spouses or community spouses.

(3) One-Time computation of spousal share.—Under current law, the total value of the resources in which either spouse has an ownership interest is computed as of the beginning of a continuous period of institutionalization of the institutionalized spouse. The Committee bill would clarify that this computation is to occur only once, at the beginning of the first continuous period of institutionalization begining on or after September 30, 1989.

(l) State utilization review systems.—Under current law, States have the option of implementing various programs to reduce unnecessary utilization of services by Medicaid beneficiaries, including second surgical opinion programs (voluntary or mandatory), inpatient hospital preadmission review, ambulatory surgery, preadmission testing, and same-day surgery programs. The Secretary is prohibited from promulgating regulations to require States to operate mandatory second surgical opinion or inpatient hospital preadmission review programs until 180 days after the submission to the

Congress of a report mandated by section 9432(b) of the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509).

On June 22, 1989, the Secretary submitted to the Congress a report entitled "High Volume and High Payment Procedures in the Medicaid Population." (85 Cong. Rec. H3082). The Committee has reviewed this report and commends the Secretary for its analytical rigor and intellectual honesty. The report will be a useful resource for any State considering adoption of second surgical opinion or preadmission review programs. In the Committee's judgment, however, the report does not present persuasive evidence for compelling all State Medicaid programs to operate mandatory second surgical opinion or inpatient hospital preadmission review programs. The report, as it acknowledges, does not contain information from a representative sample of States. Moreover, it does not provide a basis for concluding that Medicaid utilization of surgical procedures is so excessive throughout the country as to warrant the mandatory imposition of such programs in every State. The Committee bill would therefore prohibit the Secretary from publishing final or interim final regulations requiring States to operate second surgical opinion programs or inpatient hospital preadmission review programs.

At a hearing held by the Subcommittee on Health and the Environment on June 8, 1989, the HCFA representative provided a statement for the record indicating that HCFA intends to implement a regulatory initiative "to require States to implement effective ambulatory surgery, preadmission testing and same day surgery programs." Under current law, all of these programs are optional. The Committee is not persuaded by the evidence available to it that utilization of surgical procedures by Medicaid beneficiaries is excessive nationwide. The Committee is also concerned that requiring States which have chosen not to implement such programs to do so may result in the delay or reduction of beneficiary access to needed services. The Committee bill would therefore prohibit the Secretary from publishing any final or interim final regulations requiring States to implement programs for ambulatory surgery, preadmission testing, or same-day surgery until 180 days after the submission of a report to the Congress. The report, which would be due January 1, 1992, must contain, for each State in a representative sample of States, (1) an analysis of the procedures for which such ambulatory surgery, preadmission testing, or same-day surgery programs are appropriate for patients covered under Medicaid, and (2) a description of the effects of such programs on the access of Medicaid beneficiaries to necessary care, quality of care, and costs of care.

(m) Health insuring organizations

(1) Treatment of certain county-operated health insuring organization.—Under current law, Federal Medicaid matching payments are not available for services provided on a prepaid capitation or other risk basis by any entity, including a health insuring organization (HIO), unless certain requirements are met. These include a requirement that no more than 75 percent of the enrollees be eligible for Medicare or Medicaid, and a requirement that Medicaid beneficiaries be able to disenroll without cause upon one months'

notice. Certain HIOs, primarily those that were operational prior to January 1, 1986, are exempt from these requirements, which are intended to assure the quality and accessibility of care in entities participating in Medicaid on a risk basis.

Among the exempt HIOs are three pilot programs operated by the State of California to test the effectiveness of capitulated health systems organized by counties in improving access to quality care for Medicaid beneficiaries. These systems are operated by public entities created by, and responsible to, county boards of supervisors. Financially at risk, these systems organize services for all Medicaid enrollees through contracts with hospitals, physicians, and other providers. The first pilot program, the Monterey County Organized Health System, was unable to control costs and utilization, suffered financial losses, and was terminated. The Committee is informed that the other two pilot programs, operating in San Mateo and Santa Barbara counties, are operating without serious problems.

The Committee bill would exempt up to three additional county-based HIOs in California from the requirements applicable to risk-based entities under current law. The Committee bill does not specify the counties in which these HIOs would operate; they would be designated by the Governor and approved by the State Legislature. However, total enrollment in these three HIOs could not at any time exceed 10 percent of the Medicaid beneficiaries in the State (excluding qualified Medicare beneficiaries). Each of these HIOs must (1) be operated directly by a public entity established by a county under a State enabling statute; (2) enroll all Medicaid beneficiaries residing in the county, not only AFDC recipients; (3) meet the applicable requirements of the Knox-Keene Act and the Waxman-Duffy Act; (4) assure beneficiaries a reasonable choice of providers, including providers that have historically served Medicaid beneficiaries; (5) not impose any restriction which substantially impairs access to covered services of adequate quality where medically necessary; and (6) provides for a payment adjustment for disproportionate share hospitals as required by section 1923 of the Social Security Act.

(2) Extension of Waiver.—Under current law, the Secretary has waived the application of the 75 percent limit on Medicaid or Medicare enrollees with respect to the Tennessee Primary Care Network, Inc., a prepaid health plan licensed and operating as an HMO under Tennessee law, that has been receiving payment under a prepaid Medicaid contract since May, 1984. The Committee is informed that, as of July, 1989, the Network's private enrollees exceed 15 percent of its total enrollees, and that the Network is aggressively seeking additional commercial enrollees. To give the Network additional time to increase its private enrollment, the Committee bill would direct the Secretary to continue to waive, on the same terms and conditions, the application of the 75 percent limit through June 30, 1992.

(n) Day habilitation and related services.—Under current law, States may include among the services covered under their Medicaid programs (1) clinic services and (2) other diagnostic, screening, preventive, and rehabilitative services. Some States have elected, under one or the other of these optional service categories, to pay

for day habilitation services to individuals with mental retardation or a related condition, including those who are not residents of ICFs/MR and are not participating in a 1915(c) home and community-based services waiver. The Committee understands that 15 States have been providing such services (Arkansas, Idaho, Maine, Massachusetts, Michigan, Minnesota, Missouri, New Hampshire, New Jersey, New York, Rhode Island, Utah, Vermont, Virginia, and Washington) under State Medicaid plans approved by the Secretary.

It has come to the Committee's attention that HCFA is threatening to rescind or revoke previously approved State plan provisions for coverage of day habilitation services to individuals with mental retardation or a related condition who do not reside in ICFs/MR. In the view of the Committee, HCFA should be encouraging States to offer community-based services to this vulnerable population, not restricting their efforts to do so. Accordingly, the Committee bill would prohibit the Secretary from withholding, suspending, disallowing, or denying Federal Medicaid matching funds for day habilitation and related services under a State plan provision approved on or before June 30, 1989. The Committee specifically intends that this prohibition apply with respect to such States a Arkansas and Maine, who were providing day habilitation services under an approved State plan but who were notified by HCFA prior to June 30, 1989, that their State plan approvals were being rescinded. The Committee bill would further prohibit the Secretary from withdrawing Federal approval of any State plan provision under which day habilitation services have been or are being offered. Thus, HCFA would be required to reinstate the approvals of the plan provisions of such States as Arkansas and Maine that HCFA has attempted to withdraw.

Under the Committee bill, these prohibitions would apply until the Secretary promulgates a regulation specifying the types of services that a State may cover under the optional service categories of clinic or other rehabilitative services. The Committee bill would not require the Secretary to issue such a regulation. However, the Secretary would be prohibited from withholding, suspending, disallowing, or denying Federal Medicaid matching funds with respect to day habilitation or related services offered by a State under a State plan provision approved on or before June 30, 1989, unless and until the Secretary issues a final regulation and determines that a State plan does not comply with regulation. The regulation, if any, would have to be promulgated after a notice of proposed rulemaking and at least 60 days for public comment, and would have to specify the types of day habilitation and related services that a State may cover under the optional service categories and any requirements respecting such coverage. If the Secretary finds that a State plan does not comply with the final regulation, the Committee bill would require the Secretary to notify the State of the determination and its basis. The Committee bill would preclude the Secretary from withholding, suspending, disallowing, or denying any Federal Medicaid matching funds pursuant to such a determination for day habilitation services provided before the first day of the first calendar quarter beginning after the date of the notice to the State.

The Committee notes that, under section 4221 of the Committee bill, States would have the option to offer community habilitation and supportive services to individuals with mental retardation or a related condition. One element of this new optional service benefit is day habilitation and related services. The Committee emphasized that day habilitation and related services offered by States under the optional service categories of clinic services or other rehabilitative services are not subject to the same requirements that would apply to day habilitation and related services offered as an element of community habilitation and supportive services. For example, under section 4221, day habilitation and related services could only be offered as a supplement to the core benefits of case management, respite care, and personal attendant care. This core benefits requirement would not apply to day habilitation services offered under the optional service categories of clinic or other rehabilitative services.

Other Matters (Not Addressed in the Commitee Bill)

The Committee wishes to clarify with respect to payments by States under Medicaid that providers may use Medicaid receivables as collateral for loans, or may sell such receivables, so long as payment by States under Medicaid for service rendered by the provider is always made directly to the provider.

Subtitle D—Maternal and Child Health Program

Established in 1981 at Title V of the Social Security Act, the Maternal and Child Health (MCH) Block Grant (also known as "Title V") represents a consolidation of seven previous formula and categorical programs designed to serve mothers, pregnant women, infants, and children. Under the MCH Block Grant, Federal funds are available to the States for the provisions or the purchase of a broad range of maternal and child health services that will help States in (i) reducing infant mortality; (ii) increasing the availability of prenatal, delivery, and postpartum care to low-income women; (iii) reducing the incidence of preventable and handicapping conditions among low-income children; (iv) increasing the number of children immunized against disease and receiving health assessments; and (v) providing medically necessary services to children with handicaps or "children with special health care needs."

Eligibility criteria under the MCH Block Grant are set by the States themselves. States may elect to charge for services provided. No charges may be imposed, however, for services provided to mothers and children whose incomes fall below the Federal poverty level.

Funds are allocated among the States based on their proportional share of 1981 outlays for the various programs consolidated into the MCH Block Grant. In order to receive their allocation, however, States must meet a matching requirement: for every $4.00 in Federal funds a State receives under Title V, the State must spend $3.00 of its own monies on maternal and child health services.

The Title V law provides that between 10 and 15 percent of the amounts appropriated in each fiscal year are to be withheld from

the States and administered by the Secretary. Known as the Federal "set-aside", these funds support a variety of designated activities. An additional amount of funds has been withheld through FY 1989 to establish and operate projects for the screening of sickle-cell anemia and other genetic disorders.

The authorization level for the MCH Block Grant in FY 1990 and subsequent years is $561 million. Appropriations for Title V for FY 1989 are $554.3 million.

Section 4301—Increase in authorization of appropriations

(a) Purpose of Program.—Current Title V law sets out a number of purposes for which the States and the Secretary are authorized to expend appropriated MCH Block Grant funds. For the States, such purposes include (i) providing and assuring access to quality maternal and child health services for mothers and children with low incomes or with limited availability of health services; (ii) reducing infant mortality, the incidence of preventable and handicapping conditions, and the need for inpatient and long-term care services among children, and increasing the number of children immunized against peventable diseases and the number of low-income children receiving health assessments and follow-up diagnostic and treatment services: (iii) providing rehabilitation services for blind and disabled children under the age of 16 receiving benefits under Title XVI of the Social Security Act; and (iv) providing various services for "children with special health care needs." For the Secretary, such purposes include providing for (i) special projects of regional and national significance ("SPRANS" Projects); (ii) research and training projects relating to maternal and child health; (iii) genetic disease testing, counseling and information projects; (iv) grants relating to hemophilia; and (v) newborn genetic screening projects.

The Title V statute does not, however, specify any national maternal and child health goals or objectives that should be attained, in part, through funds made available under the MCH Block Grant. Over the years, this lack of program direction, coupled with the law's De minimis reporting requirements, has made it difficult for Congress to determine the MCH Block Grant's effectiveness in meeting the Nation's maternal and child health needs.

The Committee believes that the establishment of national goals and objectives for the MCH Block Grant program is in the best interests of both Title V and the individuals it is authorized to serve. Thus, the Committee bill amends section 501(a) of the Title V statute to establish—through reference to the Department's soon-to-be-published "Year 2000 National Health Objectives" ("Year 2000 Objectives")—health status goals and national health objectives for the MCH Block Grant.

The "Year 2000 Objectives" report represents a revision and update of the Department's 1980 release, "Promoting Health/Preventing Disease: Ojectives for the Nation." That volume set out specific and measurable objectives for a number of priority areas that have been identified by the Department as the cornerstones for the continued improvement in the health of the American people. Among those priority areas are (i) maternal and infant health; and (ii) immunization and control of infectious diseases.

The new report will retain these two categories as priority areas and will establish within each, a number of objectives that should be met by public health authorities within the next decade, if the national goal of enhancing the health status of all mothers and children is ever to be reached.

It is primarily to these two priority areas (and to the objectives cited within each) that the Committee is referring in amending section 501(a) to specify the "applicable" health status goals and national health objectives established by the "Year 2000 Objectives" report. In particular, within the area of maternal and infant health, the Committee intends that the MCH Block Grant be designed to help meet, at a minimum, the "Year 2000 Objectives" established for (i) rates of infant mortality; (ii) rates of low-birth weight babies; (iii) rates of maternal mortality; (iv) rates of neonatal death; (v) rates of perinatal death; and (vi) the proportion of women who deliver who do not receive prenatal care during their first trimester of pregnancy. Within the area of immunization and the control of infectious diseases, the Committee intends that the MCH Block Grant be designed to help meet, at a minimum, the "Year 2000 Objectives" established for immunization levels for children under two years of age. The Committee further intends that the objectives specified within each priority area form the basis for individual programs and projects funded by both the Secretary and by the States.

The Committee notes that there are other applicable "Year 2000 Objectives" that the Committee expects to be incorporated into the design and operation of the MCH Block Grant. Among these are the objectives relating to (i) the health status of adolescents; (ii) health education and access to preventive health services; and (iii) surveillance data systems. Again, the Committee intends that the objectives specified within each of these priority areas be applied to programs and projects funded by either the Secretary or by the individual States.

(b) Purposes for which States are authorized to expend funds.—As noted above, under current law, Title V targets specified individuals and services for which States are authorized to expend appropriated MCH Block Grant funds. The Committee bill makes no changes in the classes or groups of individuals that may be eligible for services under an individual State Title V program. It does, however, include some clarifications with respect to the services that a State may provide to such individuals.

With regard to blind and disabled children under the age of 16 who are receiving benefits under Title XVI of the Social Security Act, the Committee bill makes clear that State Title V programs can provide rehabilitation services only to the extent that such services are not covered under a State's Medicaid program. Because MCH Block Grant dollars are in such short supply, the Committee believes it is inappropriate for Title V to pay for rehabilitation services for this population if such services are already provided under a State's Medicaid plan. If, however, a State's Medicaid plan does not provide coverage for these services, the Title V program may be the most appropriate source for assistance. Under the Committee's bill, States are authorized to provide such assistance only in these limited circumstances.

With regard to "children with special health care needs", the Committee bill makes clear that State Title V programs can provide case management or "care coordination" services to assist this population and their families in obtaining the various types of services such children may require. While the term "care coordination" services is a new one for the Title V statute, the Committee bill defines it to include those services now specified by the Secretary under section 502(c)(D)(iii) of the current law.

(c) Purposes for which the Secretary is authorized to expend funds.—Again, as noted above, current Title V law specifies a number of programs and projects for which the Secretary is authorized to expend appropriated MCH Block Grant funds directly. Such programs and projects are funded through two different Federal "set-asides" which are made up of monies that are obligated directly by the Secretary.

The first set-aside, for special projects of regional and national significance ("SPRANS"), was established in 1981 and is designed to fund "SPRANS" projects and other programs relating to maternal and child health training and research, genetic diseases, and hemophilia. Under current law, the Secretary is required to retain between 10 and 15 percent of appropriated MCH Block Grant funds to support these programs.

The second set-aside was established in 1986 and is designed to fund projects for the screening of newborns with sickle-cell anemia and other genetic disorders. Under current law, the Secretary is required to retain 9 percent of appropriated MCH Block Grant funds over and above a certain level to support these projects. Current law also provides that the authority for this set-aside expires at the end of FY 1989.

The Committee bill retains the current structure of the Title V statute by providing for two different Federal set-asides. It amends current law, however, by making modifications in the statute's requirements relating both to the amount of appropriated funds that must be retained by the Secretary for each set-aside, and to the purposes for which the set-aside monies are to be used.

(1) "SPRANS" set-aside.—Under the Committee bill, the Secretary is required to retain a full 15 percent of the amounts appropriated to the MCH Block Grant for programs and projects of the type currently funded under the "SPRANS" set-aside (see section 4302, below). Such programs and projects include those for comprehensive hemophilia diagnostic and treatment centers which have received Federal set-aside funds over the last several years.

In addition, these programs and projects include those for early intervention training and services development. The Committee has specified these training and service development programs and projects in response to the critical shortage of allied health professionals needed to provide care to the thousands of infants and toddlers with disabilities who will soon become eligible to receive health-related services under the 1986 Education of the Handicapped Act (P.L. 99-457). The Committee stresses, however, that in including this provision in the Committee bill, it is authorizing the use of Title V funds for the *sole* purpose of developing service capacity (through personnel training and services development projects) to address the health-related needs of disabled infants and

toddlers to be served under P.L. 99-457; it is *not* authorizing the use of Title V dollars for payment for any actual services that are to be provided under P.L. 99-457. Such services are to be funded with monies made available under that law.

(2) Infant mortality, newborn genetic screening, and rural services set-aside.—Under the Committee bill, the Secretary is required to retain an additional 12.75 percent of the amounts appropriated to the MCH Block Grant to support infant mortality programs, newborn genetic screening projects, and service programs for mothers and children living in rural areas (see section 4302 below).

The Committee bill specifies four categories of infant mortality initiatives that are to be supported through this set-aside: (i) maternal and infant health home visiting programs; (ii) integrated maternal and child health service delivery systems; (iii) maternal and child health centers operated under the direction of not-for-profit hospitals; and (iv) projects designed to increase the participation of obstetricians and pediatricians under both the Title V and Title XIX (Medicaid) Programs. Two-thirds of the amounts appropriated under this set-aside are to be used to fund these initiatives (see section 4302, below). As the bill makes clear, each of these programs and projects must be funded by the Secretary, although the number of such programs and projects within each category remains within the Secretary's discretion. Within each category, however, the Secretary must give preference to qualified applicants able to demonstrate that their initiatives will be carried out in areas with a high infant mortality rate (relative to the average infant mortality rate in the United States or in the State in which the area is located).

The Committee's emphasis on the first category of infant mortality initiatives—maternal and infant health home visiting programs—comes in response to the findings and recommendations of the National Commission to Prevent Infant Mortality. Created by Congress in 1986, the initial focus of the Commission was to review existing programs and policies directed at the health of women of child-bearing age and their infants. Its year-long study, "Death Before Life: The Tragedy of Infant Mortality," was released in 1988. In it, the Commission called for a number of programmatic improvements, including the development and expansion of home visitors projects for pregnant women and new mothers—particularly for those in high-risk populations. In its more recent report, "Home Visiting: Opening Doors for America's Pregnant Women and Children," published in July 1989, the National Commission again found that "home visiting is an effective, cost-saving, community-oriented strategy that works . . . to promote and protect the health of pregnant women and children", and reaffirmed its view that home visiting programs should be supported and expanded. The Committee bill, in providing for maternal and infant health home visiting programs, is designed to implement the Commission's recommendation.

The purpose of these programs, as envisioned by the Committee, is to educate and work with pregnant women and mothers of infants to promote healthy outcomes. To achieve this goal, the Committee bill specifies that home visiting programs provide case management services, health education services, and related social sup-

port services to pregnant women or to families with an infant up to age one, in the home. Under the Committee bill, such services must be designed to assure access to quality prenatal, delivery, and postpartum care for pregnant women, and to assure access to quality preventive and primary care services, including immunizations and well-baby care, for infants. In addition, the Committee believes that these services should be structured so as to encourage healthy behaviors such as reducing or quitting smoking and improving dietary habits, and to help lower the incidence of accidents, abuse, and neglect. As specified in the bill, each of these services is to be provided by an appropriate health professional or by a qualified non-professional (such as a trained community worker) who is acting under the supervision of a health professional.

As discussed in section 4203, above (optional Medicaid coverage of prenatal and postpartum home visitation services), the Committee bill, in addition to expanding Medicaid eligibility for pregnant women, infants and children, also establishes a new optional Medicaid benefit for prenatal home visitation services for high-risk pregnant women (as prescribed by a physician) and/or post-partum home visitation services for high-risk infants under age one (as prescribed by a physician). Thus, under the Committee's bill, a State could have two home visiting programs in effect at the same time (if the State elected to exercise the new Medicaid option, and if it applied for, and were awarded, during the same period, a Title V Federal set-aside grant for a home visiting program).

The Committee stresses that it has no objections to such an arrangement. It would emphasize, however, that under such circumstances, the Committee does not intend—not does current law allow—for the State's Title V Federal set-aside funds to be used to pay for services that are covered under the State's Medicaid home visitation benefit. For example, if a State were to elect to pick up the Medicaid home visitation option and if, at the same time, it were awarded a Title V Federal set-aside grant for a home visitors program, the State's Title V Federal set-aside funds could not be used to pay for home visiting services provided to a pregnant woman (or to any other individual) eligible for Medicaid. Nor could they be used to supplement Medicaid payments for such services—or any other Medicaid-covered services—provided to an individual eligible for Medicaid. Such funds could be used, however, to support additional services (that is, services not covered under a State Medicaid plan) provided to Medicaid-eligible individuals.

The Committee notes that, in specifying these payments responsibilities, it is merely following current law which requires that Medicaid act as the first payor for services covered under a State's Medicaid plan.

In addition to its recommendation concerning the establishment of home visitors programs, the National Commission on Infant Mortality has called for the development and expansion of integrated maternal and child health service delivery systems. Such systems are designed to provide access—in one location—to a number of services needed by loe-income or high-risk pregnant women and their young children. These services include those provided under both the Title V and Medicaid Programs; the Supplemental Food Program for Women, Infants, and Children ("WIC");

the head Start Program; and other appropriate health and health-related programs. In authorizing funds for this second category of infant mortality programs, the Committee intnds to implement this recommendation of the National Commission.

In carrying out the Commission's recommendation, the Committee intends that systems funded under this Title V set-aside not only provide access to the services specified above, but also coordinate the application processes for, and the acutal delivery of, these services so as to cut down on administrative costs and client frustration and confusion. To further this goal, the Committee bill requires that these integrated maternal and child health service delivery systems use the model application form that is to be developed by the Secretary under section 4306 once it becomes available in 1190. As discussed below, this form is to be used in applying, simultaneously, for assistance for a pregnant woman or a child under the age of six under a variety of specified maternal and child assistance programs. Until such form becomes available, however, the Committee intends that systems funded under this set-aside make every effort both to coordinate and to expedite the application process for services that are to be provided.

Hospital-based maternal and child health centers which provide prenatal, delivery, and postpartum care for pregnant women and preventive and primary care services for infants up to age one, are the third category of infant mortality projects to be funded under this set-aside. Applicants must be not-for-profit hospitals and should be located in the geographic area of the individuals whom they intend to serve.

Applicants must also agree to provide all of the services specified in the bill in order to be designated as a maternal and child health center. The Committee emphasizes this requirement to underscore its view that prenatal, delivery, and postpartum services are most effective when delivered as a continuum of care and not in an episodic fashion. Thus, the Committee intends for centers to provide each of the services specified in the bill to each pregnant woman and each infant who participates in a center's maternal and infant health program.

In addition to these requirements, applicants must agree to use non-Federal funds to match each Federal dollar that is provided under this set-aside.

The purpose of the fourth category of infant mortality iitiatives that is to be supported through this set-aside is to increase the participation of obstetricians and pediatricians under both Title V and Medicaid. Such initiatives are to test innovative approaches to removing identified barriers to program participation by obsetricians and pediatricians so as to provide greater access to prenatal, delivery, and postpartum care for pregnant women, and to preventive and primary care for infants and young children. The Committee intends that such innovations include expediting reimbursement and using different payment mechanisms such as global fees for maternity and pediatric services (with guaranteed periodic payments); assisting in securing, or paying for medical malpractice or otherwise sharing in the risk of liability for medical malpractice; decreasing unnecessary administrative burdens in submitting claims or securing authorization for treatment; and covering medi-

cal services such as prenatal vitamins or other nutritional supplements. The Committee does not intend, however, that such innovations include the authority to limit eligibility under either a State's Title V or Medicaid program or to reduce any services that these programs provide. Nor does the Committee intend that such innovations include the authority to waive any Medicaid requirements, including the requirements relating to freedom to choice.

Under the Committee bill, Committee bill, the remaining one-third of the amounts appropriated under this set-aside are to be used to support projects to screen newborns for sickle cell anemia and other genetic disorders together with follow-up services, and for maternal and child health projects to serve rural populations (see section 4302, below). At least 25 percent of the amounts made available are to be retained by the Secretary to carry out newborn genetic screening programs and at least 25 percent of the amounts appropriated are to be retained by the Secretary to carry out maternal and child health projects in rural areas. The remaining 50 percent of the funds may be allocated to either type of project at the discretion of the Secretary.

With respect to newborn genetic screening projects, the Committee intends that the Secretary support the type of program that was established under the 1986 amendments to the MCH Block Gran (p.L. 99-509). The Committee notes, however, that the bill includes the provision of follow-up services as part of the screening process and emphasizes the requirement that such services be provided by all projects funded under this set-aside.

With respect to maternal and infant health projects in rural areas, the Committee intends that the Secretary fund initiatives to help combat infant mortality and to otherwise improve the heath of pregnant women, mothers, and children. The Committee has given the Secretary broad discretion in determining how such programs are to be structured and to be carried out. Nonetheless, the Committee intends that the Secretary design these projects consistent with the goals and objectives of the MCH Block Grant, including those specified in section 4301(a), above.

(d) Authorization of Appropriations.—Under current law, the authorization level for the MCH Block Grant Program is $561 million. The Committee bill increases this amount to $661 million, effective FY 1990 and each fiscal year thereafter.

Section 4302—Allotments to States and Federal set-asides

Under current law, funds are allocated under the MCH Block Grant in accordance with the following formula. Of the amounts appropriated in each fiscal year, between 10 and 15 percent of the total are retained directly by the Secretary to support various "SPRANS" projects. In those years in which appropriations for Title V exceed $478 million, an additional 9 percent of the remaining approprations are also retained directly by the Secretary to fund newborn genetic screening projects. In such years, two-thirds of the balance is allocated directly to the Secretary to fund additional "SPRANS" projects and to the States for various maternal and child health services. The remaining one-third is also allocated directly to the Secretary and to the States. However, these funds must be used by both the Secretary and States for primary care

services for children, and for community-based service networks and case management serviecs for "children with special health care needs." The authority for the Federal set-aside for newborn genetic screening programs expires at the end of FY 1989. The authority for the other parts of this formula have no fixed expiration date.

The Committee bill makes a number of changes in this formula.

With respect to Federal set-asides, the Committee bill requires that a full 15 percent of the amounts approprated in each fiscal year be retained directly by the Secretary to support 'SPRANS" projects. An additional 12.75 percent of such amounts is also to be retained directly by the Secretary to fund programs and projects authorized under the infant mortality, newborn genetic screening, and rural services set-aside. As noted previously (see section 4301(c)(2), above, two-thirds of the funds allocated to this set-aside are to be used to support infant mortality initiatives; the remaining one-third must be targeted for newborn genetic screening projects and maternal and child health programs in rural areas.

As under the current law, the monies that remain after allocations are made for the two Federal set-asides are to be distributed among the States on the basis of their proportional share of 1981 outlays for the various categorical programs consolidated into the MCH Block Grant. Under the Committee bill, this allotment formula has been updated and abbreviated for the sole purpose of making its calculations simpler and easier. No changes in the actual computation of the formula are intended by the Committee and none should be implemented by the Secretary on the basis of this section of the legislation.

With respect to State MCH Block Grant dollars, the Committee bill requires that, effective with appropriations made available as of FY 1991, States must use at least 30 percent of their allotted funds for services for pregnant women, mothers, and infants up to age one; at least 30 percent for services for children; and at least 30 percent for services for "children with special health care needs". The remaining 10 percent of alloted monies are to be allocated at each State's discretion (see section 4304, below).

Section 4303—Use of allotment funds and application for block grant funds

(a) State applications.—Under current law, in order for States to be entitled to receive their allotments of MCH Block Grant funds, they must submit to the Secretary both a report that describes their intended use of the payments, and a "statement of assurances" that is designed to certify the States' compliance with a number of specified conditions. However, because States have varied in their commitment to meet these requirements, these documents, in general, have proven to be inadequate for the Department to make assessments and determinations about individual State Title V programs.

In order for the Secretary to evaluate more accurately the various State Title V programs, the Committee bill amends section 505 of the current law to require, effective with FY 1991, that all States submit to the Secretary a formal application, prepared in consultation with the State maternal and child health agency, for

Secretarial review. At that time, States will no longer be required to file reports of intended expenditures or statements of assurances. Instead, they will be required to submit only a single application, in a standardized form, to be specified by the Secretary. The Committee intends that such application form be developed by the Department's Bureau of Maternal and Child Health and that it be prepared in consultation with the various organizations, including the State Title V agency directors, that are concerned about, and directly involved with, the delivery of maternal and child health services.

With respect to the application itself, the Committee's legislation requires that States use at least 30 percent of their Title V allotments for preventive and primary care serivces for pregnant women, mothers, and infants up to age one; 30 percent for preventive and primary care services for children; and at least 30 percent for services for "children with special health care needs" (the so-called "30-30-30" formula). The remaining 10 percent of funds is to be dedicated to any one of these three groups at the State's discretion. The Committee bill does not require States to provide any specific types of services to these classes. Under current law, however, States must specify what services they do intend to provide. The Committee bill makes no changes in that mandate.

The Committee's allocation formula is designed to ensure that each class of individuals that is targeted under the goals and objectives of the Title V statute, and that is eligible to receive services, will benefit from Title V funds. In addition, the formula is designed to ensure that States are able to continue to exercise their discretion in determining what types of services are to be provided to each class of individuals.

The formula is further designed to ensure that States are able to address extraordinary unmet maternal and child health needs in certain unusual circumstances. Thus, the Committee bill provides for a waiver of the State "30-30-30" allocation formula if the Secretary determines that each of following conditions has been met: (i) on the basis of its most recent annual report to the Secretary, the State has demonstrated, in its application, an extraordinary unmet need for services for one of the designated classes of individuals; (ii) the granting of a waiver is justified and will assist in carrying out the goals and objectives of the MCH Block Grant; and (iii) the State provides assurances that each class of individuals will receive some services and specifies the percentages that are to be substituted for those mandated under the "30-30-30" formula. Waivers may be granted only by the Secretary and only for the fiscal year for which an application containing a request for a waiver has been submitted.

The Committee notes that it is unaware of any State that would be adversely affected by the implementation of the bill's "30-30-30" State allocation formula. Thus, it expects both the number of requests for waivers and the number of waivers granted by the Secretary, to be few.

The Committee bill also provides that applications specify the State's Title V goals and objectives in view of "Year 2000 Objectives" as discussed in section 4301(a), above. Since the Committee bill establishes the attainment of these objectives as the general

purpose of the MCH Block Grant Program, the Committee believes it is appropriate to require States to fix their own individual maternal and child health goals in light of these national standards and to specify those individual goals in their applications to the Secretary.

In this regard, the Committee notes that no State is to be penalized through the loss of Title V funds for not attaining either the "Year 2000 Objectives" or its own individual maternal and child health goals. The purpose of establishing national maternal and child health objectives, and of requiring States to develop and specify their own maternal and child health goals (in relation to the national objectives), is to implement a process by which the maternal and child health status of the Nation can be measured. Thus, the purpose of these requirements is not to punish States if, in a given year, they are unable to reach the goals they have set for themselves. Nor is it their purpose to hurt States if, in a given year, they do not achieve the "Year 2000 Objectives".

The Committee bill further provides that applications specify the information States will collect in order to prepare the reports that are to be submitted to the Secretary on an annual basis (see section 4304, below). The Committee intends that such information include not only a description of the actual data that is to be collected, but a description of the methodology by which such data is to be obtained.

In addition to these requirements, the Committee bill provides for a number of application standards that relate to the Medicaid program. Such requirements are designed to assure that (as discussed in section 4301(c)(2), above), limited Title V funds are not used to purchase services for women and children eligible for Medicaid, unless those services are *not* covered under the State's Medicaid program.

To assure that Title V is, indeed, the second payor, the Committee bill requires that each Title V provider or practitioner enter into a participation agreement to deliver services to individuals entitled to care under a State's Medicaid plan. Such providers must be qualified not only to deliver services under the Title V program, but under this provision of the Committee bill, they must also be qualified to receive payments under the State Medicaid plan.

The Committee bill also requires that Title V agencies provide for services to identify pregnant women and infants who are eligible for services under the State's Medicaid plan and to assist them in applying for Title XIX assistance. Since the Committee's bill mandates that MCH Block Grant providers participate in the Medicaid program, the Committee believes this additional requirement does not impose a significant burden on State Title V agencies. Indeed, in the Committee's view, this requirement—in conjunction with the Medicaid mandate described above—will help ensure that State Title V agencies provide care only to those individuals whom the MCH Block Grant is designed to serve: those mothers and children who are not eligible for services under Medicaid, or whose services are not covered under the State's Medicaid plan (or a private health insurance program).

(b) Use of State MCH block grant funds.—Under section 504 of the current Title V law, States are authorized to use their MCH

Block Grant funds for a number of specified maternal and child health activities. The Committee bill amends this section of the law to include among these authorized activities, support for National Health Service Corps personnel. Under this provision, States could, at their option, use Title V funds to pay the salaries and other related expenses for Corps personnel who deliver Title V services.

(c) Limitation on State MCH block grant funds for administrative costs.—Under the current Title V statute, there are no limitations on the amount of allotted funds that States may use for administrative costs. The Committee bill places a ceiling on such costs at no more than 10 percent of the amounts allocated to each State under Title V, thus assuring that most Title V dollars will be spent on the delivery of services. The Committee notes that such restrictions are consistent with those imposed under other State block grant programs such as the Preventive Health and Health Services Block Grant and the Alcohol and Drug Abuse and Mental Health Services Block Grant, authorized under Title XIX of the Public Health Service Act.

Section 4304—Reports

(a) State reports.—Under current law, States are required to provide minimal information to the Secretary on the activities that they fund under Title V. Current law also requires virtually no data from the States on the extent to which their Title V programs are making progress in improving the health status of mothers and children. In addition, the statute does not call for standardized report forms or for uniform data collection and reporting requirements.

The Committee believes that the establishment of specific, uniform State data collection and reporting requirements for the MCH Block Grant is long overdue and is essential for States to be able to compare their performance and progress under Title V with that of the other States. Thus, the Committee bill amends section 506 of the Title V statute to require, effective FY 1991, that State reports be prepared and submitted for review in such standardized form as specified by the Secretary. In addition, the legislation requires that such reports include a description of the extent to which a State has met the goals and objectives it set forth in its application for funds, and the extent to which a State has met the "Year 2000 Objectives" (see section 4303, above).

The Committee bill further requires that such reports contain certain information and data which the Committee believes are essential for an effective evaluation of both individual State MCH Block Grant programs and the entire Title V authority. More specifically, States are required, on an annual basis, to report by class of individuals served, on the number of individuals served by the State under Title V; the proportion of such individuals who have health insurance; the types of services provided; and the amounts spent on each type of service. As defined under the bill, such classes of individuals include pregnant women, infants up to age one, children with special health care needs, other children under the age of 22, and other individuals. In addition, the Committee bill requires that State reports include information on a range of health status and health care utilization indicators. Such information will

provide the Secretary with the data that are necessary to evaluate, measure, and compare individual State Title V programs and to report to Congress—for the first time under the Title V law—on the current health status of the Nation's mothers and children.

(b) Secretarial report.—Under current Title V law, the Secretary is required to report to the Congress only on the activities funded under the "SPRANS" Federal set-aside; there is no requirement that he report to the Congress on the programs and projects supported by State MCH Block Grant dollars, or on the outcomes that have been achieved through Title V. Thus, the Committee bill requires, effective FY 1991, that the Secretary transmit to the Congress, on an annual basis, a detailed, comprehensive report on the activities, programs, and outcomes of the MCH Block Grant.

More specifically, the Committee bill requires that this report include a description of each of the projects funded under the two Federal set-asides (see section 4301(c), above); a summary of the information provided by the States in their annual reports to the Secretary; based upon the data supplied by the States to Secretary, a compilation of various key maternal and child health indicators; information on the number of pregnant women and infants receiving services under either the MCH Block Grant or Medicaid programs; and an assessment of the progress being made to meet the health status goals and national health objectives discussed in section 4301(a), above.

In the Committee's view, this report is to serve as the basis for measuring the Nation's advancements in maternal and child health. The Committee expects, therefore, that this report will contain each of the items specified in the Title V statute.

Section 4305—Federal assistance in data collection mechanisms

Under section 509 of the current Title V law, the Federal Bureau of Maternal and Child Health has responsibility for providing a range of MCH Block Grant program support activities to the States. Under the Committee bill, this section of the law is amended to expand the Bureau's areas of assistance to include the development of consistent and accurate data collection mechanisms that are necessary for States to be able to provide the required information in their annual reports to the Secretary.

Section 4306—Development of model application form for maternal and child assistant programs

Over the years, Congress has created a number of successful, cost-effective maternal and child assistance programs targeted to pregnant women and children ages zero through six. These include the MCH Block Grant; the Medicaid program; the migrant and community health centers programs; the health care for the homeless grant program; the Supplemental Food Program for Women, Infants, and Children (WIC); and the Head Start Program.

Despite their common cause, these programs are supported through several different authorities and more often than not, have very different requirements. As a result, individuals who are entitled to review services under more than one of these programs are frequently unaware of their eligibility or are frustrated by bureaucratic redtape in their attempts to obtain care.

As the National Commission to Prevent Infant Mortality suggests in its 1988 report, "Death Before Life: The Tragedy of Infant Mortality," one of the most effective ways to address this problem is to streamline or refine the application process for these various programs. The Committee agrees. Thus, the Committee bill requires the Secretary (in consultation with the Secretary of Agriculture) to develop (within one year of the enactment of this legislation) a model application form for use in applying, simultaneously, for assistance for pregnant women and children under age six under the maternal and child assistance programs specified above.

The Committee intends that this application form be as simple and as easy to understand as possible so as to avoid the costly and complicated application efforts that now consume both program beneficiaries and program agencies. It further intends that the Secretary, in preparing the model application form, consult with the various State agencies that administer these maternal and child assistance programs, as well as other organizations that actually provide maternal and child assistance services.

Once developed, the Committee bill also requires that the model application be disseminated to each State agency responsible for administering a maternal and child assistance program. The bill does not require any State agency to adopt the model form. The bill does require, however, that integrated maternal and child health service delivery systems funded under the legislation's Title V infant mortality, newborn genetic screening, and rural services Federal set-aside, use the model application in their programs as soon as it becomes available (see section 4301(c)(2), above).

Section 4307—Research on infant mortality and Medicaid services

With the expansion of the Medicaid program to improve access to prenatal care for pregnant women, the need for research on the relationship between the receipt of prenatal care under Medicaid and infant mortality as grown. Under the Committee bill, the Secretary is required to support such research by developing a national system for linking birth, infant death, and Medicaid data.

It is the Committee's understanding that the structure for implementing such a system has already been developed and put into place by the National Center for Health Statistics (NCHS). Under the NCHS program, information found on birth certificates (such as infant birthweight, mother's receipt of prenatal care, and other risk factors) is linked with information recorded on infant death certificates. The purpose of this section of the Committee's bill is to provide for the development of a national system that will allow HCFA Medicaid data to be integrated into the NHCS program.

Section 4308—Effective dates

(a) In general.—Except for the provisions relating to State applications for Title V funds (section 4303(a)) and to State and Secretarial Title V reports (section 4304), the amendments made under this subtitle of the Committee bill are to apply to appropriations for fiscal years beginning with fiscal year 1990.

(b) Title V applications and reports.—The amendments made under this subtitle relating to State applications for Title V funds (sections 4303(a)) and to State and secretarial Title V reports (sec-

tion 4304) are to apply for fiscal years beginning with fiscal year 1991.

Subtitle E—Miscellaneous Health-Related Provisions

Section 4401—Congressional access to information

Section 301(j) of the Federal Food, Drug and Cosmetic Act prohibits the release of certain information. The Committee's bill would amend that section to clarify that the section does not authorize the withholding of information from Congress. As amended, the section would simply restate the authority of the Congress to get information from the executive branch.

Section 4402—Vaccine injury compensation technicals

The National Childhood Vaccine Injury Act of 1986 (P.L. 99-660) created a system for compensating children for injuries received from routine pediatric immunizations. The Vaccine Compensation Amendments of 1987 (P.L. 100-203) provided for a source of payment for such compensation and began the functioning of the system.

Since that time the U.S. Claims Court, which was designated as the forum for the resolution of these vaccin injury claims, has received more than a hundred petitions for compensation for injuries associated with vaccines administrered before October 1, 1988, the effective date of the program. No claims for compensation for injuries associated with vaccines administered after the effective date have yet been recieved.

In addition, vaccine prices, which had skyrocketed as much as 2,000 percent before the enactment of the compenstation system, have stabilized. Indeed, some manufacturers have demonstrated renewed interest in the U.S. vaccine market.

Several problems have, however, emerged in the system as it has been begun. Some are technical in nature and are easily corrected.

Others are problems created by unforeseen circumstance, such as the delay in initial receipt of claims. These difficulties, while not technical, are also easily corrected.

But most important are other, more fundamental problems—principally in the nature of the adjudication of petitions—which cannot be remedied by statutory change alone. Correction of these problems will require revision of the vaccine rules of the Claims Court and a re-dedication of all parties to the creation of an expeditious, non-adversarial, and fair system.

The Committee proposes statutory amendments to address these difficulties with serious concern about the situation that has arisen since the receipt of the first claims. The Report accompanying the original Act makes clear that the Committee intended a quick, flexible, and streamlined system. (H.Rept. No 99-908, 99th Cong., 2nd Sess., Sept. 26, 1986) That Report called for a compensation procedure that administered awards "quickly, easily, and with certainty and generosity." The system was intended to be "fair, simple, and easy to administer" and "to compensate persons with recognized vaccine injuries without requiring the difficult individual determinations of causation to injury." The powers of discovery within the proceeding were given over to the Master, with "neither

party . . . given power to cross-examine witnesses, file interrogatories, or take depositions" in order "to replace the usual rules of discovery in civil actions in Federal Courts.

The Committee has come to understand that rather than establishing such a system, all participants have, to some degree, maintained their traditional adversarial litigation postures. The Claims Court has issued rules for vaccine proceedings that force proceedings to be formal and that virtually foreclose any opportunity for petitioners or respondents to proceed without litigators at their sides. Petitioners have failed to include adequate information in initial petitions and have pursued traditional rights of exclusion of evidence. Respondents have withheld sufficient personnel and administrative support and mounted defenses incompatible with a no-fault system of compensation.

In proposing this legislation, the Committee reiterates its intent that the vaccine injury compensation system be informal, flexible, and expeditious, and that all participants proceed accordingly. The re-invention of the adversarial process will serve neither to compensate injured children nor maintain the stability of the immunization programs of the U.S.

The Committee also reiterates its expectation that the Special Master and the powers given to the Master will allow the proceedings to be direct and straightforward. The Master should be able to require from petitioners and respondents information sufficient to evaluate the petition without resort to complex proceedings.

With such re-dedication to the original goals of the program, the Committee anticipates that all participants will benefit. The system will provide compensation, eliminate the need for litigation, and assure the continued availability of and public confidence in immunizations in the U.S.

(a) Reference.—Section 4402(a) establishes that all references are made to the Public Health Service Act.

(b) Petitions.—Paragraph (1) clarifies that certain information must be included in the original petition to the Claims Court in order to initiate a compensation proceeding. The Committee has received reports from the Department of Health and Human Services (DHHS) and the Department of Justice (DOJ) that petitions have been accepted containing little or none of the information needed to review the claim for compensation. The Committee has also heard from representatives of petitioners that the granting of the authority to initiate claims of compensation to the respondents would work a hardship on petitioners and could result in delay. The Committee acknowledges that the current content required by all of Section 2111(c) could form the basis for delay. While the Court has been responsive in its promulgation of General Order 24, which allowed a suspension of proceedings while medical records were completed, the Committee believes it necessary to set a clear standard of petition contents. The Committee has, therefore, set forth a list of records (listed below at Paragraph (5) that must be included and has retained the broader list of records that should also be made available if needed for considering the petition for compensation. The Committee anticipates that petitions for compensation can be reviewed by the Court for completeness under these standards and that the statutory time frame for compensa-

tion proceedings will commence from the receipt of a petition containing the specified materials. As specified below in Paragraph (4), materials not avialable to petitioners at the time of filing the petition may be described in lieu of provision, although the Committee would expect respondents and the Court to evaluate the compensability of a petition on the basis of information received. The Committee does not intend to preclude filings from being deemed adequate because of minor, inadvertent omissions or when material is unavailable to the petitioner.

Paragraph (2) provides technical clarification of the ability of a petitioner with a civil court action pending to enter the compensation system. Subparagraph (A) clarifies that a petitioner must petition to have his or her action dismissed and may not simply allow the action to lie dormant during the compensation proceeding. Subparagraph (B) clarifies that a plaintiff in such an action whose action is still pending may not enter the compensation system. In keeping with the purposes of the Act and this legislation, the Committee intends that plaintiffs in pending actions who wish to have such actions dismissed without prejudice so that they may enter the compensation system be allowed to do so without prejudice or other disincentives.

Paragraph (3) amends the Act's restrictions on entry into the compensation system. The Act prohibits anyone who brings a civil action after the effective date (October 1, 1988) from entering the compensation system. The Committee has received information, however, that the Claims Court did not accept petitions for compensation until November 15, 1988. Persons who chose between a civil action and a petition during that six-week period did not, therefore, have a true choice. Rather than statutorily barring such persons from the system, the Committee intends to allow such persons to petition to have their civil actions dismissed (as provided in Section 2111(a)(5)) and to enter into the compensation system.

Paragraph (4) inserts a new paragraph to allow petitions to be brought by persons who had appeals of civil actions pending on the effective date of the Act. Under the Act, plaintiffs in a civil action who were denied damages before October 1, 1988, are allowed to file petitions for compensation. Similarly, plaintiffs in a civil action pending on October 1, 1988, may petition to have such action dismissed before judgment and may file petitions for compensation. Conversely, plaintiffs who have civil actions pending on October 1, 1988 and do not have their civil actions dismissed may not file a compensation petition. Finally, if a person brings a civil action after deadline (originally October 1, 1988; amended by Paragraph (3) above to be November 15, 1988), he or she may not file a compensation petition. In crafting these original transition rules, the Committee did not anticipate the situation in which a person had an appeal of a civil action pending on October 1, 1988, and did not have such action dismissed. The legislation would amend the Act to allow such a person to file a petition for compensation if damages were ultimately denied in the civil action (whether in the original trial verdict or in the appeals of the trial verdict).

Paragraph (5) adds a new paragraph to the Act to specify (as described above at Paragraph (1) the minimum supportive materials that must be supplied in order to initiate a compensation proceed-

ing. Minimum materials include maternal and infant doctor and hospital records and, if applicable, autopsy results. The legislation would also add a new paragraph to allow petitioners to submit an identification of records that are unavailable (and the reasons for their unavailability) in lieu of submitting the materials. The Committee intends for the parties and the Court to construe this provision broadly so as to require the submission of a meaningful file of information but not so as to hold up proceedings unreasonably if petitioner makes a good faith effort to supply records and name unavailable ones. The Committee intends that petitioner also make every effort to continue to obtain unavailable records and that petitioners submit records as they become available.

Paragraph (6) adds a new subsection to Section 2111(c) of the Act regarding the timing of submissions and the bifurcation of proceedings. The Committee intends that the Special Master and the Court make efforts to allow compensation proceedings to begin on the issue of whether compensation is to be awarded without requiring petitioners to submit information that is needed only to decide how much compensation is to be awarded and without requiring respondents to evaluate such information, and the Committee expects that the Master will initially restrict inquiry to the question of whether to award compensation. The Committee believes that this structure, similar to that established for vaccine civil actions by the Act, will serve petitioners, respondents, and the Court well by allowing all participants to avoid needless documentation of issues that may never arise.

Paragraph (7) is a technical amendment.

Paragraph (8) makes a conforming amendment to make a reference parallel to that established by Paragraph (2) above.

(c) Special masters.—Section 4402(c) revises the provisions of the Act regarding the authorities of Special Masters. The Act provides the Master with powers to require such evidence as he or she may need to determine whether compensation should be awarded and, if so, the amount of compensation to be awarded. The Act, however, provided these powers in a non-parallel fashion, giving all authorities in determining whether to award and not explicitly providing some in determining how much the award should be and setting a standard of "appropriate" in one authority and "reasonable and necessary" in others.

The legislation revises these authorities to make them parallel and consistent. All authority granted to the Master may be exercised in the determination of whether compensation should be awarded and in the determination of how much the award should be. All authority is to be used when reasonable and necessary to achieve these results.

In addition to these changes, the legislation also makes two substantive changes in the authorities of the Masters. First, the legislation has limited hearings to those requested by one of the parties and found to be reasonable and necessary by the Master. The Committee does not intend to restrict the Master's ability to gather relevant oral and written materials and has made no similar limitation on the authority to require evidence, information, or testimony. The Committee is, however, concerned that the routine use of hearings as a method of gathering such information may produce

unnecessary formality in the gathering of such information and may tend to create an adversary process rather than a no-fault compensation proceeding.

Second, the legislation amends the Act to require—rather than simply permit—the Master to prepare and submit proposed findings of fact and conclusions of law to the Court.

The Committee reiterates its concern that these authorities not be used to re-create an adversarial process before the Special Masters. The system is intended to allow the proceedings to be conducted in what has come to be known as an "inquisitorial" format, with the Master conducting discovery (as needed), cross-examination (as needed), and investigation. As was stated in the Report accompanying the original Act, "In order to expedite the proceedings, the power of the Special Master is intended to replace the usual rules of discovery in civil actions in Federal courts." The parties are, of course, free to request that the Master develop the record by obtaining necessary information. (For example, the Master might be asked to subpoena further records.)

The Committee also believes that the Masters may, in some cases, be well-advised to retain independent medical experts to assist in the evaluation of medical issues associated with eligibility for compensation and the amounts of compensation to be awarded. In cases where petitioners assert a theory of vaccine causation of injury and respondents claim other causation, the Master may find it most expeditious to receive outside advice rather than attempt a full adversarial proceeding on the questions of causation. The Act authorizes such action by the Master and the Committee would encourage its use as appropriate.

(d) De Novo proceedings.—Section 4402(d) clarifies that the Claims Court, in acting upon the recommendations of the Master, may receive further evidence in addition to that contained in the Master's report. The Committee recognizes that the regrettable lack of representation on behalf of DOJ and DHHS has, in some cases, resulted in the omission of useful evidence from the record. The Committee intends that the Court, as appropriate, exercise its authority to complete records and to receive additional evidence. The Committee does not, however, anticipate that this authority will be generally used in pending cases or frequently required in future cases.

(e) Time for judgment.—Section 4402(e) extends the time period for the Court to make its judgment on petitions relating to vaccines administered before October 1, 1988. The Committee recognizes that in the initial implementation, delays have arisen in proceedings on early cases. Rather than holding the Court to unrealistic time frames, the Committee has chosen to allow an extra six months to deal with the backlog of pre-enactment cases. The Committee intends that this extra time be used only as necessary and not be used as a general delay to cases that might quickly be resolved.

(f) Table.—Section 4402(f) makes a technical correction in references in the Vaccine Injury Table.

(g) Compensation.—Paragraph (1) of Section 4402(g) makes technical changes to clarify the compensation that is to be allowed in cases involving injuries associated with a vaccine administered

before the effective date of the Act (October 1, 1988). The Committee is aware that there may be some confusion about the allowable compensation and intends that pre-enactment injuries be eligible for actual unreimbursable expenses incurred from the date of judgment (as provided in 2115(a)(1)(A) of the Act), death benefits (as provided in 2115(1)(2)) and a total amount up to $30,000 for the combined amounts of lost earnings (as provided in 2115(a)(3)), pain and suffering (as provided in 2115(a)(4)), and attorneys' fees and costs (as provided in 2115(e)). This represents no change in policy from the Act and is only intended to clarify the amount of damages.

Paragraph (2) of Section 4402(g) makes technical changes to clarify that the Claims Court award for amounts to cover attorneys' fees and costs is to be included after proceedings are complete.

(h) Technical.—Section 4402(h) makes technical amendments to clarify that judgments entered are final judgments and to remove any ambiguity that the Act contemplated different points in the proceeding by its use of different terms. The Committee does not intend to alter the effect of the Act but simply to make clear that the stay is to continue in effect until all appeals, if any, are resolved. Similarly, under Section 2121(a), an election by the petitioner need not be made until 90 days after all appeals, if any, are resolved.

(i) Vaccine information.—Section 4402(i) amends the Act's requirement of vaccine information materials to be provided to parents and guardians of children receiving immunizations. The Act provided for these materials to include a summary of relevant State and Federal laws on vaccination requirements. The legislation would substitute a summary of relevant Federal recommendations concerning the schedule of childhood immunizations.

(j) Authorizations.—The Act provides no authorizations for administrative expenses related to the Compensation Program. Section 4402(j) authorizes funds to be used for administrative expenses for FY 90 and 91 for DHHS, DOJ, and the Claims Court. The Committee is concerned by the inadequate support and personnel that DHHS and DOJ have committed to the system and is disturbed by the failure of DOJ to make appearances and act as a representative of DHHS in these cases and the Committee expects DOJ to return to its responsibilities to represent the government in these cases (to the extent that the government may require representation). The Committee does not intend that these funds be used to substitute existing resources devoted to these programs and expects DHHS and DOJ to continue to provide at least the current level of support in addition to these authorizations. As is made clear by other sections of this report, the Committee also does not intend that any of the three recipients of these authorized funds use them to prolong proceedings in a legalistic or unnecessarily detailed manner. These funds are provided to expedite the review and processing of information in order to simplify proceedings and allow for a quick resolution of claims.

(k) Rules changes.—Section 4402(k) requires the Claims Court to review its rules for vaccine proceedings and to make revisions in the rules in a manner conforming to the applicable law regarding issuance of rules and opportunity for public comment and consulta-

tion. The Committee intends that the revisions provide for a non-adversarial, expeditious, and informal proceedings. The Committee has received reports that the current rules of the Court are formal rules akin to those of the Federal Courts for civil litigation. The Committee once more reiterates its desire that the Court make vaccine proceedings as swift and uncomplicated as possible.

(l) Study.—Section 4402(l) requires that DHHS evaluate the National Vaccine Injury Compensation Program and report the results to the Committee on Energy and Commerce of the House and Committee on Labor and Human Resources of the Senate.

(m) Effective date.—Section 4402(m) provides that the changes made by these amendments apply to petitions filed after the date of enactment of this section. The Committee intends that the Court interpret this provision broadly, allowing itself and the parties to use this legislation to expedite proceedings and to clarify confusion that may exist in petitions already filed. The Committee recognizes that some confusion could arise, however, if rules changes were strictly enforced in pending claims and has provided this effective date to allow the Court to administer proceedings equitably.

Section 4403—Study by General Accounting Office with respect to loss by retired individuals of health benefits due to liquidation of employer in bankruptcy

Most Americans are insured through their employer by private group health insurance. The Consolidated Budget Reconciliation Act of 1985 included a requirement that employers with 20 or more employees that offer a group health insurance plan offer qualified employees and their families the option of continued health insurance at group rates when faced with the loss of coverage because of certain events. In the Omnibus Reconciliation Act of 1986, Congress added as a "qualifying event" a proceeding in a case under the bankruptcy provisions of Title 11 of the United States Code commencing on or after July 1, 1986.

Thus, under chapter 11 bankruptcy, employees' health benefits are somewhat protected. However, under chapter 7 bankruptcy, companies liquidate and pay off certain creditors, but employees' and retirees' continued health benefits have no guaranteed protection.

The committee directs the General Accounting Office to conduct a study to identify options for providing health benefits for any retired individual whose employer-provided health benefits are terminated because the employer receives a discharge under chapter 7 of Title 11, U.S. Code. The committee requests that the GAO examine a range of approaches and determine for each method the cost to the federal and state governments; the cost to individuals; the extent of benefits to be provided; and the administrative structure required and its cost.

In addition, the committee has noted the increasing trend toward early retirement and the fact that one third of all retirees are now under age 65. Many companies in recent years have increased beneficiary cost-sharing and reduced benefits in an effort to limit cost increases to the former employers. The committee is directing GAO to also examine the extent to which employer-provided health ben-

efits for retirees have been reduced since 1984 and to project trends in the near future.

APPENDICES

The following three appendices set forth specifications for the implementation of section 4001 of the Committee bill. Section 4001 establishes a fee schedule, using a resource-based relative value scale, for making payments for physician services under Medicare. An explanation of how these appendices are to be used is set forth in the section-by-section analysis for section 4001.

Appendix A. List of Procedures and Relative Values

Code and description	Relative value	Physician work component expenses (percent)	Practice component (percent)
Group A: Procedure codes:			
19160 Removal of breast tissue	24.5	51	49
19162 Remove breast tissue: Nodes	56	48	52
19180 Removal of breast	34.7	51	49
19182 Removal of breast tissue	36.5	50	50
19200 Extensive breast surgery	62	47	53
19220 Extensive breast surgery	66	48	52
19240 Extensive breast surgery	61	49	51
20550 Injection treatment	2.22	62	38
20600 Drainage joint/bursa/cyst	2.39	65	35
20605 Drainage joint/bursa/cyst	2.80	66	34
20610 Inject/drain joint/bursa	2.83	65	35
27125 Revise hip with prosthesis	86	39	61
27126 Revise hip with prosthesis	90	40	60
27127 Revise hip with prosthesis	105	38	62
27130 Total hip joint replacement	132	39	61
27132 Total hip joint replacement	156	37	63
27134 Revise hip joint replacement	156	41	59
27137 Revise hip joint component	121	43	57
27138 Revise hip joint component	120	44	56
27230 Treat fracture of femur	18.3	50	50
27232 Treat fracture of femur	41.0	48	52
27234 Treat fracture of femur	107	50	50
27235 Repair of femur fracture	80	44	56
27236 Repair of femur fracture	80	46	54
27238 Treatment of femur fracture	24.0	51	49
27240 Treatment of femur fracture	45.3	48	52
27242 Repair of femur fracture	70	53	47
27244 Repair of femur fracture	79	47	54
27246 Treatment of femur fracture	20.6	48	52
27248 Repair of femur fracture	60	52	48
28290 Correction of bunion	21.0	38	62
28292 Correction of bunion	29.8	37	63
28293 Correction of bunion	33.5	37	63
28294 Correction of bunion	33.0	37	63
28296 Correction of bunion	34.2	39	61
28297 Correction of bunion	34.6	34	66
28298 Correction of bunion	26.4	37	63

Code	Description	Relative value	Physician work component (percent)	Practice expenses component (percent)
28299	Correction of bunion	42.5	35	65
29870	Knee arthroscopy	14.5	38	62
29871	Knee arthroscopy/drainage	26.0	38	62
29872	Knee arthroscopy/drainage	28.2	36	64
29874	Knee arthroscopy/surgery	32.3	32	68
29875	Knee arthroscopy/surgery	40.7	32	68
29876	Knee arthroscopy/surgery	41.9	33	67
29877	Knee arthroscopy/surgery	48.1	25	75
29879	Knee arthroscopy/surgery	47.9	31	69
29880	Knee arthroscopy/surgery	62	27	73
29881	Knee arthroscopy/surgery	46.7	31	69
29882	Knee arthroscopy/surgery	45.3	34	66
29884	Knee arthroscopy/surgery	30.5	36	64
29886	Knee arthroscopy/surgery	39.3	32	68
29887	Knee arthroscopy/surgery	33.8	33	67
29889	Knee arthroscopy/surgery	72	41	59
31000	Irrigation maxillary sinus	2.09	39	62
31001	Irrigation maxillary sinuses	3.07	35	66
31002	Irrigation sphenoid sinus	1.91	45	55
31020	Exploration maxillary sinus	10.6	44	56
31021	Exploration of sinuses	16.3	41	59
31030	Exploration maxillary sinus	36.0	39	61
31031	Exploration of sinuses	51	40	61
31032	Explore sinus: remove polyps	37.1	41	60
31033	Enter sinuses, remove polyps	47.0	39	61
31360	Removal of larynx	93	46	54
31365	Removal of larynx	128	45	55
31367	Partial removal of larynx	96	46	54
31368	Partial removal of larynx	125	48	52
31500	Endotracheal intubation	6.8	59	41
32000	Drainage of chest	8.8	72	28
32020	Treatment of collapsed lung	13.5	52	48
32035	Exploration of chest	36.6	51	49
32036	Exploration of chest	39.8	52	48
32440	Removal of lung	110	47	53
32480	Partial removal of lung	101	47	53
32485	Partial removal of lung	116	49	51
32490	Partial removal of lung	121	49	51
32500	Partial removal of lung	80	47	53
32520	Remove lung and revise chest	110	47	53
32522	Remove lung and revise chest	113	48	52
32525	Remove lung and revise chest	137	47	53
33206	Insertion of heart pacemaker	45.0	29	71
33207	Insertion of heart pacemaker	44.0	31	69
33208	Insertion of heart pacemaker	57	31	69
33210	Insertion of heart electrode	13.7	31	70
33212	Insertion of pulse generator	25.7	31	69
33216	Revision implanted electrode	21.6	34	66
33218	Repair pacemaker electrodes	17.9	34	66
33219	Repair of pacemaker	25.0	34	66
33232	Removal of pacemaker	15.5	39	62
33405	Replacement of aortic valve	168	38	62
33510	Coronary artery bypass	141	34	66
33511	Coronary arteries bypass	168	35	65
33512	Coronary arteries bypass	184	35	65
33513	Coronary arteries bypass	195	36	64
33514	Coronary arteries bypass	202	36	64
33516	Coronary arteries bypass	212	35	65
35001	Repair defect of artery	87	47	53
35011	Repair defect of artery	78	47	53
35013	Repair artery rupture, arm	94	48	52
35021	Repair defect of artery	99	48	52

Code	Description	Relative value	Physician work component expenses (percent)	Practice component (percent)
35022	Repair artery rupture, chest	45.8	50	50
35045	Repair defect of arm artery	69	46	54
35081	Repair defect of artery	128	45	55
35082	Repair artery rupture: aorta	144	44	57
35091	Repair defect of artery	140	47	53
35092	Repair artery rupture, belly	156	46	54
35102	Repair defect of artery	136	46	54
35103	Repair artery rupture: groin	149	45	55
35111	Repair defect of artery	93	52	48
35112	Repair artery rupture, spleen	96	42	58
35121	Repair defect of artery	95	47	53
35122	Repair artery rupture, belly	108	41	59
35131	Repair defect of artery	81	48	52
35132	Repair artery rupture, groin	115	46	54
35141	Repair defect of artery	88	45	55
35142	Repair artery rupture, thigh	95	47	53
35151	Repair defect of artery	88	47	53
35152	Repair artery rupture, knee	104	47	53
35161	Repair defect of artery	68	45	55
35301	Rechanneling of artery	83	39	61
35311	Rechanneling of artery	105	38	62
35321	Rechanneling of artery	65	42	58
35331	Rechanneling of artery	66	42	58
35341	Rechanneling of artery	76	42	58
35351	Rechanneling of artery	75	41	59
35355	Rechanneling of artery	84	40	60
35361	Rechanneling of artery	96	39	61
35363	Rechanneling of artery	111	39	61
35371	Rechanneling of artery	71	38	62
35372	Rechanneling of artery	71	38	62
35381	Rechanneling of artery	76	41	59
39400	Visualization of mediastinum	30.1	47	53
44120	Removal of small intestine	64	49	51
44125	Removal of small intestine	65	51	49
44130	Bowel to bowel fusion	59	49	51
44140	Partial removal of colon	73	48	52
44141	Partial removal of colon	75	49	51
44143	Partial removal of colon	84	48	52
44144	Partial removal of colon	79	49	51
44145	Partial removal of colon	86	49	51
44146	Partial removal of colon	97	47	53
44147	Partial removal of colon	93	50	50
44150	Removal of colon	94	47	53
44151	Removal of colon/ileostomy	102	51	49
44152	Removal of colon/ileostomy	99	47	53
44153	Removal of colon/ileostomy	102	46	54
44155	Removal of colon	106	49	51
44156	Removal of colon/ileostomy	96	44	56
44160	Removal of colon	78	47	53
44950	Appendectomy	29.6	45	55
44960	Appendectomy	35.1	46	54
45378	Diagnostic colonoscopy	20.4	35	66
45379	Colonoscopy	22.3	36	64
45380	Colonoscopy and biopsy	22.8	34	66
45382	Colonoscopy, control bleeding	28.1	35	65
45383	Colonoscopy, lesion removal	24.6	35	65
45385	Colonoscopy: lesion removal	30.7	33	76
47600	Removal of gallbladder	47.4	45	56
47605	Removal of gallbladder	51	45	55
47610	Removal of gallbladder	59	46	54
47612	Removal of gallbladder	87	46	54
47620	Removal of gallbladder	69	46	54

Code and description		Relative value	Physician work component expenses (percent)	Practice component (percent)
49500	Repair inguinal hernia	27.4	40	60
49505	Repair inguinal hernia	27.4	37	63
49510	Repair hernia: remove testis	29.5	38	62
49515	Repair inguinal hernia	30.9	39	61
49520	Rerepair inguinal hernia	31.8	37	63
49525	Repair inguinal hernia	33.7	35	65
49530	Repair incarcerated hernia	30.9	38	62
49535	Repair strangulated hernia	29.7	40	60
49540	Repair lumbar hernia	31.3	39	61
49550	Repair femoral hernia	28.3	37	63
49552	Repair femoral hernia	29.7	41	59
49555	Remove femoral hernia	30.9	39	61
49560	Repair abdominal hernia	33.3	38	63
49565	Rerepair abdominal hernia	37.1	38	62
49570	Repair epigastric hernia	20.6	40	60
49575	Repair epigastric hernia	27.7	41	59
49580	Repair umbilical hernia	22.4	40	60
49581	Repair umbilical hernia	25.7	37	63
49590	Repair abdominal hernia	28.8	38	62
50590	Fragmenting of kidney stone	55	49	51
52340	Cystoscopy and treatment	22.3	55	45
52500	Revision of bladder neck	43.8	47	53
52601	Prostatectomy (tur)	62	48	52
53606	Control postop bleeding	14.2	58	42
52612	Prostatectomy, first stage	57	53	47
52614	Prostatectomy, second stage	34.4	52	48
52620	Remove residual prostage	26.3	58	42
52630	Remove prostate regrowth	57	48	52
52640	Relieve bladder constructure	31.9	49	51
52650	Prostatectomy	44.4	44	56
58102	Curettage of uterus lining	4.45	42	58
58103	Menstrual extraction	4.98	46	54
58120	Dilation and curettage	15.2	42	58
58150	Total hysterectomy	54	39	61
58152	Total hysterectomy	62	40	60
58180	Partial hysterectomy	50	43	57
58200	Extensive hysterectomy	66	38	62
58210	Extensive hysterectomy	90	39	61
58260	Vaginal hysterectomy	52	36	64
58265	Hysterectomy and vagina repair	56	39	61
58267	Hysterectomy and vagina repair	58	37	64
58270	Hysterectomy and vagina repair	59	38	62
58275	Hysterectomy, revise vagina	62	43	57
58280	Hysterectomy, revise vagina	61	41	59
58285	Extensive hysterectomy	71	39	61
63001	Removal of spinal lamina	97	45	55
63003	Removal of spinal lamina	94	44	56
63005	Removal of spinal lamina	93	44	56
63010	Removal of spinal lamina	96	42	58
63011	Removal of spinal lamina	65	46	54
63015	Removal of spinal lamina	117	43	57
63016	Removal of spinal lamina	119	44	56
63017	Removal of spinal lamina	112	43	57
63020	Neck spine disk surgery	83	46	54
63021	Neck spine disk surgery	104	42	58
63030	Low back disk surgery	80	46	54
63031	Low back disk surgery	99	43	57
63035	Added spinal disk surgery	29.7	51	49
63040	Neck spine disk surgery	109	42	58
63042	Low back disk surgery	104	44	56
64716	Revision of cranial nerve	30.0	32	68
64718	Revise ulnar nerve at elbow	28.8	35	65

Code	Description	Relative value	Physician work component expenses (percent)	Practice component (percent)
64719	Revise ulnar nerve at wrist	16.9	34	66
64721	Revise median nerve at wrist	22.7	33	67
65850	Incision of eye	57	35	65
65855	Laser surgery of eye	42.7	35	65
66840	Removal of lens material	42.8	48	52
66850	Removal of lens material	73	39	61
66920	Extraction of lens	58	41	59
66930	Extraction of lens	49.5	49	51
66940	Extraction of lens	62	45	55
66983	Remove cataract: insert lens	85	39	61
66984	Remove cataract: insert lens	82	42	59
66985	Insert lens prosthesis	56	42	58
67107	Repair detached retina	95	42	59
67108	Repair detached retina	145	41	59
67208	Treatment of retinal lesion	43.4	37	63
67210	Treatment of retinal lesion	40.4	36	64
67218	Treatment of retinal lesion	53	41	59
67227	Treatment of retinal lesion	44.7	38	62
67228	Treatment of retinal lesion	40.4	37	63
69631	Repair eardrum structures	72	47	54
69632	Rebuild eardrum structures	81	48	52
69633	Rebuild eardrum structures	80	49	51
69635	Repair eardrum structures	84	47	53
69636	Rebuild eardrum structures	89	49	51
69637	Rebuild eardrum structures	100	43	57
69641	Revise middle ear and mastoid	90	47	53
69642	Revise middle ear and mastoid	93	49	51
69643	Revise middle ear and mastoid	97	48	52
69644	Revise middle ear and mastoid	110	47	53
69645	Revise middle ear and mastoid	95	48	52
69646	Revise middle ear and mastoid	103	46	54
76700	Echo exam of abdomen	6.9	42	58
76705	Echo exam of abdomen	4.59	45	55
76770	Echo exam of abdomen	6.2	42	58
76775	Echo exam abdomen back wall	4.78	43	57
92225	Extended ophthalmoscopy, new	2.09	44	56
92226	Extended ophthalmoscopy	1.90	42	58
92230	Ophthalmoscopy/angioscopy	3.23	43	57
92235	Ophthalmoscopy/angiography	7.8	44	56
92250	Ophthalmoscopy; fundus photo	1.56	45	55
92260	Ophthalmoscopy/dynamometry	2.51	46	54
92265	Eye muscle evaluation	1.25	24	76
92270	Electro-oculography	2.14	23	77
92275	Electroretinography	4.07	21	79
92280	Special eye evaluation	3.13	21	79
92283	Color vision examination	1.23	25	75
92284	Dark adaptation eye exam	1.72	20	80
92285	Eye photography	1.06	22	78
92286	Internal eye photography	4.59	23	77
92287	Internal eye photography	4.12	18	82
93000	Electrocardiogram: complete	1.62	34	66
93005	Electrocardiogram: tracing	0.68	35	66
93010	Electrocardiogram report	0.61	39	61
93012	Transmission of ECG	1.61	35	65
93014	Report on transmitted ECG	0.88	39	61
93015	Cardiovascular stress test	6.4	35	65
93017	Cardiovascular stress test	2.29	39	61
93018	Cardiovascular stress test	3.17	40	60
93024	Cardiac drug stress test	5.6	42	58
93040	Rhythm ECG with report	0.81	39	61
93041	Rhythm ECG, tracing	0.55	42	58
93042	Rhythm ECG: report	0.51	46	54

Code and description		Relative value	Physician work component expenses (percent)	Practice component (percent)
93045	Special ECG	1.18	36	64
93501	Right heart catheterization	17.2	36	64
93503	Right heart catheterization	13.7	35	65
93505	Biopsy of heart lining	15.2	37	63
93510	Left heart catheterization	20.6	32	68
93511	Left heart catheterization	13.2	35	65
93524	Left heart catheterization	17.5	40	60
93526	Right and left heart catheterization	27.1	35	65
93527	Right and left heart catheterization	26.1	36	64
93528	Right and left heart catheterization	21.7	33	67
Group B: Evaluation and management codes:				
90000	Office visit, new, brief			
90010	Office visit, new, limited			
90015	Office visit, new, intermediate			
90017	Office visit, new, extended			
90020	Office visit, new, comprehensive			
90030	Office visit, minimal			
90040	Office visit, brief			
90050	Office visit, limited			
90060	Office visit, intermediate			
90070	Office visit, extended			
90080	Office visit, comprehensive			
90100	Home visit, new, brief			
90110	Home visit, new, limited			
90115	Home visit, new intermediate			
90117	Home visit, new, extended			
90130	Home visit, minimal			
90140	Home visit, brief			
90150	Home visit, limited			
90160	Home visit, intermediate			
90170	Home visit, extended			
90200	Hospital care, new, brief			
90215	Hospital care, new, intermediate			
90220	Hospital care, new, comprehensive			
90225	Hospital care, new, newborn			
90240	Hospital care, brief			
90250	Hospital visit, limited			
90260	Hospital visit, intermediate			
90270	Hospital visit, extended			
90280	Hospital visit, comprehensive			
90282	Normal newborn care hospital			
90292	Hospital discharge day			
90300	Care facility visit, brief			
90315	Care facility visit, intermediate			
90320	Care facility visit, comprehensive			
90340	Care facility visit, brief			
90350	Care facility visit, limited			
90360	Care facility visit, Intermediate			
90370	Care facility visit, extended			
90400	Care facility visit, brief			
90410	Care facility visit, limited			
90415	Care facility visit, intermediate			
90420	Care facility visit, comprehensive			
90430	Care facility visit, minimal			
90440	Care facility visit, brief			
90450	Care facility visit, limited			
90460	Care facility visit, intermediate			
90470	Care facility visit, extended			
90500	Emergency care, new, minimal			
90505	Emergency care, new, brief			
90510	Emergency care, new, limited			
90515	Emergency care, new, intermediate			

Code and description		Relative value	Physician work component expenses (percent)	Practice component (percent)
90517	Emergency care, new, extended			
90520	Emergency care, new, comprehensive			
90530	Emergency care, minimal			
90540	Emergency care, brief			
90550	Emergency care, limited			
90560	Emergency care, intermediate			
90570	Emergency care, extended			
90580	Emergency care, comprehensive			
90600	Limited consultation			
90605	Intermediate consultation			
90610	Extended consultation			
90620	Comprehensive consultation			
90630	Brief foillow-up consultation			
90640	Brief follow-up consultation			
90641	Limited follow-up consultation			
90642	Intermediate follow-up consultation			
90643	Complex follow-up consultation			
90650	Second or third opinion			
90651	Second or third opinion			
90652	Second or third opinion			
90653	Second or third opinion			
90654	Second or third opinion			
90750	Preventive medicine, adult			
90751	Preventive medicine, age 12–17			
90752	Preventive medicine, age 5–11			
90753	Preventive medicine, age 1–4			
90754	Preventive medicine, infant			
90755	Infant care to one year			
90757	Newborn care not in hospital			
90760	Preventive medicine, adult			
90761	Preventive medicine, age 12–17			
90762	Preventive medicine, age 5–11			
90763	Preventive medicine, age 1–4			
90764	Preventive medicine, infant			
99062	Emergency care services			
99064	Emergency care services			
99065	Emergency care services			
99160	Critical care, each hour			
99162	Critical care, added thirty minutes			
99171	Critical care, follow-up			
99172	Critical care, follow-up			
99173	Critical care, follow-up			
99174	Critical care, follow-up			
Number of codes		389		

Appendix B. Calculation of Conversion Factor

This appendix specifies the data base, adjustments, and behavioral parameters to be used by the Secretary of Health and Human Services in calculating the conversion factor for 1990 under Section 4001(a)(5) of the bill in a manner that will maintain budget neutrality after taking into account changes in the volume of services that might occur as a response to payment changes specified for 1990 in this section of the bill.

The model differentiates between "first order" or pre-behavioral estimates of the conversion factor and "second order" or post-be-

havioral calculations. First order estimates yield a conversion factor that takes into account the adjustments in prevailing charges that would be made in each of the services listed in Appendix A. However, the first order estimate does not take into account changes in the mix, intensity, and volume (hereinafter simply referred to as volume) of services that might result from behavioral changes that occur as a result of these adjustments. The purpose of the second order adjustment is to account for such changes in volume as necessary to maintain budget neutrality.

Behavioral changes could reflect altered demand for services by patients or changes in demand inducement by physicians in response to new Medicare payment amounts and new limits on actual charges. Estimated behavioral responses are not symmetric, however. Practices whose receipts would fall because of a payment change by Medicare would have a larger offsetting behavioral response than would practices whose receipts would increase. In particular, the offset to a reduction in payments is larger (55.5 percent) than the offset to an increase in payments (37.5 percent). In application, these offsets are adjustments to the underlying rate of growth in the volume of Medicare services per enrollee, so that volume growth would temporarily accelerate for practices that were "losers" under the payment change, while growth would decelerate for "winners."

This appendix consists of three sections. The first section provides instructions on selecting and adjusting the data base to be used in simulating the payment change. The second section contains instructions on how to calculate the first-order conversion factor. The third section describes the iterative process used to adjust the first-order conversion factor to take account of behavioral responses so as to achieve budget neutrality.

I. DATA SELECTION AND ADJUSTMENT

The data base to be used is the Part B Medicare Annual Data provider (BMAD III) file for calendar year 1987. This is a five-percent sample of all Medicare providers. Two carriers—for Railroad Retirees and for Puerto Rico—are eliminated because of difficulties in defining appropriate cost indexes for the claims they process. In addition, all supplier specialties are eliminated because they are unaffected by the payment changes here.

Although only the services listed in Appendix A will be affected by the payment changes to be simulated here, all Medicare services provided by each practice must be retained in order to estimate behavioral responses appropriately. Entire physician practices may be eliminated, however, when they have no claims for the affected services. This means that radiologists and anesthesiologists may be eliminated, among others.

Three kinds of adjustments to this data base are made. First, prevailing charges are added to all records. Second, the data are adjusted to reflect projected participation rates and assignment rates. Finally, prevailing charges, submitted charges, and allowed charges are adjusted to reflect values as projected for 1990. Each of these adjustments is explained in detail below.

Imputing prevailing charges.—The controlling prevailing charge during 1987 is added to each record. This can be completed in the sequence described below, but in each stage the process is constrained so that the imputed prevailing charge is greater than or equal to the allowed charge. Further, adjustment is made for the 4 percent prevailing charge differential that existed in 1987 between participating and nonparticipating physicians. For example, if an imputed prevailing charge for a nonparticipating practice is obtained from a participating practice, the value imputed is 96 percent of the value obtained from the participating practice. Finally, for assistants at surgery (type of service 8), the prevailing charge is set at 20 percent of the prevailing charge for surgery (type of service 2), separately by locality, specialty, service, and participating status.

First, the prevailing charge for each record is set to the allowed charge when the record's payment indicator shows that payment was set by the prevailing charge. Second, prevailing charge values for records still without a prevailing charge are imputed from other records for the same service, locality, and specialty. Where this fails, prevailing charge values are imputed from other records for the same service and locality, using the specialty most likely to provide the service. Where this fails, matching prevailing charge values from the prevailing charge file (BMAD II) applicable during calendar year 1987 are imputed. If none of these methods succeeds, the prevailing charge is set equal to the allowed charge.

Adjusting participation and assignment rates.—Practice participation rates are adjusted so that 60 percent of allowed charges are attributed to participating practices. To do this, records for practices with any pariticpating claims are altered so that all claims submitted by those practices are identified as participating. if this is insufficient to reach the target, then nonparticipating practices are randomly reassigned as participating practices until those practices categorized as participating account for 60 percent of allowed charges. This can be done by assigning a 7-digit random number to each nonparticipating practice and using that random number to reclassify practices as participating ones until the target is reached.

For all records reclassified as participating, the assignment indicator is changed appropriately. Also, the associated prevailing charge is increased by dividing the original prevailing charge by 0.96.

For the remaining nonparticipating practices, another random number is assigned to each record and used to adjust assignment rates until 50 percent of all allowed charges for nonparticipating practices are assigned and 50 percent are unassigned. Because nonparticipating practices will (after the adjustment in the previous paragraph) account for 40 percent of all allowed charges, this means that 20 percent of all allowed charges will be unassigned in the adjusted data base to this point. The assignment indicator is changed appropriately on all affected records.

Adjusting charges.—Appropriate adjustments to reflect projected 1990 charges differ for participating and nonparticipating practices, as redefined above.

For participating practices:

A. Prevailing charges are reduced for selected procedures (denoted hereinafter as OP codes) pursuant to Public Law 100-203 (OBRA-87, Section 4045). The affected procedures, and the national average prevailing charges used to calculate the reductions, are listed in Table 2 of Section 5254 of the Medicare Part B Carriers' Manual, Part 3, Claims Process. The appropriate reductions are calculated for each record using the formulas below, where MEAN denotes the national average prevailing charge for the service and PC87 and PC88 denote the prevailing charge for 1987 and 1988, respectively.

RATIO=Min (1.5, PC87/MEAN):
If PC87<.85*MEAN then PC88=PC87;
Else if PC87>.87*MEAN and if .98*PC87<=.85*MEAN then PC88=.85*MEAN;
Else PC88=.98*PC87*[1-(e/13)*(RATIO-0.85)].

Then, for these records only, PC87 is redefined as:

PC87=PC88/1.01;

so that OP records can be included with all other nonprimary services in the updates made in the following steps. This is necessary because OP services did not receive the 1 percent prevailing charge update for 1988.

B. The 1987 prevailing charges are updated to 1990 values by using the multiplicative product of the updates enacted for 1988 and 1989 in Public Law 100-203 (OBRA-87; Section 4042), and enacted in this bill (Section 4002) for 1990. For 1988 and 1989, the updates differ for primary care and all other services. Here, primary care services include HCPCS codes 90000-90080, 90100-901710, 90300-90370, 90400-90470, 90500-90570.

	Primary care	Other services
Update:		
1988	1.036	1.010
1989	1.030	1.010
1990	1.000	1.000
Total	1.067	1.020

C. The 1987 actual charges are increased to 1989 and 1990 values by using actual or projected values of the physician fee component of the Consumer Price Index, using the same values for primary care and other services:

	Primary care	Other services
Update:		
1988	1.072	
1989	1.073	
1990	1.074	
Total	1.235	

These are the values reported in the 1989 Trustees' Report for the Supplementary Medical Insurance fund. If different values are used to compute Medicare premiums for 1990 in the 1989 promul-

gation notice, those actual charge update factors will be used instead.

D. Allowed charges for 1990 are calculated for each record as the minimum of the updated prevailing charge or the customary charge (defined as the updated actual charge for 1989).

For nonparticipating practices:

E. All 1987 prevailing charges on these records are first divided by 0.96, and then step A above is replicated.

F. The new 1987 prevailing charges are multiplied by 0.95, to adjust for the 1 percent increase in the nonparticipating differential between 1987 and 1990. Then step B above is replicated to increase these adjusted prevailing charges to 1990 values.

G. Actual charges are increased to 1989 and 1990 values by using actual or projected values of the physician fee component of the Consumer Price Index as given in step C above, subject to ceilings shown below by year. The net effect of maximum allowable actual charge ceilings and OP ceilings are shown below as MAAC amounts which are service and practice specific. These ceilings were enacted in Public Law 99-509 (OBRA-86, Section 9331(b)) and in Public Law 100-203 (OBRA-87, Section 4045).

MAAC87=Mean actual charge for this service by this practice in 1987.

If MAAC87 < 1.15*PCV88 then
MAAC88=Max(MAAC87+0.33*(1.15*PC88-MAAC87), 1.01*MAAC87);
Else MAAC88=1.01*MAAC87;
If HCPCS=OP code then MAAC88=Min(MAAC88, 1.25*PC88+0.5*(Max(0,MAAC87-1.25*PC88)));
If MAAC88 < 1.15*PC89 then
MAAC89=Max(MAAC88+0.5*(1.15*PC89-MAAC88), 1.01*MAAC88);
Else MAAC89=1.01*MAAC88;
If HCPCS=OP code then MAAC89=Min(MAAC89, 1.25*PC89);
If MAAC89 If < 1.15*PCV90 then
MAAC90=Max(1.15*PC90, 1.01*MAAC89);
Else MAAC90=1.01*MAAC89;
If HCPCS=OP code then MAAC90=Min(MAAC90, 1.25*PC90);

H. Allowed charges for 1990 for each record are the minimum of the updated prevailing charge, the customary charge (defined as the updated actual charge for 1989), or the actual charge for 1990.

II. FIRST ORDER (PRE-BEHAVIOR) CONVERSION FACTOR

This section specifies how to calculate the first-order conversion factor described under Section 4001 of the bill. The formulas here are an algebraic representation of the fee schedule specified in Section 4001.

The initial (pre-behavior) budget neutral conversion factor (CF1) for the reference fee schedule can be obtained algebraically from the adjusted BMAD III data as follows:

CF1=sum of 1990 allowed amounts for all affected services under prior payment policies (that is, in the absence of imple-

mentation of Section 4001, but including the MEI freeze specified in Section 4002), divided by the sum over all affected services of (RV(i,k)*GPCI(j)* service frequency).

RV(i,k) denotes the relative value of service i by specialty k, which is equal to the sum of the physician work component and the practice expense component (W(i)+E(i,k)), as specified in Appendix A.

GPCI(j) denotes the geographic practice cost index for locality j, which is equal to the weighted sum of cost indexes for physician work (WGPCI) and for practice expense (EGPCI), as specified in Appendix C. That is, GPCI(j) may be written as:

(WGPCI(j)*W(i)/RV(i,k))+(EGPCI(j)*E(i,k)/RV(i,k)).

Hence, the first-order reference fee schedule amount for each affected service i and locality j may be written as:

RFS1(i,j,k)=RV(i,k)*CF1*GPCI(j);

or=RV(i,k)*[CF1*(WGPCI(j)*W(i)/RV(i,k))+

CF1*(EGPCI(j)*E(i,k)/RV(i,k))].

This is equivalent to the following, which is a more convenient formulation for obtaining the conversion factor:

RFS1(i,j,k)=CF1*[W(i)*WGPCI(j)+E(i,k)*EGPCI(j)].

III. SECOND-ORDER (POST-BEHAVIOR) CONVERSION FACTOR

This section explains how to make the second-order adjustment called for in Section 4001(a)(5) to achieve budget neutrality for 1990.

The final (post-behavior) budget neutral conversion factor (CF2) is equal to:

CF2=ADJ*CF1,

so that the final reference fee schedule amounts will be:

RFS2(i,j,k)=ADJ*CF1*[W(i)*WGPCI(j)+E(i,k)*EGPCI(j)].

In the expression for RFS2, ADJ is a volume adjustment factor obtained by iterative simulations from the BMAD III data, as described below.

For 1990, the bill specifies that payment rates are to be set by the usual customary, prevailing, and reasonable criteria, but that prevailing rates for the affected services are to be adjusted as follows:

New PC90=PC90+.2*(RFS2−PC90).

In this formula, RFS2 is set at whatever level necessary (via the value set for ADJ) to achieve new Medicare payment amounts for all services (not only affected services) that equal, in the aggregate, what payments would have been had the prior prevailing charge (PC90) been used instead.

Medicare payment rates under both prior prevailing charges and those set in this bill are the smallest of the customary, actual, and prevailing charges for each service. Because the bill continues current limits on actual charges—which are defined relative to prevailing charges—both actual and prevailing charges might change relative to prior law.

Aggregate payments made by Medicare will change for two reasons—changes in payment rates for affected services, and changes in the volume of all services induced by the payment rate changes. The adjustment factor (ADJ) is set so that changes due to new pay-

ment rates are just offset by changes due to volume responses, in the aggregate.

In the simulation model, the value of ADJ (initialized to a value of 1) is reduced if estimated new aggregate payments exceed prior law payments, and ADJ is increased if estimated new aggregate payments are below prior law payments. This is an iterative process repeated until equality is achieved.

More precisely, the simulation model must specify that for each service i in the locality j, physicians' allowed amounts (A) and Medicare receipts (R) under prior law are:

A(i,j)=Min(customary, prevailing, actual) charges;
and, if the claim is assigned: R(i,j)=A(i,j);
else: R(i,j)=S(i,j);
where S(i,j) denotes the actual (submitted) charge.

New pre-behavior allowed amounts (new A(i,j)) and receipts (new R(i,j)) under the bill are calculated analogously, but new prevailing and new actual charges must be used for the calculation where appropriate (that is, for affected services).

Post-behavior values for allowed amounts and receipts are obtained as follows. First, sum up prior law (A0, R0) and pre-behavior new law (A1, R1) allowed amounts and receipts for all services, separately for each practice in the data set. Then calculate post-behavior new law allowed amounts and receipts (A2, R2) for each practice as follows:

R2=R1−X*(R1-R0); and
A2=A1−X*(R1-R0)*A0/R0.

For 1991 and later years, X=0.375 if (R1-R0) is greater than or equal to zero; X=0.555 if (R1-R0) is less than zero. However, for 1990 these values for X are divided by 2, to account for the delayed implementation date of these payment changes and for the likelihood that behavioral responses to payment changes lag behind implementation of the changes.

The effect of this information is partially to offset the first-order impact of the payment change, both for gaining and losing practices. The behavioral parameters used in this formulation were obtained by regression analysis of Medicare claims for physicians' services in Colorado, subsequent to an abrupt and substantial realignment of prevailing charges in the late 1970s ("Volume Responses to Exogenous Changes in Medicare's Payment Rates," Technical Memorandum, August 1988, U.S. Congressional Budget Office.)

Initially, ADJ is set equal to 1; the resulting values for A0 and for A2 are summed over all practices. If the sum of A2 is greater than the sum of A0, then the value of ADJ is reduced until the sums are equal for A2 and A0. Conversely, if the initial sum of A2 is less than the sum of A0, the value of ADJ is increased until the sums are equal.

Appendix C. Geographic Practice Cost Indexes

State	Carrier	Locality	Name	PE index [1]	PW index [2]
Alabama	00510	01	Northeast AL	0.864	0.971
Alabama	00510	02	North Central AL	0.862	0.940
Alabama	00510	03	Southeast AL	0.863	0.945
Alabama	00510	04	Southwest AL	0.900	0.928
Alabama	00510	05	Montgomery, AL	0.903	0.962
Alabama	00510	06	Rural AL	0.848	0.949
Alaska	01020	01	Alaska	1.229	1.213
Arizona	01030	01	Phoenix (city), AZ	1.045	1.006
Arizona	01030	02	Tucson (city), AZ	1.022	0.974
Arizona	01030	05	Flagstaff (city), AZ	0.953	0.966
Arizona	01030	07	Prescott (city), AZ	0.953	0.966
Arizona	01030	08	Yuma (city), AZ	0.953	0.966
Arizona	01030	99	Rural Arizona	0.981	0.974
Arkansas	00520	13	Arkansas	0.789	0.921
California	00542	01	N. Coastal Cntys, CA	1.109	1.006
California	00542	02	NE Rural CA	1.037	1.002
California	00542	03	Marin/Napa/Solano, CA	1.219	1.024
California	00542	04	Sacramento/Surr. Cntys, CA	1.123	1.052
California	00542	05	San Francisco, CA	1.311	1.075
California	00542	06	San Mateo, CA	1.311	1.075
California	00542	07	Oakland-Berkeley, CA	1.272	1.057
California	00542	08	Stockton/Surr. Cntys, CA	1.070	1.037
California	00542	09	Santa Clara, CA	1.297	1.096
California	00542	10	Merced/Surr. Cntys, CA	1.053	1.035
California	00542	11	Fresno/Madera, CA	1.054	1.012
California	00542	12	Monterey/Santa Cruz, CA	1.140	1.046
California	00542	13	Kings/Tulare, CA	1.046	0.997
California	00542	14	Bakersfield, CA	1.089	1.056
California	00542	15	San Bernadino/E. Central CA	1.114	1.051
California	00542	27	Riverside, CA	1.116	1.053
California	02050	16	Santa Barbara, CA	1.110	1.024
California	02050	17	Ventura, CA	1.161	1.067
California	02050	18	Los Angeles, CA (1st of 8)	1.218	1.119
California	02050	19	Los Angeles, CA (2nd of 8)	1.218	1.119
California	02050	20	Los Angeles, CA (3rd of 8)	1.218	1.119
California	02050	21	Los Angeles, CA (4th of 8)	1.218	1.119
California	02050	22	Los Angeles, CA (5th of 8)	1.218	1.119
California	02050	23	Los Angeles, CA (6th of 8)	1.218	1.119
California	02050	24	Los Angeles, CA (7th of 8)	1.218	1.119
California	02050	25	Los Angeles, CA (8th of 8)	1.218	1.119
California	02050	26	Anaheim-Santa Ana, CA	1.239	1.092
California	02050	28	San Diego/Imperial, CA	1.125	1.052
Colorado	00550	01	Colorado	0.951	0.998
Connecticut	03070	01	NW and N. Central Conn	1.066	1.004
Connecticut	03070	02	SW Connecticut	1.151	1.106
Connecticut	03070	03	South Central Conn.	1.113	1.037
Connecticut	03070	04	Eastern Conn.	1.054	0.998
Delaware	00570	01	Delaware	0.975	1.051
District of Columbia	00580	01	D.C. + MD/VA Suburbs	1.138	1.118
Florida	00590	01	Rural Florida	0.900	0.931
Florida	00590	02	N/NC Florida Cities	0.954	0.951
Florida	00590	03	Fort Lauderdale, FL	1.030	0.986
Florida	00590	04	Miami, FL	1.100	1.068
Georgia	13110	01	Atlanta, GA	0.990	0.951
Georgia	13110	02	Small GA cities 02	0.878	0.923
Georgia	13110	03	Small GA cities 03	0.851	0.922
Georgia	13110	04	Rural Georgia	0.830	0.911
Hawaii	01120	01	Hawaii	1.086	1.006
Idaho	05130	11	South Idaho	0.930	0.934
Idaho	05130	12	North Idaho	0.913	0.929
Illinois	00621	01	Northwest, IL	0.926	0.948
Illinois	00621	02	Rockford, IL	1.059	1.019

State	Carrier	Locality	Name	PE index [1]	PW index [2]
Illinois	00621	03	De Kalb, IL	0.951	0.957
Illinois	00621	04	Rock Island, IL	0.943	0.990
Illinois	00621	05	Peoria, IL	1.044	1.019
Illinois	00621	06	Kankakee, IL	0.951	0.944
Illinois	00621	07	Quincy, IL	0.926	0.948
Illinois	00621	08	Normal, IL	0.989	0.993
Illinois	00621	09	Springfield, IL	0.987	0.992
Illinois	00621	10	Champaign-Urbana, IL	0.947	0.929
Illinois	00621	11	Decatur, IL	0.953	0.962
Illinois	00621	12	East St. Louis, IL	1.008	0.978
Illinois	00621	13	Southeast IL	0.926	0.948
Illinois	00621	14	Southern IL	0.926	0.948
Illinois	00621	15	Suburban Chicago, IL	1.132	1.041
Illinois	00621	16	Chicago, IL	1.195	1.087
Indiana	00630	01	Metropolitan Indiana	0.913	0.996
Indiana	00630	02	Urban Indiana	0.859	0.960
Indiana	00630	03	Rural Indiana	0.851	0.959
Iowa	00640	01	SE Iowa (escl. Iowa City)	0.897	0.956
Iowa	00640	02	Northeast Iowa	0.887	0.943
Iowa	00640	03	North Central Iowa	0.886	0.942
Iowa	00640	04	S. Cen. IA (excl Des Moines)	0.855	0.924
Iowa	00640	05	Des Moines (Polk/Warren), IA	0.929	0.994
Iowa	00640	06	Northwest Iowa	0.862	0.938
Iowa	00640	07	Southwest Iowa	0.865	0.935
Iowa	00640	08	Iowa City (City limits)	0.931	0.920
Kansas	00650	01	Rural Kansas	0.879	0.907
Kansas	00740	04	Suburban Kansas City, KA	0.990	0.956
Kansas	00740	05	Kansas City, KA	0.990	0.956
Kentucky	00660	01	Lexington & Louisville, KY	0.886	0.968
Kentucky	00660	02	Sm. Cities (city limits) KY	0.875	0.952
Kentucky	00660	03	Rural Kentucky	0.851	0.949
Louisiana	00528	01	New Orleans, LA	1.025	0.988
Louisiana	00528	02	Shreveport, LA	0.924	1.005
Louisiana	00528	03	Baton Rouge, LA	0.947	0.982
Louisiana	00528	04	Lake Charles, LA	0.895	0.949
Louisiana	00528	05	Monroe, LA	0.871	0.959
Louisiana	00528	06	Lafayette, LA	0.913	0.963
Louisiana	00528	07	Alexandria, LA	0.879	0.971
Louisiana	00528	50	Rural Louisiana	0.877	0.943
Maine	21200	01	Northern Maine	0.889	0.894
Maine	21200	02	Central Maine	0.880	0.885
Maine	21200	03	Southern Maine	0.948	0.912
Maryland	00690	01	Baltimore/Surr. Cntys, MD	1.032	1.055
Maryland	00690	02	Western Maryland	0.996	1.012
Maryland	00690	03	South + E. Shore, MD	0.990	1.022
Massachusetts	00700	01	Massachusetts Urban	1.098	1.004
Massachusetts	00700	02	Mass. Suburbs/Rural (cities)	1.046	0.993
Michigan	00710	01	Detroit, MI	1.170	1.117
Michigan	00710	02	Michigan, not Detroit	1.006	1.019
Minnesota	00720	02	Northern Minnesota	0.898	0.966
Minnesota	00720	04	Southern Minnesota	0.883	0.958
Minnesota	10240	01	St. Paul-Minneapolis, MN	.990	1.028
Mississippi	10250	01	Rural Mississippi	0.814	0.920
Mississippi	10250	02	Urban MS (city limits)	0.871	0.933
Missouri	00740	01	St. Joseph, MO	0.906	0.900
Missouri	00740	02	N. K.C. (Clay/Platte), MO	0.990	0.956
Missouri	00740	03	K.C. (Jackson County), MO	0.990	0.956
Missouri	00740	06	Rural NW Counties, MO	0.904	0.906
Missouri	11260	01	St. Louis/Lg. E. Cities, MO	1.015	0.976
Missouri	11260	02	Sm. E. Cities + Jeff. Cnty, MO	0.955	0.947
Missouri	11260	03	Rural (excl Rural NW) MO	0.889	0.901
Montana	00751	01	Montana	0.901	0.935
Nebraska	00645	15	Omaha + Lincoln, NE	0.869	0.942
Nebraska	00645	16	Ruban (Cnty Pop > 25000) NE	0.813	0.912
Nebraska	00645	17	Rural Nebraska	0.800	0.905

State	Carrier	Locality	Name	PE index [1]	PW index [2]
Nevada	01290	01	Las Vegas, et al (cities), NV	1.090	1.073
Nevada	01290	02	Reno, et al (cities), NV	1.142	1.016
Nevada	01290	03	Elko & Ely (cities), NV	1.041	0.969
Nevada	01290	99	Rural Nevada	1.087	1.039
New Hampshire	00780	40	New Hampshire	0.961	0.925
New Jersey	13310	01	Northern New Jersey	1.134	1.080
New Jersey	13310	02	Middle New Jersey	1.098	1.069
New Jersey	13310	03	Southern New Jersey	1.084	1.031
New Mexico	05320	05	New Mexico	0.906	0.962
New York	00801	01	Buffalo/Surr. Cntys, NY	0.945	1.011
New York	00801	02	Rochester/Surr. Cntys, NY	1.011	1.043
New York	00801	03	N. Central Cities, NY	0.953	0.993
New York	00801	04	Rural New York	0.939	0.976
New York	00803	01	Manhattan, NY	1.330	1.118
New York	00803	02	NYC Suburbs/Long I., NY	1.318	1.120
New York	00803	03	Poughkpsie/N. NYC Suburbs	1.043	1.007
New York	14330	04	Queens, NY	1.330	1.118
North Carolina	13340	94	Urban (City limits) NC	0.859	0.950
North Carolina	13340	95	Rural North Carolina	0.821	0.927
North Dakota	00820	01	North Dakota	0.870	0.930
Ohio	16360	01	Akron, OH	0.941	0.985
Ohio	16360	02	Cincinati, OH	0.952	0.978
Ohio	16360	03	Cleveland, OH	0.963	1.023
Ohio	16360	04	Columbus, OH	0.952	0.966
Ohio	16360	05	Dayton, OH	0.934	0.998
Ohio	16360	06	Northwest (Lima) OH	0.920	0.946
Ohio	16360	07	Mansfield, OH	0.908	0.943
Ohio	16360	08	Springfield, OH	0.938	1.008
Ohio	16360	09	E. Central (Steubenvl), OH	0.914	0.948
Ohio	16360	10	Toledo (Lucas/Wood), OH	0.987	0.982
Ohio	16360	11	Youngstown, OH	0.935	0.975
Ohio	16360	12	W. Centr (Lake Plains), OH	0.908	0.938
Ohio	16360	13	Marion + Surr. Cntys, OH	0.913	0.941
Ohio	16360	14	Scioto Valley, OH	0.935	0.955
Ohio	16360	15	Southeast (Ohio Valley) OH	0.902	0.946
Oklahoma	01370	01	OK City, et al (cities), OK	0.907	0.938
Oklahoma	01370	02	Tulsa, et al. (cities), OK	0.900	0.956
Oklahoma	01370	03	Sm. cities (Southern), OK	0.823	0.934
Oklahoma	01370	04	Sm. cities (Northern), OK	0.830	0.922
Oklahoma	01370	99	Rural Oklahoma	0.833	0.935
Oregon	01380	01	Portland, et al. (cities), OR	1.023	0.986
Oregon	01380	02	Eugene, et al. (cities), OR	1.002	0.937
Oregon	01380	03	Salem, et al. (cities), OR	0.986	0.948
Oregon	01380	12	SW Dr. Cities (city limits)	0.983	0.947
Oregon	01380	99	Rural Oregon	0.991	0.957
Pennsylvania	00865	01	Philly/Pitt Med Schs/Hosps	1.070	1.028
Pennsylvania	00865	02	Lg. Pennslyvania cities	1.045	1.015
Pennsylvania	0003865	03	Small Pennsylvania cities	0.942	0.967
Pennsylvania	00865	04	Rural Pennsylvania	0.934	0.952
Rhode Island	00870	01	Rhode Island	0.966	1.017
South Carolina	00880	01	South Carolina	0.823	0.941
South Dakota	00820	02	South Dakota	0.836	0.901
Tennessee	05440	35	Tennessee	0.836	0.939
Texas	00900	02	Northeast rural Texas	0.833	0.937
Texas	00900	03	Southeast Rural Texas	0.845	0.946
Texas	00900	04	Western Rural Texas	0.803	0.922
Texas	00900	06	Temple, TX	0.840	0.938
Texas	00900	078	San Antonio, TX	0.877	0.945
Texas	00900	08	Texarkana, TX	0.837	0.907
Texas	00900	09	Brazoria, TX	0.900	1.051
Texas	00900	10	Brownsville, TX	0.842	0.961
Texas	00900	11	Dallas, TX	0.914	0.992
Texas	00900	12	Denton, TX	0.914	0.992
Texas	00900	13	Odessa, TX	0.914	1.016
Texas	00900	14	El Paso, TX	0.847	0.989

State	Carrier	Locality	Name	PE index [1]	PW index [2]
Texas	00900	15	Galveston, TX	0.912	0.964
Texas	00900	16	Grayson, TX	0.854	0.928
Texas	00900	17	Longview, TX	0.878	0.935
Texas	00900	18	Houston, TX	0.942	1.028
Texas	00900	19	Mc Allen, TX	0.828	0.890
Texas	00900	20	Beaumont, TX	0.900	0.995
Texas	00900	21	Lubbock, TX	0.835	0.900
Texas	00900	22	Waco, TX	0.826	0.961
Texas	00900	23	Midland, TX	0.938	1.045
Texas	00900	24	Corpus Christi, TX	0.891	0.953
Texas	00900	25	Orange, TX	0.900	0.995
Texas	00900	26	Amarillo, TX	0.852	0.944
Texas	00900	27	Tyler, TX	0.879	0.969
Texas	00900	28	Fort Worth, TX	0.883	0.946
Texas	00900	29	Abilene, TX	0.833	0.941
Texas	00900	30	San Angelo, TX	0.854	0.908
Texas	00900	31	Austin, TX	0.911	0.937
Texas	00900	32	Victoria, TX	0.916	0.953
Texas	00900	33	Laredo, TX	0.813	0.935
Texas	00900	34	Wichita Falls, TX	0.849	0.938
Utah	00910	09	Utah	0.926	0.985
Vermont	00780	50	Vermont	0.891	0.885
Virginia	10490	01	Richmond+Charlottesvl, VA	0.893	0.950
Virginia	10490	02	Tidewater+N. VA counties	0.959	0.977
Virginia	10490	03	Sm. Town/Industrial VA	0.849	0.941
Virginia	10490	04	Rural Virginia	0.843	0.933
Washington	00930	01	W+SE WA (excl Seattle)	1.001	1.016
Washington	00930	02	Seattle (King Cnty), WA	1.051	1.038
Washington	00930	03	Spokane+Richlnd (cities), WA	1.006	0.993
Washington	00930	04	E. Cen+NE WA (excl Spokane)	0.989	0.981
West Virginia	16510	16	Charleston, WV	0.929	0.974
West Virginia	0016510	17	Wheeling, WV	0.880	0.949
West Virginia	0016510	18	Eastern Valley, WV	0.861	0.923
West Virginia	0016510	19	Ohio River Valley, WV	0.858	0.925
West Virginia	0016510	20	Southern Valley, WV	0.853	0.919
Wisconsin	00951	04	Milwaukee, WI	0.964	1.015
Wisconsin	00951	12	Northwest Wisconsin	0.868	0.939
Wisconsin	00951	13	Central Wisconsin	0.857	0.921
Wisconsin	00951	14	Southwest Wisconsin	0.857	0.921
Wisconsin	00951	15	Madison, WI (Dane County)	0.937	0.955
Wisconsin	00951	19	La Crosse, WI (W-Central)	0.889	0.948
Wisconsin	00951	36	Wausau, WI (N-Central)	0.866	0.941
Wisconsin	00951	40	Green Bay, WI (Northeast)	0.879	0.958
Wisconsin	00951	46	Milwaukee Suburbs, WI (SE)	0.962	1.019
Wisconsin	00951	54	Janesville, WI (S-Central)	0.872	0.940
Wisconsin	00951	60	Oshkosh, WI (E-Central)	0.878	0.948
Wyoming	05530	21	Wyoming	0.902	0.975

PE INDEX = Practice Expense Component Index.
PW INDEX = Physician Work Component Index.

Subtitle F—Nuclear Regulatory Commission User Fees

The Committee on Energy and Commerce, having considered the Committee Print of July 17, 1989 entitled "Proposed Budget Reconciliation Provisions of the Committee on Energy and Commerce Relating to Nuclear Regulatory Commission User Fees" (proposed Sections 4501 and 4502 of the House budget reconciliation bill), reports favorably thereon, without amendment, and recommends that it be referred to the Committee on the Budget pursuant to section 310 of the Congressional Budget Act of 1974.

DISSENTING VIEWS ON THE RELATIVE VALUE SCALE SYSTEM TO THE BUDGET RECONCILIATION LEGISLATION FOR FY90 (TITLE IV, SUBTITLE A)

We are compelled to register our strong opposition to the Medicare fee schedule based on the Resource Based Relative Value Scale system (RBRVS), reported by the Committee on Energy and Commerce on July 13, 1989 as part of the budget reconciliation legislation for fiscal year 1990. While we agree that changes are needed within the current reasonable charge methodology for paying physicians, we are of the opinion that we need to evaluate the serious repercussions the RBRVS fee schedule may create for certain doctors and patients.

It is our belief that there may be a rush to implement the proposed fee schedule without examining the effects it may have on the health care delivery system. The recommendations of the Physician Payment Review Commission emphasizes the continuing need for additional studies and refinements on the RBRVS fee schedule. In fact, the Commission's report specifically states that there are several areas where the methodology must be improved. According to the report, even data used to study specialties must be reanalyzed and, in some cases, individual specialties must be restudied with the improved methodology.

For this reason, we must argue for a delay in adopting the new fee schedule so that methodologies for determining Medicare reimbursement to physicians for a particular service can be evaluated appropriately. It appears that eight of the eighteen medical specialties reviewed in the Hsiao study may be reanalyzed.

In addition, we are particularly concerned about the effects the RBRVS fee schedule will have on patients and physicians from specific geographic regions of the country such as Florida, California, and Texas. According to the Health Care Financing Administration, this proposal will create reductions in Medicare reimbursement of well over 30% for some physicians in these states. These reductions, in our view, could drastically affect services to both Medicare and non-Medicare patients. It is possible that all patients would bear the burden of the reductions in several ways, including less incentives for physicians to accept Medicare patients and higher medical bills for non-Medicare patients.

Finally, Congress must decide if the RBRVS fee schedule would actually lead to improvements in the Medicare program. It is our fear that a new fee schedule is just as likely to create difficulties in the Medicare reimbursement process as the current system. It is important to realize that a new reimbursement system will have

inconsistencies and inadequacies that will need to be resolved. Therefore, we must proceed with great caution when implementing a new Medicare reimbursement fee schedule so the adverse impacts of this proposal will be minimized.

MICHAEL BILIRAKIS.
JACK FIELDS.
BILL DANNEMEYER.

DISSENTING VIEWS OF MEDICAID BUDGET RECONCILIATION AMENDMENTS (TITLE IV, SUBTITLE C)

We are compelled to register our strong opposition to the Medicaid Budget Reconciliation Amendments of 1989, reported by the Committee on Energy and Commerce on July 13, 1989. The five Medicaid provisions will greatly increase Federal spending in the Medicaid program, and accomplishes this by means of a Reconciliation bill which is supposed to be a budget-cutting vehicle. Under the Concurrent Resolution on the Budget for FY 1990 (H. Con. Res. 106), $200 million of new budget entitlement authority (NEA) is available for fiscal year 1990 Medicaid spending. And, by slipping effective dates on some of the pending provisions so that only one calendar quarter's worth of spending occurs in fiscal year 1990, the provisions will technically meet the budget target. But in the outyears, these Medicaid provisions will cost additional billions of dollars. The Administration estimates that, taken together, these Medicaid measures will increase Federal spending in the Medicaid program by approximately $8.6 billion over a five-year period.

We also think this legislation must be considered in the context of the Gramm-Rudman-Hollings Law. The Administration is the official scorekeeper, and to the extent that the legislation matches the Health Care Financing Administration (HCFA) estimates, the Fiscal Year 1991 budget deficit will be increased by $1.2 billion. This is at a time when the Gramm-Rudman-Hollings' deficit target is set at $64 billion.

Irrespective of the various merits of these Medicaid provisions, the spending levels that these measures will produce violate any sense of restraint on increases in the Federal budget. And we must also not forget the Medicaid expansions that Congress has already enacted in the last few years as part of the Medicare Catastrophic Coverage Act, the Family Support Act, OBRA–87, and the Tax Technicals of 1988 which will have a major impact on Federal spending in fiscal year 1990. In FY 1990 alone these four laws will increase Federal Medicaid expenditures by over $1 billion and the five-year costs will exceed $11 billion.

Another major concern we have in the attempt to rationally analyze these Medicaid provisions is the vast difference between the cost estimates of these measures by the Congressional Budget Office (CBO) and the Health Care Financing Administration (HCFA). The Congressional Budget Office estimates the federal costs of these Medicaid provisions at approximately $4.1 billion over five years. Preliminary estimates from HCFA are five-year costs of $8.6 billion. The fact that these estimates by CBO and HCFA *differ by $4.5 billion over a five-year period* makes it extremely difficult to evaluate the true fiscal impact of these provisions. Though forecasting is not an exact science, a difference of this magnitude is truly disturbing.

In the recent past when we were considering the drug benefit under the Catastrophic Coverage Act in the Medicare program, there was a similar dispute between HCFA and CBO about the projected costs of a benefit. When the Catastrophic legislation was being considered, HCFA actuaries estimated that the cost of the drug benefit would be 2 to 3 times the cost estimated by CBO. Now, CBO has re-examined its estimates on the basis of the latest availble data and has concluded that the HCFA projections were essentially accurate. CBO has now substantially raised its estimates of outlays for both benefits and administrative costs to a total of $11.8 billion for the 1990–1993 period. This figure of $11.8 billion is more than twice CBO's estimate of $5.7 billion of one year ago.

We must also be aware that the Federal costs of these Medicaid provisions, while great, are only half of the story. The States face equally large expenditures if these measures are enacted. There is also a fundamental equity issue among the States that arises in the Medicaid program with respect to these provisions. The more prosperous States are able to adopt Medicaid optional services because they have richer State treasuries. Because these States already offer a generous package of social services, expanding Medicaid options often allow these States to refinance such services. In terms of their programs and treasuries, these Medicaid options would make the rich States even richer. On the other hand, the Medicaid mandates tend to affect States experiencing tight budgets due to economic downturns. Richer States have already adopted these measures when they were first made optional in the past. Thus, these mandates have no effect on the richer States but cause others increased difficulty. The poorer States will be forced to choose among competing priorities when they finance these new mandates. The point is that these continuing cycles of options which later become mandates only serve to make the rich States richer and the poor States poorer.

A final concern is the provision in the legislation that directs the Physician Payment Review Commission to review Medicaid rates for physician services. This is an unnecessary intrusion of Federal oversight into an area that has been within the States' purview for many years. This would entail a dramatic expansion of the Physician Payment Review Commission's power and resources. The effect of this expansion of power would literally make the Commission a "junior" Health Care Financing Administration in the area of Medicaid policy.

Norman F. Lent.
Edward R. Madigan.
Carlos J. Moorhead.
William E. Dannemeyer.
Don Ritter.
Thomas J. Bliley, Jr.
Jack Fields.
Michael G. Oxley.
Howard C. Nielson.
Michael Bilirakis.
Joe Barton.
Sonny Callahan.
Alex McMillan.

ADDITIONAL DISSENTING VIEWS ON THE HEALTH BUDGET RECONCILIATION AMENDMENTS (TITLE IV, SUBTITLE D)

I concur entirely with the dissenting views regarding the Medicaid provisions of the budget reconciliation package. These expansions are proving to be a tyranny over the United States and are certainly unjustifiable in light of the Fiscal Year 1990 budget resolution and ongoing budget constraints. Beyond the immediate fiscal impact, however, there are long-term losses for many of the individuals Medicaid is intended to serve, particularly women and children.

It is clear from the hearings held in the Subcommittee on Health and other committees, as well as the National Commission to Prevent Infant Mortality, that poor health outcomes for infants and children result from many circumstances. Most of them are not cured by the provisions contained in these amendments. Rather, the amendments continue and expand a system that has already failed many women and children.

If we are truly committed to improving maternal and child health, we must reevaluate our methods or providing services. Above all, we must have the courage to loosen the bureaucratic reins, thereby demonstrating confidence in each State's concern for the well-being of its citizens and its ability to meet their needs in the most efficient and responsible manner.

During Committee consideration of the health-related provisions of the budget reconciliation package, I offered an amendment which would have consolidated all pregnancy-related services to women and preventive services to children, including nutrition, so that they could be offered in integrated setttings. While the amendment was not adopted during the Committee meeting, I hope that, at the very least, it marked the start of a new look at health care for low-income families in our country.

THOMAS J. BLILEY, Jr.

ADDITIONAL VIEWS ON ENERGY AND COMMERCE BUDGET RECONCILIATION (TITLE IV, SUBTITLE H) THE HONORABLE HOWARD C. NIELSON

As a member who has cosponsored both Fairness Doctrine legislation and Dial-Porn legislation I must object to the fact that the Committee has addressed these issues in the Energy and Commerce budget reconciliation bill. I still firmly support Dial-Porn and Fairness Doctrine Legislation, however, it is clear that these issues should be addressed in separate individual bills and should not have been attached to budget reconciliation. Appropriate procedure requires that budget and money bills be considered separately from policy bills. Members of the Committee should have the opportunity to address these issues on their own merits rather than by including them with a reconciliation package.

HOWARD C. NIELSON.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black blackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * * * *

TITLE V—MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT

AUTHORIZATION OF APPROPRIATIONS

SEC. 501 [(a) For the purpose of enabling each State—

[(1) to assure mothers and children (in particular those with low income or with limited availability of health services) access to quality maternal and child health services,

[(2) to reduce infant mortality and the incidence of preventable diseases and handicapping conditions among children, to reduce the need for inpatient and long-term care services, to increase the number of children (especially preschool children) appropriately immunized against disease and the number of low income children receiving health assessments and follow-up diagnostic and treatment services, and otherwise to promote the health of mothers and children (especially by providing preventive and primary care services for low income children, and prenatal, delivery, and postpartum care for low income mothers),

[(3) to provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under title XVI of this Act, and

[(4) to provide services for locating, and for medical, surgical, corrective, and other services, and care for, and facilities for diagnosis, hospitalization, and aftercare for, children who are "children with special health care needs" or who are suffering from conditions leading to such status;

and for the purpose of enabling the Secretary to provide for special projects of regional and national significance, research, and training with respect to maternal and child health and children with special health care needs, for genetic disease testing, counseling, and information development and dissemination programs, and for grants relating to hemophilia (without regard to age), there are authorized to be appropriated $553,000,000 for fiscal year 1987, $557,000,000 for fiscal year 1988, and $561,000,000 for fiscal year 1989 and each fiscal year thereafter.]

(a) To improve the health of all mothers and children consistent with the applicable health status goals and national health objectives established by the Secretary under the Public Health Service Act for the year 2000, there are authorized to be appropriated $661,000,000 for fiscal year 1990 and each fiscal year thereafter—

(1) for the purpose of enabling each State—

(A) to provide and to assure mothers and children (in particular those with low income or with limited availability of health services) access to quality maternal and child health services;

(B) to reduce infant mortality and the incidence of preventable diseases and handicapping conditions among children, to reduce the need for inpatient and long-term care services, to increase the number of children (especially preschool children) appropriately immunized against disease and the number of low income children receiving health assessments and follow-up diagnostic and treatment services, and otherwise to promote the health of mothers and infants by providing prenatal, delivery, and postpartum care for low income, at-risk pregnant women, and to promote the health of children by providing preventive and primary care services for low income children;

(C) to provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under title XVI, to the extent medical assistance for such services is not provided under title XIX; and

(D) to provide and to promote family-centered, community-based, coordinated care (including care coordination services, as defined in subsection (b)(3)) for children with special health care needs and to facilitate the development of community-based systems of services for such children and their families;

(2) for the purpose of enabling the Secretary (through grants, contracts, or otherwise) to provide for special projects of regional and national significance, research, and training with respect to maternal and child health and children with special health care needs (including early invervention training and

services development), for genetic disease testing, counseling, and information development dissemination programs, and for grants relating to hemophilia (without regard to age) and including funding for comprehensive hemophilia diagnostic and treatment centers; and

(3) for the purpose of enabling the Secretary (through grants, contracts, or otherwise) to provide for developing and expanding each of the following—

(A)(i) maternal and infant health home visiting programs in which case management services (as defined in subparagraphs (B) and (C) of subsection (b)(3)), health education services, and related social support services are provided in the home to pregnant women or families with an infant up to age one by an appropriate health professional or by a qualified non-professional acting under the supervision of a health care professional,

(ii) integrated maternal and child health service delivery systems (of the type described in section 1136 and using, once developed, the model application form developed under section 4306 of the Omnibus Budget Reconciliation Act of 1989),

(iii) maternal and child health centers which (I) provide prenatal, delivery, and postpartum care for pregnant women and preventive and primary care services for infants up to age one and (II) operate under the direction of a not-for-profit hospital, and

(iv) projects designed to increase the participation of obstetricians and pediatricians under the program under this title and under State plans approved under title XIX; and

(B)(i) projects for the screening of newborns for sickle cell anemia and other genetic disorders and follow-up services, and

(ii) maternal and child health projects to serve rural populations.

(b) For purposes of this title:

(1) * * *

* * * * * * *

(3) The term "care coordination services" means services to promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families.

(4) The term "case management services" means—

(A) with respect to pregnant women, services to assure access to quality prenatal, delivery, and postpartum care; and

(B) with respect to infants up to age 1, services to assure access to quality preventive and primary care services.

ALLOTMENTS TO STATES AND FEDERAL SET-ASIDE

SEC. 502. (a)(1) [Of the amounts appropriated under section 501(a) for a fiscal year that are not in excess of $478,000,000, the Secretary shall retain an amount equal to 15 percent thereof in the case of fiscal year 1982, and an amount equal to not less than 10,

nor more than 15, percent thereof in the case of each fiscal year thereafter, for the purpose of carrying out (through grants, contracts, or otherwise) special projects of regional and national significance, training, and research and for the funding of genetic disease testing, counseling, and information development and dissemination programs and of comprehensive hemophilia diagnostic and treatment centers.] *Of the amounts appropriated under section 501(a) for a fiscal year, the Secretary shall retain an amount equal to 15 percent for the purpose of carrying out activities described in section 501(a)(2).* The authority of the Secretary to enter into any contracts under this title is effective for any fiscal year only to such extent or in such amounts as are provided in appropriations Acts.

* * * * * * *

(3) No funds may be made available by the Secretary under this subsection *or subsection (b)* unless an application therefor has been submitted to, and approved by, the Secretary. Such application shall be in such form, be submitted in such manner, and contain and be accompanied by such information as the Secretary may specify. No such application may be approved unless it contains assurances that the applicant will use the funds provided only for the purposes specified in the approved application and will establish such fiscal control and fund accounting procedures as may be necessary to assure proper disbursement and accounting of Federal funds paid to the applicant under this title.

(b)(1) Of the amounts appropriated under section 501(a) for a fiscal year, the Secretary shall retain an amount equal to 12¾ percent, of which ⅔ shall be retained for the purpose of carrying out activities described in section 501(a)(3)(A) and ⅓ shall be retained for the purpose of carrying out activities described in section 501(a)(3)(B).

(2)(A) Of the amounts retained for the purpose of carrying out activities described in section 501(a)(3)(A), the Secretary shall provide preference to qualified applicants which demonstrate that the activities to be carried out with such amounts shall be in areas with a high infant mortality rate (relative to the average infant mortality rate in the United States or in the State in which the area is located).

(B) In carrying out activities described in section 501(a)(3)(A)(iii), the Secretary shall not provide for developing or expanding a maternal and child health center unless the Secretary has received satisfactory assurances that there will be applied, towards the costs of such development or expansion, non-Federal funds in an amount at least equal to the amount of funds provided under this title toward such development or expansion.

(3) Of the amounts retained for the purpose of carrying out activities described in section 501(a)(3)(B)—

(A) not less than 25 percent shall be retained to carry out projects described in clause (i) of such section, and

(B) not less than 25 percent shall be retained to carry out projects described in clause (ii) of such section.

[(c)(1) Of the amounts appropriated for a fiscal year in excess of $478,000,000, an amount equal to 7 percent for fiscal year 1987, 8

percent for fiscal year 1988, and 9 percent for fiscal year 1989 shall be retained by the Secretary for the purpose of carrying out (through grants, contracts, or otherwise) projects for the screening of newborns for sickle-cell anemia and other genetic disorders. The provisions of paragraph (3) of subsection (a) shall apply to projects authorized by this paragraph to the same extent as such provisions apply to projects authorized under such subsection.

[(2)(A) Of the amounts appropriated for a fiscal year in excess of $478,000,000 that remain after the Secretary has retained the applicable amount (if any) for such fiscal year under paragraph (1), an amount equal to 33⅓ percent shall be retained and allotted in the same manner as the amounts retained and allotted under subsections (a) and (b).

[(B) The amounts retained by the Secretary under this paragraph shall be used for the purpose of carrying out (through grants, contracts, or otherwise) special projects of regional or national significance, training, and research to promote access to primary health services for children and community-based service networks and case management services for children with special health care needs.

[(C) The amounts allotted to the States under this paragraph shall be used to develop primary health services demonstration programs and projects for children and to promote the development of community-based service networks and case management services for children with special health care needs.

[(D) For purposes of this paragraph—

[(i) the term "primary health services" includes—

[(I) any assessment, diagnosis, or treatment service provided on an outpatient basis that is designed to promote the health, to prevent the development of disease or disability, or to treat an illness or other health condition, of a child, and

[(II) any service designed to promote the access of children to high quality, continuous, and comprehensive primary health services, including case management;

[(ii) the term "community-based service network for children with special health care needs" means a network of coordinated, high-quality services that is located in or near the home communities of children with special health care needs in order to improve the health status, functioning, and well-being of such children;

[(iii) the term "case management services" means services to promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children and their families; and

[(iv) the term "comprehensive services" includes early identification and intervention services, diagnostic and evaluation services, treatment services, rehabilitation services, family support services, and special education services.

[(3) Of the amounts appropriated for a fiscal year in excess of $478,000,000 that remain after the Secretary has retained the applicable amount (if any) for such fiscal year under paragraph (1), an amount equal to 66⅔ percent shall be retained and allotted in

the same manner and for the same purposes as the amounts retained and allotted under subsections (a) and (b).]

[(b)](c) From the remaining amounts appropriated under section 501(a) for any fiscal year [that are not in excess of $478,000,000], the Secretary shall allot to each State which has transmitted [a description of intended activities and statement of assurances] an application for the fiscal year under section [505,] *505(a),* an amount determined as follows:

(1) The Secretary shall determine, for each State—

(A)(i) the amount provided or allotted by the Secretary to the State and to entities in the State under the provisions of the consolidated health programs (as defined in section 501(b)(1)), other than for any of the projects or programs described in subsection (a), from appropriations for fiscal year 1981,

(ii) the proportion that such amount for that State bears to the total of such amounts for all the States, and

(B)(i) The number of low income children in the State, and

(ii) the proportion that such number of children for that State bears to the total of such numbers of children for all the States.

[(2)(A) For each of fiscal years 1982 and 1983, each such State shall be allotted for that fiscal year an amount equal to the State's proportion (determined under paragraph (1)(A)(ii)) of the amounts available for allotment to all the States under this subsection for that fiscal year.

[(B) For fiscal years beginning with fiscal year 1984, if the amount available for allotment under this subsection for that fiscal year—

[(i) does not exceed the amount available under this subsection for allotment for fiscal year 1983, each such State shall be allotted for that fiscal year an amount equal to the State's proportion (determined under paragraph (1)(A)(ii)) of the amounts available for allotment to all the States under this subsection for that fiscal year, or

[(ii) exceeds the amounts available under this subsection for allotment for fiscal year 1983, each such State shall be allotted for that fiscal year an amount equal to the sum of—

[(I) the amount of the allotment to the State under this subsection in fiscal year 1983 (without regard to paragraph (3) of this subsection), and

[(II) the State's proportion (determined under paragraph (1)(B)(ii)) of the amount by which the allotment available under this subsection for all the States for that fiscal year exceeds the amount that was available under this subsection for allotment for all the States for fiscal year 1983.]

(2) Each such State shall be allotted for each fiscal year an amount equal to the sum of—

(A) the amount of the allotment to the State under this subsection in fiscal year 1983, and

(B) the State's proportion (determined under paragraph (1)(B)(ii)) of the amount by which the allotment available

under this subsection for all the States for that fiscal year exceeds the amount that was available under this subsection for allotment for all the States for fiscal year 1983.

(d)(1) To the extent that all the funds appropriated under this title for a fiscal year are not otherwise allotted to States either because all the States have not qualified for such allotments under section [505] *505(a)* for the fiscal year or because some States have indicated in their descriptions of activities under section [505] *505(a)* that they do not intend to use the full amount of such allotments, such excess shall be allotted among the remaining States in proportion to the amount otherwise allotted to such States for the fiscal year without regard to this paragraph.

* * * * * * *

PAYMENTS TO STATES

SEC. 503. (a) From the sums appropriated therefor and the allotments available under section [502(b)] *502(c),* the Secretary shall make payments as provided by section 6503(a) of title 31, United States Code to each State provided such an allotment under section [502(b)] *502(c),* for each quarter, of an amount equal to four-sevenths of the total of the sums expended by the State during such quarter in carrying out the provisions of this title.

* * * * * * *

(c) The Secretary, at the request of a State, may reduce the amount of payments under subsection (a) by—

(1) the fair market value of any supplies or equipment furnished the State, and

(2) the amount of pay, allowances, and travel expenses of any officer or employee of the Government when detailed to the State and the amount of any other costs incurred in connection with the detail of such officer or employee,

when the furnishing of supplies or equipment or the detail of an officer or employee is for the convenience of and at the request of the State and for the purpose of conducting activities described in section [505] *505(a)* on a temporary basis. The amount by which any payment is so reduced shall be available for payment by the Secretary of the costs incurred in furnishing the supplies or equipment or in detailing the personnel, on which the reduction of the payment is based, and the amount shall be deemed to be part of the payment and shall be deemed to have been paid to the State.

USE OF ALLOTMENT FUNDS

SEC. 504. (a) Except as otherwise provided under this section, a State may use amounts paid to it under section 503 for the provision of health services and related activities (including planning, administration, education, and evaluation *and including payment of salaries and other related expenses of National Health Service Corps personnel)* consistent with [its description of intended expenditures and statement of assurances *its application* transmitted under section 505.] *505(a).*

* * * * * * *

(d) Of the amounts paid to a State under section 503 from an allotment for a fiscal year under section 502(c), not more than 10 percent may be used for administering the funds paid under such section.

[DESCRIPTION OF INTENDED EXPENDITURES AND STATEMENT OF ASSURANCES] *APPLICATION FOR BLOCK GRANT FUNDS*

SEC. 505. *(a)* In order to be entitled to payments for allotments under section 502 for a fiscal year, a State must prepare and transmit to the Secretary an application (in a standardized form specified by the Secretary) that—

(1) except as provided under subsection (b), provides that the State will use—

(A) at least 30 percent of the amounts paid to it under section 503 for preventive and primary care services for pregnant women, mothers, and infants up to age one, including prenatal, delivery, and postpartum care,

(B) at least 30 percent of such payment amounts for preventive and primary care services for children, and

(C) at least 30 percent of such payment amounts for services for children with special health care needs (as specified in section 501(a)(1)(D));

[(1) a report describing] *(2) provides a description of* the intended use of payments the State is to receive under this title for the fiscal year, including (A) a description of those populations, areas, and localities in the State which the State has identified as needing maternal and child health services, (B) *subject to paragraph (1),* a statement of goals and objectives for meeting those needs *(consistent with the health status goals and national health objectives referred to in section 501(a)),* (C) information on the types of services to be provided and the categories or characteristics of individuals to be served, and (D) [data the State intends to collect respecting activities conducted with such payments] *information the State will collect in order to prepare the reports required under section 506(a); and*

[(2) a statement of assurances that represents to the Secretary] *(3) provides* that—

(A) the State will [provide] *establish* a fair method (as determined by the State) for allocating funds allotted to the State under this title among such individuals, areas, and localities identified under paragraph (1)(A) as needing maternal and child health services, and the State will identify and apply guidelines for the appropriate frequency and content of, and appropriate referral and followup with respect to, health care assessments and services financially assisted by the State under this title and methods for assuring quality assessments and services;

* * * * * * *

[(C) the State will use—

[(i) a substantial proportion of the sums expended by the State for carrying out this title for the provision of health services to mothers and children, with special consideration given (where appropriate) to the

continuation of the funding of special projects in the State previously funded under this title (as in effect before the date of the enactment of the Maternal and Child Health Services Block Grant Act), and

[(ii) a reasonable proportion (based upon the State's previous use of funds under this title) of such sums to carry out the purposes described in paragraphs (1) through (3) of section 501(a);]

(C) special consideration will be given (where appropriate) to the continuation of the funding of special projects in the State previously funded under this title (as in effect before August 31, 1981);

(D) if any charges are imposed for the provision of health services assisted by the State under this title, such charges (i) will be pursuant to a public schedule of charges, (ii) will not be imposed with respect to services provided to low income mothers or children, and (iii) will be adjusted to reflect the income, resources, and family size of the individual provided the services; [and]

(E) the State agency (or agencies) administering the State's program under this title will [participate]—

(i) *participate* in the coordination of activities between such program and the early and periodic screening, [diagnosis] *diagnostic,* and treatment program under [title XIX,] *section 1095(a)(4)(B) (including the establishment of periodicity and content standards for early and periodic screening, diagnostic, and treatment services),* to ensure that such programs are carried out without duplication of effort,

(ii) *participate* in the arrangement and carrying out of coordination agreements described in section 1902(a)(11) (relating to coordination of care and services available under this title and title XIX, [and]

(iii) *participate* in the coordination of activities within the State with programs carried out under this title and related Federal grant programs (including supplemental food programs for mothers, infants, and children, related education programs, and other health, developmental disability, and family planning programs[.] *, and*

(iv) provide, directly and through their providers and institutional contractors, for services to identify pregnant women and infants who are eligible for medical assistance under subparagraph (A) or (B) of section 1902(l)(1) and, once identified, to assist them in applying for such assistance; and

(F) each health care provider or practitioner providing health care services under this title has entered into an ageeement, with the single State agency under section 1902(a)5), to provide services under the State plan under title XIX to individuals entitled to medical assistance for such services under the plan.

[The description and statement shall be made public within the State in such manner as to facilitate comment from any person (in-

cluding any Federal or other public agency) during development of the description and statement and after its transmittal. The description and statement shall be revised (consistent with this section) throughout the year as may be necessary to reflect substantial changes in any element of such description or statement, and any revision shall be subject to the requirements of the preceding sentence.] *The application shall be developed by, or in consultation with, the State maternal and child health agency and shall be made public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during its development and after its transmittal.*

(b) The Secretary may waive the requirement under subsection (a)(1) that a State's application for a fiscal year provide for the use of funds for specific activities if for that fiscal year—

(1) the Secretary determines—

(A) on the basis of information provided in the State's most recent annual report submitted under section 506(a)(1), that the State has demonstrated an extraordinary unmet need for one of the activities described in subsection (a)(1), and

(B) that the granting of the waiver is justified and will assist in carrying out the purposes of this title; and

(2) the State provides assurances to the Secretary that the State will provide for the use of some amounts paid to it under section 503 for each of the activities described in subparagraphs (A), (B), and (C) of subsection (a)(1) and specifies the percentages to be substituted in each of such subparagraphs.

REPORTS AND AUDITS

SEC. 506. (a)(1) Each State shall prepare and submit to the Secretary annual reports on its activities under this title. *Each such report shall be prepared by, or in consultation with, the State maternal and child health agency.* In order properly to evaluate and to compare the performance of different States assisted under this title and to assure the proper expenditure of funds under this title, such reports shall [be in such form and contain such information] *be in such standardized form and contain such information (including information described in paragraph (2))* as the Secretary determines (after consultation with the States and the Comptroller General) to be necessary (A) to secure an accurate description of those activies, (B) to secure a complete record of the purposes for which funds were spent, of the recipients of such funds, [and of the progress made toward achieving the purposes of this title, and (C)], *(C) to describe the extent to which the State has met the goals and objectives it set forth under section 505(a)(1)(B) and the national health objectives referred to in section 501(a), and (D)* to determine the extent to which funds were expended consistent with the State's [description and statement] *application* transmitted under section [505] *505(a).* Copies of the report shall be provided, upon request, to any interested public agency, and each such agency may provide its views on these reports to the Congress.

(2) Each annual report under paragraph (1) shall include the following information:

(a)(i) The number of individuals served by the State under this title (by class of individuals).

(ii) The proportion of each class of such individuals which has health coverage.

(iii) The types (as defined by the Secretary) of services provided under this title to individuals within each such class.

(iv) The amounts spent under this title on each type of services, by class of individuals served.

(B) Information on the status of maternal and child health in the State, including—

(i) information (by county and by racial and ethnic group) on—

(I) the rate of infant mortality, and

(II) the rate of low-birth-weight births;

(ii) information (on a State-wide basis) on—

(I) the rate of maternal mortality,

(II) the rate of neonatal death,

(III) the rate of perinatal death,

(IV) the proportion of infants born with fetal alcohol syndrome,

(V) the proportion of infants born with drug dependency,

(VI) the proportion of women who deliver who do not receive prenatal care during the first trimester of pregnancy, and

(VII) the proportion of children, who at their second birthday, have been vaccinated against each of measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, Hib meningitis, and hepatitis B; and

(iii) information on such other indicators of maternal, infant, and child health care status as the Secretary may specify.

(C) Information (by racial and ethnic group) on——

(i) the number of deliveries in the State in the year, and

(ii) the number of such deliveries to pregnant women who were provided prenatal, delivery, or postpartum care under this title or were entitled to benefits with respect to such deliveries under the State plan under title XIX in the year.

(D) Information (by racial and ethnic group) on——

(i) the number of infants under one year of age who were in the State in the year, and

(ii) the number of such infants who were provided services under this title or were entitled to benefits under the State plan under title XIX at any time during the year.

(E) Information on the number of——

(i) obstetricians,

(ii) family practitioners,

(iii) certified family nurse practitioners,

(iv) certified nurse midwives,

(v) pediatricians, and

(vi) certified pediatric nurse practitioners, who were licensed in the State in the year.

For purposes of subparagraph (A), each of the following shall be considered to be a separate class of individuals: pregnant women,

infants up to age 1, children with special health care needs, other children under age 22, and other individuals.

[(2) The Secretary shall annually report to the Congress on activities funded under section 502(a) and shall provide for transmittal of a copy of such report to each State.] *(3) The Secretary shall annually transmit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report that includes——*

(A) a description of each project receiving funding under paragraph (2) or (3) of section 502(a), including the amount of Federal funds provided, the number of individuals served or trained, as appropriate, under the project, and a summary of any formal evaluation conducted with respect to the project;

(B) a summary of the information described in paragraph (2)(A) reported by States;

(C) based on information described in paragraph (2)(B) supplied by the States under paragraph (1), a compilation of the following measures of maternal and child health in the United States and in each State:

(i) Information on——

(I) the rate of infant mortality, and

(II) the rate of low-birth-weight births.

Information under this clause shall also be compiled by racial and ethnic group.

(ii) Information on——

(I) the rate of maternal mortality, and

(II) the rate of neonatal death,

(III) the rate of perinatal death,

(IV) the proportion of infants born with fetal alcohol syndrome,

(V) the proportion of infants born with drug dependency,

(VI) the proportion of women who deliver who do not receive prenatal care during the first trimester of pregnancy, and

(VII) the proportion of children, who at their second birthday, have been vaccinated against each of measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, Hib meningitis, and hepatitis B.

(iii) Information on such other indicators of maternal, infant, and child health care status as the Secretary has specified under paragraph (2)(B)(iii).

(iv) Information on (by racial and ethnic group)—

(I) the number of such deliveries in the State in the year, and

(II) the number of such deliveries to pregnant women who were provided prenatal, delivery, or postpartum care under this title or were entitled to benefits with respect to such deliveries under the State plan under title XIX in the year;

(D) based on information described in subparagraphs (C), (D), and (E) of paragraph (2) supplied by the States under paragraph (1), a compilation of the following information in the United States and in each State:

(i) Information on—

(I) the number of deliveries in the year, and

(II) the number of such deliveries to pregnant women who were provided prenatal, delivery, or postpartum care under this title or were entitled to benefits with respect to such deliveries under a State plan under title XIX in the year.

Information under this clause shall also be compiled by racial and ethnic group.

(ii) Information on—

(I) the number of infants under one year of age in the year, and

(II) the number of such infants who were provided services under this title or were entitled to benefits under a State plan under title XIX at any time during the year.

Information under this clause shall also be compiled by racial and ethnic group.

(iii) Information on the number of—

(I) obstetricians,

(II) family practitioners,

(III) certified family nurse practitioners,

(IV) certified nurse midwives,

(V) pediatricians, and

(VI) certified pediatric nurse practitioners,

who were licensed in a State in the year; and

(E) an assessment of the progress being made to meet the health status goals and national health objectives referred to in section 501(a).

* * * * * * *

NONDISCRIMINATION

SEC. 508. (a) * * *

(b) Whenever the Secretary finds that a State, or an entity that has received a payment from an allotment to a State under section [502(b),] *502(c),* has failed to comply with a provision of law referred to in subsection (a)(1), with subsection (a)(2), or with an applicable regulation (including one prescribed to carry out subsection (a)(2)), he shall notify the chief executive officer of the State and shall request him to secure compliance. If within a reasonable period of time, not to exceed sixty days, the chief executive officer fails or refuses to secure compliance, the Secretary may—

(1) refer the matter to the Attorney General with a recommendation that an appropriate civil action be instituted,

(2) exercise the powers and functions provided by title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, or section 504 of the Rehabilitation Act of 1973, as may be applicable, or

(3) take such other action as may be provided by law.

* * * * * * *

ADMINISTRATION OF TITLE AND STATE PROGRAMS

SEC. 509. (a) The Secretary shall designate an identifiable administrative unit with expertise in maternal and child health within the Department of Health and Human Services, which unit shall be responsible for—

(1) * * *

* * * * * * *

(4) providing technical assistance, upon request, to the States in such areas as program planning, establishment of goals and objectives, standards of care, and evaluation *and in developing consistent and accurate data collection mechanisms in order to report the information required under section 506(a)(2);*

* * * * * * *

(6) assisting in the preparation of reports to the Congress on the activities funded and accomplishments achieved under this title from the information required to be reported by the States under sections [505] *505(a)* and 506.

* * * * * * *

TITLE VII—ADMINISTRATION

* * * * * * *

OFFICE OF RURAL HEALTH POLICY

SEC. 711. (a) There shall be established in the Department of Health and Human Services (in this section referred to as the "Department") an Office of Rural Health Policy (in this section referred to as the "Office"). The Office shall be headed [by a Director, who shall advise the Secretary] *by a Deputy Under Secretary for Rural Health, who shall report directly to the Secretary and the Under Secretary of Health and Human Services* on the effects of current policies and proposed statutory, regulatory, administrative, and budgetary changes in the programs established under titles XVIII and XIX on the financial viability of small rural hospitals, the ability of rural areas (and rural hospitals in particular) to attract and retain physicians and other health professionals, and access to (and the quality of) health care in rural areas. *The Office shall not serve as a component of any other office, service, or component of the Department of Health and Human Services.*

(b) In addition to advising the Secretary with respect to the matters specified in subsection (a), [the Director] *the Deputy Under Secretary for Rural Health,* through the Office shall—

(1) oversee compliance with the requirements of section 1102(b) of this Act and section 4403 of the Omnibus Budget Reconciliation Act of 1987 (as such section pertains to rural health issues),

(2) establish and maintain a clearinghouse for collecting and disseminating information on—

(A) rural [health care issues] *health care issues, including rural mental health, rural infant mortality prevention,*

and rural occupantional safety and preventive health promotion,

(B) research findings relating to rural health care, and

(C) innovative approaches to the delivery of health care in [rural areas] *rural areas, including programs providing community-based mental health services, pre-natal and infant care services, and rural occupational safety and preventive health education and promotion,*

(3) coordinate the activities within the Department that relate to rural health care, and

(4) provide information to the Secretary and others in the Department with respect to the activities, of other Federal departments and agencies, that relate to [rural health care] *rural health care, including activities relating to rural mental health, rural infant mortality, and rural occupational safety and preventive health promotion.*

* * * * * * *

TITLE XI—GENERAL PROVISIONS AND PEER REVIEW

Part A—General Provisions

* * * * * * *

ADMINISTRATIVE LAW JUDGES FOR HEALTH-RELATED CASES

SEC. 1123. Insofar as this title, title XVIII, or title XIX provides for a hearing before an administrative law judge relating to a matter under title XVIII, title XIX, part B of this title, or a provision of this part relating to such titles or part, notwithstanding any other provision of law, such a hearing shall be held before such a judge appointed by the Secretary exclusively for hearings relating to such matters.

* * * * * * *

EXCLUSION OF CERTAIN INDIVIDUALS AND ENTITIES FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS

SEC. 1128. (a) * * *

(b) PERMISSIVE EXCLUSION.—The Secretary may exclude the following individuals and entities from participation in any program under title XVIII and may direct that the following individuals and entities be excluded from participation in any State health care program:

(1) * * *

* * * * * * *

(4) LICENSE REVOCATION OR SUSPENSION.—Any individual or entity—

(A) whose license to provide health care has been revoked or suspended by any State licensing authority, or who otherwise lost such a license *or the right to apply for or renew such a license,* for reasons bearing on the individ-

ual's or entity's professional competence, professional performance, or financial integrity, or

* * * * * * *

(12) FAILURE TO GRANT IMMEDIATE ACCESS.—Any individual or entity that fails to grant immediate access, upon reasonable request (as defined by the Secretary in regulations) to any of the following:

(A) * * *

(B) To the Secretary or the State agency, to perform the reviews and surveys required under State plans under paragraphs [(26), (31), and (33)] *(26) and (33)* of section 1902(a) and under section 1903(g).

* * * * * * *

CIVIL MONETARY PENALTIES

SEC. 1128A. (a) * * *

(b)(1) If a hospital [, an eligible organization with a risk-sharing contract under section 1876, or an entity with a contract under section 1903(m)] knowingly makes a payment, directly or indirectly, to a physician as an inducement to reduce or limit services provided with respect to individuals who—

(A) are entitled to benefits under part A or part B of title XVIII or to medical assistance under a State plan approved under title XIX, *and*

[(B) in the case of an eligible organization or an entity, are enrolled with the organization or entity, and]

[(C)] *(B)* are under the direct care of the physician,

the hospital [or organization] shall be subject, in addition to any other penalities that may be prescribed by law, to a civil money penalty of not more than $2,000 for each such individual with respect to whom the payment is made.

* * * * * * *

CRIMINAL PENALTIES FOR ACTS INVOLVING MEDICARE OR STATE HEALTH CARE PROGRAMS

SEC. 1128B. (a) * * *

(b)(1) * * *

(3) Paragraphs (1) and (2) shall not apply to—

(A) * * *

* * * * * * *

(C) any amount paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of individuals or entities who are furnishing services reimbursed under title XVIII or a State health care program if—

(i) the person has a written contract, with each such individual or entity, which specifies the amount to be paid the person, which amount may be a fixed amount or a fixed percentage of the value of the purchases made by each such individual or entity under the contract, and

((ii) in the case of an entity that is a provider of services (as defined in section 1861(u)), the person discloses (in such

form and manner as the Secretary requires) to the entity and, upon request, to the Secretary the amount received from each such vendor with respect to purchases made by or on behalf of the entity; [and]

(D) a waiver of any coinsurance under part B of title XVIII by a Federally qualified health care center with respect to an individual who qualifies for subsidized services under a provision of the Public Health Service Act; and

[(D)] *(E)* any payment practice specified by the Secretary in regulations promulgated pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution, facility or entity in order that such institution, facility, or entity may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, nursing facility, [intermediate care facility for the mentally retarded], *habilitation facility,* home health agency, or other entity (including an eligible organization under section 1876(b)) for which certification is required under title XVIII or a State health care program shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(d) Whoever knowingly and willfully—

(1) * * *

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under title XIX, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)—

(A) as a precondition of admitting a patient to a hospital, nursing facility, or [intermediate care facility for the mentally retarded], *habilitation facility,* or

* * * * * * *

RESEARCH ON OUTCOMES OF HEALTH CARE SERVICES AND PROCEDURES

SEC. 1142. (a) ESTABLISHMENT OF PROGRAM.—

(1) IN GENERAL.—The Secretary, acting through the Administrator for Health Care Research and Policy, shall conduct and support research with respect to the outcomes of health care services and procedures in order to identify the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be diagnosed and treated.

(2) EVALUATIONS OF ALTERNATIVE SERVICES AND PROCEDURES.—In carrying out paragraph (1), the Administrator shall conduct or support evaluations of the comparative effects, on health and functional capacity, of alternative services and procedures utilized in diagnosing and treating diseases, disorders, and other health conditions.

(b) PRIORITY WITH RESPECT TO CERTAIN HEALTH CONDITIONS.—

(1) IN GENERAL.—The Administrator shall establish priorities with respect to hte diseases, disorders, and other health conditions for which evaluations are to be conducted under subsection (a). In establishing such priorities, the Administrator shall, with respect to a disease, disorder, or other health condition, consider the extent to which—

(A) improved methods of diagnosis and treatment can benefit a significant number of individuals;

(B) there is a significant variation among physicians in the particular services and procedures utilized in making diagnoses and providing treatments or there is significant variation in the outcomes of health care services or procedures due to different patterns of diagnosis or treatment;

(C) the services and procedures utilized for diagnosis and treatment result in relatively substantial expenditures; and

(D) the data necessary for such evaluations are readily available or can readily be developed.

(2) PRELIMINARY ASSESSMENTS.—For the purpose of establishing priorities under paragraph (1), the Administrator may, with respect to services and procedures utilized in diagnosing and treating diseases, disorders, and other health conditions, conduct or support assessments of the extent to which—

(A) rates of utilization vary among similar populations for particular diseases, disorders, and other health conditions;

(B) uncertainties exist on the effect of utilizing a particular service or procedure; or

(C) inappropriate services and procedures are provided.

(c) METHODOLOGIES AND CRITERIA FOR EVALUATIONS.—For the purpose of facilitating research under subsection (a), the Administrator shall conduct and support—

(1) research with respect to improvement of the methodologies and criteria utilized in conducting research with respect to outcomes of health care services and procedures; and

(2) evaluations of methodologies that utilize large data bases (including claims data and clinical data) in conducting research with respect to such outcomes.

(d) STANDARDS FOR RESEARCH INFORMATION.—In order to promote the research described in subsection (a), the Administrator shall, consistent with section 923(a) of the Public Health Service Act, develop and promote the use of uniform standards and formats in the collection and maintenance of information on the outcomes of health care services and procedures, including the effect on health and functional capacity resulting from such services and procedures.

(e) DISSEMINATION OF FINDINGS AND EDUCATION OF PROVIDERS.—The Administrator shall provide for the dissemination of the findings of research described in subsection (a) and for the education of providers in the application of such research.

(f) EVALUATIONS.—The Administrator shall conduct and support evaluations of the activities carried out under this section to determine the extent to which such activities have had an effect on the practices of physicians in providing medical treatment, the delivery of health care, and the outcomes of health care service and procedures.

(g) RESEARCH WITH RESPECT TO DISSEMINATION.—The Administrator may conduct or support research with respect to improving methods of disseminating information on the effectiveness and appropriateness information on the effectiveness and appropriateness of health care services and procedures.

(h) APPLICABILITY OF CERTAIN AGENCY AUTHORITIES.—Authorities and duties of the Administrator under part C of title IX of the Public Health Service Act, and under section 903 of such Act, shall apply with respect to activities carried out under this section to the same extent and in the same manner as such authorities and duties apply with respect to activities under such title IX.

(i) FUNDING.—

(1) AUTHORIZATION OF APPROPRIATIONS.—For carrying out this section, there are authorized to be appropriated $8,300,000 for fiscal year 1990, $12,500,000 for fiscal year 1991, and $16,700,000 for fiscal year 1992.

(2) TRANSFER OF CERTAIN FUNDS.—

(A) In addition to amounts made available under paragraph (1) for carrying out this section, there are authorized to be transferred for such purpose, from the trust fund specified in subparagraph (B), $16,700,000 for fiscal year 1990, $25,000,000 for fiscal year 1991, and $33,300,000 for fiscal year 1992.

(B) The fund referred to in subparagraph (A), known as the Federal Supplementary Medical Insurance Trust Fund, is the trust fund provided for in section 1841 of part B of title XVIII.

(j) DEFINITION.—For purposes of this section, the term "Administrator" means the Administrator for Health Care Research and Policy.

PART B—PEER REVIEW OF THE UTILIZATION AND QUALITY OF HEALTH CARE SERVICES

* * * * * * *

FUNCTIONS OF PEER REVIEW ORGANIZATIONS

SEC. 1154. (a) Any utilization and quality control peer review organization entering into a contract with the Secretary under this part must perform the following functions:

(1) * * *

* * * * * * *

(3)(A) Subject to [subparagraph (B)] *subparagraphs (B) and (D)* whenever the organization makes a determination that any health care services or items furnished or to be furnished to a patient by any practitioner or provider are disapproved, the organization shall promptly notify such patient and the agency or organization responsible for the payment of claims under title XVIII of this Act of such determination.

(B) The notification under subparagraph (A) *with respect to services or items denied for payment by reason of subparagraph (A) or (C) of paragraph (1)* shall not occur until 20 days after the date that the organization has—

(i) made a preliminary notification to such practitioner or provider of such proposed determination, and

(ii) provided such practitioner or provider an opportunity for discussion and review of the proposed determination.

(C) The discussion and review conducted under subparagraph (B)(ii) shall not affect the rights of a practitioner or provider to a formal reconsideration of a determination under this part (as provided under section 1155).

(D) The notification under subparagraph (A) with respect to services or items denied for payment by reason of paragraph (1)(B) shall not occur until after—

(i) the organization has notified the practitioner or provider involved of the determination and of the practitioner's or provider's right to a formal reconsideration of the determination under section 1155, and

(ii) if the provider or practitioner requests such a reconsideration, the organization has made such a reconsideration.

If a provider or practitioner is provided a reconsideration, such reconsideration shall be in lieu of any subsequent reconsideration to which the provider or practitioner may be otherwise entitled under section 1155, but shall not affect the right of a beneficiary from seeking reconsideration under such section of the organization's determination (after any reconsideration requested by the provider or physician under clause (ii)).

(E) In the case of services and items denied by reason of paragraph (1)(B), the notice to the patient shall state the following: "In the judgment of the peer review organization, the medical care received was not acceptable under the medicare program. The reasons for the denial have been discussed with your physician and hospital.

* * * * * * *

RIGHT TO HEARING AND JUDICIAL REVIEW

SEC. 1155. Any beneficiary who is entitled to benefits under title XVIII, and, *subject to section 1154(a)(3)(C),* any practitioner or provider, who is dissatisfied with a determination made by a contracting peer review organization in conducting its review responsibilities under this part, shall be entitled to a reconsideration of such determination by the reviewing organization. Where the reconsideration is adverse to the beneficiary and where the matter in controversy is $200 or more, such beneficiary shall be entitled to a hearing by the Secretary (to the same extent as is provided in section 205(b)), and, where the amount in controversy is $2,000 or more, to judicial review of the Secretary's final decision.

OBLIGATIONS OF HEALTH CARE PRACTITIONERS AND PROVIDERS OF HEALTH CARE SERVICES; SANCTIONS AND PENALTIES; HEARINGS AND REVIEW

SEC. 1156. (a) * * *

(b)(1) If after reasonable notice and opportunity for discussion with the practitioner or person concerned, *and after such practitioner or person has been given an adequate opportunity to pursue a*

recommended course of remedial education if appropriate any organization having a contract with the Secretary under this part determines that such practitioner or person has—

(A) failed in a substantial number of cases substantially to comply with any obligation imposed on him under subsection (a), or

(B) grossly and flagrantly violated any such obligation in one or more instances,

such organization shall submit a report and recommendations to the Secretary. If the Secretary agrees with such determination, and determines that such practitioner or person, in providing health care services over which such organization has review responsibility and for which payment (in whole or in part) may be made under this Act, has demonstrated an unwillingness or a lack of ability substantially to comply with such obligations, the Secretary (in addition to any other sanction provided under law) may exclude (permanently or for such period as the Secretary may prescribe) such practitioner or person from eligibility to provide services under this Act on a reimbursable basis. *In determining whether a practitioner or person has demonstrated an unwillingness or a lack of ability substantially to comply with such obligations, the Secretary shall take into account the practitioner's or person's refusal or willingness to pursue, or failure to comply with, an appropriate course of remedial education recommended by the peer review organization or the practitioner's or person's failure or willingness to take any other corrective action on the practitioner's or person's own initiative before or during the administrative appeal.* If the Secretary fails to act upon the recommendations submitted to him by such organization within 120 days after such submission, such practitioner or person shall be excluded from eligibility to provide services on a reimbursable basis until such time as the Secretary determines otherwise.

* * * * * * *

(3) In lieu of the sanction authorized by paragraph (1), the Secretary may require that (as a condition to the continued eligibility of such practitioner or person to provide such health care services on a reimbursable basis) such practitioner or person pays to the United States, in case such acts or conduct involved the provision or ordering by such practitioner or person of health care services which were medically improper or unnecessary, an amount not in excess of [the actual or estimated cost of the medically improper or unnecessary services so provided.] *$2,500.* Such amount may be deducted from any sums owing by the United States (or any instrumentality thereof) to the practitioner or person from whom such amount is claimed.

* * * * * * *

(5) Before the Secretary may effect an exclusion under paragraph (2) in the case of a provider or practitioner located in a rural health manpower shortage area (HMSA) or in a county with a population of less than [70,000] *140,000,* the provider or practitioner adversely affected by the determination is entitled to a hearing before an administrative law judge (described in section 205(b)) re-

specting whether the provider or practitioner should be able to continue furnishing services to individuals entitled to benefits under this Act, pending completion of the administrative review procedure under paragraph (4). If the judge does not determine, by a preponderance of the evidence, that the provider or practitioner will pose a serious risk to such individuals if permitted to continue furnishing such services, the Secretary shall not effect the exclusion under paragraph (2) until the provider or practitioner has been provided reasonable notice and opportunity for an administrative hearing thereon under paragraph (4).

* * * * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * * * *

NOTICE OF MEDICARE BENEFITS *AND DISTRIBUTION OF PREVENTIVE HEALTH INFORMATION*

SEC. 1804. *(a)* The Secretary shall prepare (in consultation with groups representing the elderly and with health insurers) and provide for distribution of a notice containing—

(1) a clear, simple explanation of the benefits available under this title and the major categories of health care for which benefits are not available under this title,

(2) the limitations on payment (including deductibles and coinsurance amounts) that are imposed under this title, and

(3) a description of the limited benefits for long-term care services available under this title and generally available under State plans approved under title XIX.

Such notice shall be mailed annually to individuals entitled to benefits under part A or part B of this title and when an individual applies for benefits under part A or enrolls under part B.

(b)(1) The Secretary shall develop (and, from time to time, shall revise) a summary of recommended preventive health care practices for elderly individuals entitled to benefits under this title. The summary shall indicate, for recommended preventive screening tests, for which tests payment may be made under this title.

(2) The Secretary also shall develop a 1-page form that may be used by elderly individuals to record information, such as a personal and family medical history, which may be useful to physicians in connection with furnishing appropriate health care.

(3) The summary and form shall be developed in consultation with national physician, consumer, and other health-related groups and shall be based on recommendations of an appropriate task force or similar group established by the Secretary.

(4) The Secretary shall provide for the distribution of—

(A) the summary developed under paragraph (1), and the form developed under paragraph (2), to each individual at the time of the individual's first becoming eligible for benefits under part A under section 226(a) or section 1818, as part of other materials sent to such an individual at such time, and

(B) the summary developed under paragraph (1) to individuals entitled to benefits under this title in conjunction with general mailings sent under this title to such individuals.

* * * * * * *

PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

* * * * * * *

SCOPE OF BENEFITS

SEC. 1832. (a) The benefits provided to an individual by the insurance program established by this part shall consist of—

(1) * * *

(2) entitlement to have payment made on his behalf (subject to the provisions of this part) for—

(A) * * *

* * * * * * *

(D)*(i)* rural health clinic services *and (ii) Federally qualified health center services;*

* * * * * * *

PAYMENT OF BENEFITS

SEC. 1833. (a) Except as provided in section 1876, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund or, as provided in section 1841A(c), from the Federal Catastrophic Drug Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

(1) in the case of services described in section 1832(a)(1)—80 percent of the reasonable charges for the services; except that (A) an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b), (B) with respect to items and services described in section 1861(s)(10)(A), the amounts paid shall be 100 percent of the reasonable charges for such items and services, (C) with respect to expenses incurred for those physicians' services for which payment may be made under this part that are described in section 1862(a)(4), the amounts paid shall be subject to such limitations as may be prescribed by regulations, (D) with respect to clinical diagnostic laboratory tests for which payment is made under this part (i) on the basis of a fee schedule under subsection (h)(1), the amount paid shall be equal to 80 percent (or 100 percent, in

the case of such tests for which payment is made on an assignment-related basis, or for tests furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion)) of the lesser of the amount determined under such fee schedule, the limitation amount for that test determined under subsection (h)(4)(B), or the amount of the charges billed for the tests, or (ii) on the basis of a negotiated rate established under subsection (h)(6), the amount paid shall be equal to 100 percent of such negotiated rate, (E) with respect to services furnished to individuals who have been determined to have end stage renal disease, the amounts paid shall be determined subject to the provisions of section 1881, (G) with respect to items and services (other than clinical diagnostic laboratory tests) furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion), the amounts paid shall be 100 percent of the reasonable charges for such items and services, (H) with respect to services of a certified registered nurse anesthetist under section 1861(s)(11), the amounts paid shall be 80 percent of the least of the actual charge, the prevailing charge that would be recognized *(or, for services furnished on or after January 1, 1992, the adjusted fee schedule amount or fee schedule amount specified in subsection (c)(1)(A)(ii) or (d)(1) of section 1848, as the case may be)* if the services had been performed by an anesthesiologist, or the fee schedule for such services established by the Secretary in accordance with subsection (l), (I) with respect to covered items (described in section 1834(a)(13)), the amounts paid shall be the amounts described in section 1834(a)(1), and (J) with respect to expenses incurred for radiologist services (as defined in section 1834(b)(6)) *or physician pathology services, subsect to section 1848,* the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount provided under the fee schedule established under section 1834(b) *or section 1834(f), respectively* (K) with respect to certified nurse-midwife services under section 1861(s)(2)(L), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph (but in no event shallsuch fee schedule exceed 65 percent of the prevailing charge that would be allowed for the same service performed by a physician, *or, for services furnished on or after January 1, 1992, 65 percent of the adjusted fee schedule amount or fee schedule amount specified in subsection (c)(1)(A)(ii) or (d)(1) of section 1848, as the case may be, for the same service performed by a physician),* (L) with respect to qualified psychologist services under section 1861(s)(2)(M), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph and (M) with respect to expenses incurred for

covered outpatient drugs, the amounts paid shall be the amounts determined under section 1834(c)(2);

* * * * * * *

(b) Before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of $75; except that (1) such total amount shall not include expenses incurred for items and services described in section 1861(s)(10)(A) or for covered outpatient drugs, (2) such deductible shall not apply with respect to home health services or with respect to covered outpatient drugs and home intravenous drug therapy services, (3) such deductible shall not apply with respect to clinical diagnostic laboratory tests for which payment is made under this part (A) under subsection (a)(1)(D)(i) or (a)(2)(D)(i) on an assignment-related basis, or to a provider having an agreement under section 1866, or (B) on the basis of a negotiated rate determined under subsection (h)(6), [and] (4) such deductible shall not apply with respect to items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion), *and (5) such deductible shall not apply to Federally qualified health center services.* The total amount of the expenses incurred by an individual as determined under the preceding sentence shall, after the reduction specified in such sentence, be further reduced by an amount equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during the calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence. The deductible under the previous sentence for blood or blood cells furnished an individual in a year shall be reduced to the extent that a deductible has been imposed under section 1813(a)(2) to blood or blood cells furnished the individual in the year.

* * * * * * *

(d)(1) Notwithstanding any other provision of this part, with respect to expenses incurred in any calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital at the time such expenses are incurred, there shall be considered as incurred

expenses for purposes of subsections (a) through (c) only [whichever of the following amounts is the smaller:

[(A) $1375.00, or

[(B) 62½ percent of such expenses.

For purposes of this paragraph, the term "treatment" does not include brief office visits (as defined by the Secretary) for the sole purpose of monitoring or changing drug prescriptions used in the treatment of such disorders or partial hospitalization services that are not directly provided by a physician.] *62½ percent of such expenses.*

* * * * * * *

(g) In the case of services described in the second sentence of section 1861(p), with respect to expenses incurred in any calendar year, no more than [$500] *$750* shall be considered as incurred expenses for purposes of subsections (a) through (c). In the case of outpatient occupational therapy services which are described in the second sentence of section 1861(p) through the operation of section 1861(g), with respect to expenses incurred in any calendar year, no more than [$500] *$750* shall be considered as incurred expenses for purposes of subsections (a) through (b).

(h)(1)(A) * * *

(B) In the case of clinical diagnostic laboratory tests performed by a physician or by a laboratory (other than tests performed by a qualified hospital laboratory (as defined in subparagraph (D)) for outpatients of such hospital), the fee schedules established under subparagraph (A) shall be established on a regional, statewide, or carrier service area basis (as the Secretary may determine to be appropriate) for tests furnished [during the period beginning on July 1, 1984, and ending of December 31, 1989. For such tests furnished on or after January 1, 1990, the fee schedule shall be established on a nationwide basis] *on or after July 1, 1984.*

(C) In the case of clinical diagnostic laboratory tests performed by a qualified hospital laboratory (as defined in subparagraph (D)) for outpatients of such hospital, the fee schedules established under subparagraph (A) shall be established on a regional, statewide, or carrier service area basis (as the Secretary may determine to be appropriate) for tests furnished [during the period beginning on July 1, 1984, and ending on December 31, 1989. For such tests furnished on or after January 1, 1990, the fee schedule shall be established on a nationwide basis] *on or after July 1, 1984.*

* * * * * * *

(4)(A) * * *

(B) For purposes of subsections (a)(1)(D)(i) and (a)(2)(D)(i), the limitation amount for a clinical diagnostic laboratory test performed—

(i) on or after July 1, 1986, and before April 1, 1988, is equal to 115 percent of the median of all the fee schedules established for that test for that laboratory setting under paragraph (1), [or]

(ii) after March 31, 1988, [and so long as a fee schedule for the test has not been established on a nationwide basis,] *and before January 1, 1990,* is equal to the median of all the fee

schedules established for that test for that laboratory setting under paragraph (1)[.], *and*

(iii) after December 31, 1989, is equal to 95 percent of the median of all the fee schedules established for that test for that laboratory setting under paragraph (1).

(5)(A) In the case of a bill or request for payment for a clinical diagnostic laboratory test for which payment may otherwise be made under this part on an assignment-related basis or under a provider agreement under section 1866, payment may be made only to the person or entity which performed or supervised the performance of such test; except that—

(i) if a physician performed or supervised the performance of such test, payment may be made to another physician with whom he shares his practice,

(ii) in the case of a test performed at the request of a laboratory by another laboratory, payment may be made to the [referring laboratory, and] *referring laboratory but only if—*

(I) the referring laboratory is located in, or is part of, a rural hospital, or

(II) not more than 30 percent of the clinical diagnostic laboratory tests for which such referring laboratory submits bills or requests for payment in any year are performed by another laboratory, and

* * * * * * *

(l)(1) * * *

(3)(A) * * *

(B) The Secretary shall also reduce the prevailing charge of physicians for medical direction of a certified registered nurse anesthetist, or the fee schedule for services of certified registered nurse anesthetists, or both, to the extent necessary to ensure that the estimated total amount which will be paid under this title plus applicable coinsurance for such medical direction and such services in 1989 [and 1990] will not exceed the estimated total amount which would have been paid plus applicable coinsurance but for the enactment of the amendments made by section 9320 of the Omnibus Budget Reconciliation Act of 1986. A reduced prevailing charge under this subparagraph shall become the prevailing charge but for subsequent years for purposes of applying the economic index under the fourth sentence of section 1842(b)(3).

(C)(i) In establishing fee schedules under this subsection for services furnished in 1990, subject to clause (ii), the Secretary shall establish a uniform national conversion factor which shall be $14 for services furnished under the medical direction of a physician and $21 for other services.

(ii) The conversion factor described in clause (i) as applied for any locality shall not exceed the conversion factor applied to anesthesiologists's services in the same locality, except that this clause shall not apply in the case of services furnished in a facility in which there is no physician furnishing anesthesia services.

* * * * * * *

SPECIAL PAYMENT RULES FOR PARTICULAR ITEMS AND SERVICES

SEC. 1834. (a) PAYMENT FOR DURABLE MEDICAL EQUIPMENT, PROSTHETIC DEVICES, ORTHOTICS, AND PROSTHETICS.—

(1) GENERAL RULE FOR PAYMENT.—

(A) * * *

* * * * * * * *

(D) REDUCTION IN FEE SCHEDULES FOR CERTAIN ITEMS.—With respect to a seat-lift chair, power-operated vehicle, or transcutaneous electrical nerve stimulator, the Secretary shall reduce the payment amount applied under subparagraph (B)(ii) for such an item by 15 percent.

(2) PAYMENT FOR INEXPENSIVE AND OTHER ROUTINELY PURCHASED DURABLE MEDICAL EQUIPMENT.—

(A) IN GENERAL.—Payment for an item of durable medical equipment (as defined in paragraph (13)(A))—

(i) the purchase price of which does not exceed $150, [or]

(ii) which the Secretary detemines is acquired at least 75 percent of the time by purchase, *or*

(iii) which is a power-driven wheelchair,

shall be made on a rental basis or in a lump-sum amount for the purchase of the item. The payment amount recognized for purchase or rental of such equipment is the amount specified in subparagraph (B) for purchase or rental, except that the total amount of payments with respect to an item may not exceed the payment amount specified in subparagraph (B) with respect to the purchase of the item.

* * * * * * * *

(8) PURCHASE PRICE RECOGNIZED FOR MISCELLANEOUS DEVICES AND ITEMS.—For purposes of paragraphs (6) and (7), the amount that is recognized under this paragraph as the purchase price for a covered item is the amount described in subparagraph (C) of this paragraph, determined as follows:

(A) COMPUTATION OF LOCAL PURCHASE PRICE.—Each carrier under section 1842 shall compute a base local purchase price for the item as follows:

(i) * * *

(ii) the carrier shall compute a local purchase price, with respect to the furnishing of each particular item—

(I) * * *

(II) in 1990[, 1991, or 1992] *or 1991,* equal to the local purchase price computed under this clause for the previous year increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year.

(B) COMPUTATION OF REGIONAL PURCHASE PRICE.—With respect to the furnishing of a particular item in each

region (as defined by the Secretary), the Secretary shall compute a regional purchase price—

(i) for [1991 and for 1992,] *1990 and for 1991,* equal to the average (weighted by relative volume of all claims among carriers) of the local purchase prices for the carriers in the region computed under subparagraph (A)(ii)(II) for the year, and

* * * * * * *

(C) PURCHASE PRICE RECOGNIZED.—For purposes of paragraphs (6) and (7) and subject to subparagraph (D), the amount that is recognized under this paragraph as the purchase price for each item furnished—

(i) in [1989 or 1990,] *1989* is 100 percent of the local purchase price computed under subparagraph (A)(ii)(I);

(ii) in [1991] *1990,* is the sum of (I) 75 percent of the local purchase price computed under subparagraph (A)(ii)(II) for [1991] *1990,* and (II) 25 percent of the regional purchase price computed under subparagraph (B) for [1991] *1990;*

(iii) in [1992] *1991,* is the sum of (I) 50 percent of the local purchase price computed under subparagraph (A)(ii)(II) for [1992] *1991,* and (II) 50 percent of the regional purchase price computed under subparagraph (B) for [1992] *1991;* and

(iv) [in 1993 or a subsequent year,] *in 1992 or a subsequent year,* is the regional purchase price computed under subparagraph (B) for that year.

(D) RANGE ON AMOUNT RECOGNIZED.—The amount that is recognized under subparagraph (C) as the purchase price for an item furnished—

(i) in [1991, may not exceed 130 percent, and may not be lower than 80 percent] *1990, may not exceed 125 percent, and may not be lower than 85 percent,* of the average of the purchase prices recognized under such subparagraph for all the carrier service areas in the United States in that year; and

(ii) in a subsequent year, may not exceed [125 percent, and may not be lower than 85 percent] *120 percent, and may not be lower than 90 percent,* of the average of the purchase prices recognized under such subparagraph for all the carrier service areas in the United States in that year.

(9) MONTHLY PAYMENT AMOUNT RECOGNIZED WITH RESPECT TO OXYGEN AND OXYGEN EQUIPMENT.—For purposes of paragraph (5), the amount that is recognized under this paragraph for payment for oxygen and oxygen equipment is the monthly payment amount described in subparagraph (C) of this paragraph. Such amount shall be computed separately (i) for all items of oxygen and oxygen equipment (other than portable oxygen equipment) and (ii) for portable oxygen equipment (each such group referred to in this paragraph as an "item").

(A) COMPUTATION OF LOCAL MONTHLY PAYMENT RATE.—Each carrier under this section shall compute a base local payment rate for each item as follows:

(i) * * *

(ii) The carrier shall compute a local average monthly payment rate for the item applicable—

(I) * * *

(II) to 1990[, 1991, and 1992, equal to] *or 1991, equal to* the local average monthly payment rate computed under this clause for the item for the previous year increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year.

(B) COMPUTATION OF REGIONAL MONTHLY PAYMENT RATE.—With respect to the furnishing of an item in each region (as defined by the Secretary), the Secretary shall compute a regional monthly payment rate—

(i) for [1991 and 1992,] *1990 and for 1991,* equal to the average (weighted by relative volume of all claims among carriers) of the local monthly payment rates for the carriers in the region computed under subparagraph (A)(ii)(II) for the year, and

* * * * * * *

(C) MONTHLY PAYMENT AMOUNT RECOGNIZED.—For purposes of paragraph (5), the amount that is recognized under this paragraph as the base monthly payment amount for each item furnished—

(i) in [1989 and in 1990,] *1989* is 100 percent of the local average monthly payment rate computed under subparagraph (A)(ii) for the item;

(ii) in [1991,] *1990,* is the sum of (I) 75 percent of the local average monthly payment rate computed under subparagraph (A)(ii)(II) for the item for [1991,] *1990,* and (II) 25 percent of the regional monthly payment rate computed under subparagraph (B)(i) for the item for [1991;] *1990;*

(iii) in [1992,] *1991,* is the sum of (I) 50 percent of the local average monthly payment rate computed under subparagraph (A)(ii)(II) for the item for [1992,] *1991,* and (II) 50 percent of the regional monthly payment rate computed under subparagraph (B)(i) for the item for [1992;] *1991;* and

(iv) [in a subsequent year,] *in 1992 or a subsequent year,* is the regional monthly payment rate computed under subparagraph (B) for the item for that year.

(D) RANGE ON AMOUNT RECOGNIZED.—The amount that is recognized under subparagraph (C) as the base monthly payment amount for an item furnished—

(i) in [1991, may not exceed 130 percent, and may not be lower than 80 percent] *1990, may not exceed 125 percent, and may not be lower than 85 percent,* of the average of the base monthly payment amounts

recognized under such subparagraph for all the carrier service areas in the United States in that year; and

(ii) in a subsequent year, may not exceed [125 percent and may not be lower than 85 percent] *120 percent, and may not be lower than 90 percent,* of the average of the base monthly payment amounts recognized under such subparagraph for all the carrier service areas in the United States in that year.

* * * * * * *

(13) COVERED ITEM.—In this subsection, the term "covered item" means—

(A) durable medical equipment (as defined in section 1861(n))[, including such equipment described in section 1861(m)(5)];

(B) prosthetic devices (described in section 1861(s)(8)), but not including parenteral and enteral nutrition nutrients [, supplies, and equipment] *and supplies;* and

(C) orthotics and prosthetics (described in section 1861(s)(9));

but does not include intraocular lenses *or items described in section 1861(m)(5);*

(b) FEE SCHEDULES FOR RADIOLOGIST SERVICES.—

(1) * * *

* * * * * * *

(3) CONSIDERATIONS.—In developing the relative value scale and fee schedules under paragraph (1), the Secretary—

(A) shall take into consideration variations in the cost of furnishing such services among geographic areas and among different sites where services are furnished, and

(B) may also take into consideration such other factors respecting the manner in which physicians in different specialties furnish such services as may be appropriate to assure that payment amounts are equitable and designed to promote effective and efficient provision of radiologist services by physicians in the different specialties.

In carrying out subparagraph (A) with respect to services furnished in 1990, the conversion factor applicable to a locality shall be the average of such conversion factor (as determined under the policies in effect on December 31, 1989) for the locality and the conversion factor that would result from establishing a national average conversion factor and adjusting such factor, in each locality, by the applicable geographic adjustment factors applied to physicians' services under section 1848 during 1989 (after April 1). In carrying out subparagraph (A) with respect to services furnished in a year after 1990, the Secretary shall establish a national average conversion factor and, in applying such a factor to fee schedule areas, shall adjust such factor by the applicable geographic adjustment factors applied to physicians' services under section 1848 during that year.

* * * * * * *

(f) FEE SCHEDULE FOR PHYSICIAN PATHOLOGY SERVICES.—

(1) APPLICATION.—The Secretary shall provide for application of a fee schedule with respect to physician pathology services. Subject to paragraph (2), such fee schedule shall be based on the relative value scale and conversion factors developed under section 4050(a) of the Omnibus Budget Reconciliation Act of 1987.

(2) GEOGRAPHIC AREA ADJUSTMENT.—The Secretary shall provide for a geographic area adjustment of the conversion factors in a manner comparable to the geographic area adjustment applied to physicians' services under section 1848 during the year in which the services are furnished.

* * * * * * *

USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

SEC. 1842. (a) * * *
(b)(1) * * *

* * * * * * *

(3) Each such contract shall provide that the carrier—
(A) * * *

* * * * * * *

(G) will provide to each nonparticipating physician, at the beginning of each year, a list of the physician's [maximum allowable actual charges (established under section (j)(1)(C))] *limiting charge established under subsection (j)(1)(C)* for the year for the physicians' services mostly commonly furnished by that physician;

* * * * * * *

(4)(A)(i) * * *

* * * * * * *

(iv) The reasonable charge for physicians' services furnished on or after January 1, 1987, by a nonparticipating physician shall be no greater than the applicable percent of the [prevailing charge levels established under the third and fourth sentences of paragraph (3) (or under any other applicable provision of law affecting the prevailing charge level).] *fee schedule amount (or, for 1992, adjusted fee schedule amount) provided for under section 1848.* In the previous sentence, the term "applicable percent" means for services furnished (I) on or after January 1, 1987, and before April 1, 1988, 96 percent, (II) on or after April 1, 1988, and before January 1, 1989, 95.5 percent, and (III) on or after January 1, 1989, 95 percent.

* * * * * * *

(E)(i) * * *

* * * * * * *

(iv) For purposes of this part for items and services furnished in 1990, the percentage increase in the MEI is 0 percent.

* * * * * * *

(6) No payment under this part for a service provided to any individual shall (except as provided in section 1870) be made to anyone

other than such individual or (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) the physician or other person who provided the service, except that (A) payment may be made (i) to the employer of such physician or other person if such physician or other person is required as a condition of his employment to turn over his fee for such service to his employer, or (ii) (where the service was provided in a hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service, (B) payment may be made to an entity (i) which provides coverage of the services under a health benefits plan, but only to the extent that payment is not made under this part, (ii) which has paid the person who provided the service an amount (including the amount payable under this part) which that person has accepted as payment in full for the service, and (iii) to which the individual has agreed in writing that payment may be made under this part, and (C) in the case of services described in section 1861(s)(2)(K) payment shall be made to the employer of the physician assistant *or nurse practitioner* involved. No payment which under the preceding sentence may be made directly to the physician or other person providing the service involved (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) shall be made to anyone else under a reassignment or power of attorney (except to an employer or facility as described in clause (A) of such sentence); but nothing in this subsection shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the individual to whom the service was provided or a reassignment from the physician or other person providing such service if such assignment or reassignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of the physician or other person providing the service from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such physician or other person under this title is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment. *In the case of residents of nursing facilities who receive services described in section 1861(s)(2)(K)(i) performed by a member of a team, the Secretary shall instruct carriers to develop mechanisms which permit routine payment under this part for up to 1.5 visits per month per resident. In the previous sentence, the term "team" refers to a physician and includes a physician assistant acting under the supervision of the physician or a nurse practitioner working in collaboration with that physician, or both.*

(12)(A) With respect to services described in section 1861(s)(2)(K) (relating to a [physician assistant acting under the supervision of a physician] *physician assistants and nurse practitioners)*—

(i) payment under this part may only be made on an assignment-related basis; and

(ii) the prevailing charges determined under paragraph (3) shall not exceed—

(I) in the case of services performed as an assistant at surgery, 65 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery, or

(II) in other cases, the applicable percentage (as defined in subparagraph (B)) of the prevailing charge rate determined for such services *(or, for services furnished on or after January 1, 1992, the adjusted fee schedule amount or fee schedule amount specified in subsection (c)(1)(A)(ii) or (d)(1) of section 1848, as the case may be)* performed by physicians who are not specialists.

(j)(1)(A) * * *

[(B)(i) During any period (on or after January 1, 1987, and before the date specified in clause (ii))] *During any period (on or after January 1, 1987),* during which a physician is a nonparticipating physician, the Secretary shall monitor the actual charges of each such physician for physicians' services furnished to individuals enrolled under this part. If such physician knowingly and willfully bills on a repeated basis for such a service an actual charge in excess of the [maximum allowable actual charge determined] *actual charge permitted under subparagraph (C) for that service, the Secretary may apply sanctions against such physician in accordance with paragraph (2).*

[(ii) Clause (i) shall not apply to services furnished after the earlier of (I) December 31, 1990, or (II) one-year after the date the Secretary reports to Congress, under section 1845(e)(3), on the development of the relative value scale under section 1845.]

[(C)(i) For a particular physicians' service furnished by a nonparticipating physician to individuals enrolled under this part during a year, for purposes of subparagraph (B), the maximum allowable actual charge is determined as follows: If the physician's maximum allowable actual charge for that service in the previous year was—

[(I) less than 115 percent of the applicable percent (as defined in subsection (b)(4)(A)(iv)) of the prevailing charge for the year and service involved, the maximum allowable actual charge for the year involved is the greater of the maximum allowable actual charge described in subclause (II) or the charge described in clause (ii), or

[(II) equal to, or greater than, 115 percent of the applicable percent (as defined in subsection (b)(4)(A)(iv)) of the prevailing charge for the year and service involved, the maximum allowable actual charge is 101 percent of the physician's maximum allowable actual charge for the service for the previous year.

[(ii) For purposes of clause (i)(I), the charge described in this clause for a particular physicians' service furnished in a year is the maximum allowable actual charge for the service of the physician for the previous year plus the product of (I) the applicable fraction (as defined in clause (iii)) and (II) the amount by which 115 percent of the prevailing charge for the year involved for such service furnished by nonparticipating physicians, exceeds the physician's

maximum allowable actual charge for the service for the previous year.

[(iii) In clause (ii), the "applicable fraction" is—

[(I) for 1987, ¼,

[(II) for 1988, ⅓,

[(III) for 1989, ½, and

[(IV) for any subsequent year, 1.

[(iv) For purposes of determining the maximum allowable actual charge under clauses (i) and (ii) for 1987, in the case of a physicians' service for which the physician has actual charges for the calendar quarter beginning on April 1, 1984, the "maximum allowable actual charge" for 1986 is the physician's actual charge for such service furnished during such quarter.

[(v) For purposes of determining the maximum allowable actual charge under clauses (i) and (ii) for a year after 1986, in the case of a physicians' service for which the physician has no actual charges for the calendar quarter beginning on April 1, 1984, and for which a maximum allowable actual charge has not been previously established under this clause, the "maximum allowable actual charge" for the previous year shall be the 50th percentile of the customary charges for the service (weighted by frequency of the service) performed by nonparticipating physicians in the locality during the 12-month period ending June 30 of that previous year.

[(vi) For purposes of this subparagraph, a "physician's actual charge" for a physicians' service furnished in a year or other period is the weighted averaged (or, at the option of the Secretary for a service furnished in the calendar quarter beginning April 1, 1984, the median) of the physician's charges for such service furnished in the year or other period.

[(vii) In the case of a nonparticipating physician who was a participating physician during a previous period, for the purpose of computing the physician's maximum allowable actual charge during the physician's period of nonparticipation, the physician shall be deemed to have had a maximum allowable actual charge during the period of participation, and such deemed maximum allowable actual charge shall be determined accordingly to clauses (i) through (vi).

[(viii) Notwithstanding any other provision of this subparagraph, the maximum allowable actual charge for a particular physician's service furnished by a nonparticipating physician to individuals enrolled under this part during the 3-month period beginning on January 1, 1988, shall be the amount determined under this subparagraph for 1987. The maximum allowable actual charge for any such service otherwise determined under this subparagraph for 1988 shall take effect on April 1, 1988.

[(ix) If there is a reduction under subsection (b)(13) in the reasonable charge for medical direction furnished by a nonparticipating physician, the maximum allowable actual charge otherwise permitted under this subsection for such services shall be reduced in the same manner and in the same percentage as the reduction in such reasonable charge.]

(C)(i) For a particular phsyicians' service furnished by a nonparticipating physician to individuals enrolled under this part during a year, for purposes of subparagraph (B), the actual charge may not

exceed 120 percent of the reference payment amount described in clause (ii) for the year.

(ii) For purposes of clause (i), the reference payment amount for—

(I) 1991, is the prevailing charge level for the services for the year increased or descreased by ¼ of the amount by which the applicable reference fee schedule amount (determined under section 1848(b)(2)(A)) with respect to the services is greater or less, respectively, than such prevailing charge level;

(II) 1992, is the fee schedule amount (determined under section 1848(c)(2)(A)) with respect to the services increased or decreased by ½ of the amount by which the prevailing charge level otherwise applied with respect to the services is greater or less, respectively, than such fee schedule amount; or

(III) 1993 and any succeeding year, is the fee schedule amoutnt (determined pursuant to section 1848(d)) with respect to the services.

* * * * * * *

(k)(1)*(A)* If a physician knowingly and willfully presents or causes to be presented a claim or bills an individual enrolled under this part for charges for services as an assistant at surgery for which payment may not be made by reason of section 1862(a)(15)*(B)*, the Secretary may apply sanctions against such physician in accordance with subsection (j)(2) in the case of surgery performed on or after March 1, 1987.

(B) If a physician knowingly and willful presents or causes to be presented a claim or bills an individual enrolled under this part for charges for medical direction as a surgeon of a certified registered nurse anesthetist for which payment may not be made by reason of section 1862(a)(15)(B), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2) in the case of surgery performed on or after January 1, 1990.

(2) If a physician knowingly and willfully presents or causes to be presented a claim or bills an individual enrolled under this part for charges that includes a charge for an assistant at surgery for which payment may not be made by reason of section 1862(a)(15) *(B)*, the Secretary may apply sanctions against such physician in accordance with subsection (j)(2) in the case of surgery performed on or after March 1, 1987.

* * * * * * *

(q)(1) Payment for physicians' services furnished to an individual who is enrolled under this part and eligible for any medical assistance (including a qualified medicare beneficiary, as defined in section 1905(p)(1)) with respect to such services under a State plan approved under title XIX may only be made on an assignment-related basis.

(2) A person may not bill for physicians' services subject to paragraph (1) other than on an assignment-related basis. If a person knowingly and willfully bills for physicians' services in violation of the previous sentence, the Secretary may apply sanctions against the person in accordance with subsection (j)(2).

* * * * * * *

PHYSICIAN PAYMENT REVIEW COMMISSION

SEC. 1845. (a) * * *
(b)(1) * * *

* * * * * * *

(3) The Commission also shall advise and make recommendations to the Secretary [respecting the development of the relative value scale under subsection (e) and respecting the index and the adjustment described in subsection (e)(4)(A).] *respecting the payment methodology established under section 1848, specifically including (A) the relative values established under such section, and any adjustments to such values, (B) the national conversion factors to be applied, and (C) the geographic adjustment factors.*

(4) The Commission also shall review the adequacy and appropriateness of payment rates provided for physicians' services under State plans approved under title XIX.

* * * * * * *

RESOURCE-BASED RELATIVE VALUE SCALE FOR PHYSICIANS' SERVICES

SEC. 1848. (a) APPLICATION DURING 1990 AFTER APRIL 1.—

(1) TO ADJUSTMENT OF PREVAILING CHARGES.—

(A) IN GENERAL.—For physicians' services specified under paragraph (2) which are furnished under this part during 1990 on or after April 1, 1990, the Secretary shall provide for an adjustment in the prevailing charge otherwise applied. Such adjustment shall be equal to an increase or decrease of 1/5 of the amount by which the applicable reference fee schedule amount (as determined under paragraph (3)(A)) with respect to each such service is greater or less, respectively, than the prevailing charge otherwise applied with respect to the service. The prevailing charge for such a service, as so adjusted, shall be treated, for purposes of this part for all subsequent periods, as the prevailing charge determined under this part for 1990.

(B) TREATMENT OF EVALUATION AND MANAGEMENT SERVICES.—

(i) IN GENERAL.—In the case of the class of physicians' services consisting of evaluation and management services (as defined in clause (ii)), the Secretary shall provide for the applications of subparagraph (A) in such a manner as will result in a percentage increase (or decrease) equal to the weighted average of such an increase (or decrease, respectively) that the Secretary estimates would have occurred if subparagraph (A) had applied to individual evaluation and management services (rather than to the class of such services).

(ii) EVALUATION AND MANAGEMENT SERVICES.—In clause (i), the term "evaluation and management services" means primary care (as defined in section 1842(i)(2)) and also includes hospital medical services and consultations.

(2) PHYSICIANS' SERVICES COVERED.—This subsection shall only apply to those physicians' services that are specified in Ap-

pendix A of the explanation of title IV (Committee on Energy and Commerce) contained in the report of the Committee on the Budget, House of Representatives, to accompany H.R. (the "Omnibus Budget Reconciliation Act of 1989"), 101st Congress, which specification is based on available data and the recommendations of the Physician Payment Review Commission.

(3) APPLICATION OF REFERENCE FEE SCHEDULE.—

(A) IN GENERAL.—The Secretary shall apply a reference fee schedule covering each of the physicians' services to which this subsection applies. The applicable reference fee schedule amounts specified in such schedule with respect to a physicians' service furnished in a fee schedule area shall represent the product of—

(i) the relative value for the service (specified under paragraph (4)),

(ii) the national standard conversion factor (specified under paragraph (5)), and

(iii) the geographic adjustment factor (specified under paragraph (6)(A)) for the service for the fee schedule area.

(B) FEE SCHEDULE AREA DEFINED.—In this subsection, the term "fee schedule area" means a locality used for purposes of computing payment amounts for physicians' services under section 1842(b).

(4) DETERMINATION OF RELATIVE-VALUE.—

(A) APPLICATION OF RELATIVE VALUE SCALE.—In applying this subsection, the Secretary shall use as the relative value for a physicians' service the sum of the relative values of the components for practice expenses and for physician work specified in Appendix A of the explanation of title IV (Committee on Energy and Commerce) contained in the report of the Committee on the Budget, House of Representatives, to accompany H.R. (the "Omnibus Budget Reconciliation Act of 1989"), 101st Congress for such service, which values are based on the relative resources used with respect to such expenses and such work.

(B) DESCRIPTION OF COMPONENTS.—In this subsection:

(i) PRACTICE EXPENSES.—The component relating to practice expenses is based on the relative expenses of items (such as office rent, wages of personnel, etc.) comprising practice expenses (as defined in subsection (k)(2)).

(ii) PHYSICIAN WORK.—The component relating to physician work is based on the relative resources (reflecting such factors as relative time and effort) relating to physician work.

(5) NATIONAL STANDARD CONVERSION FACTOR.—The Secretary shall, by not later than February 1, 1990, establish (and report to Congress concerning) the national standard conversion factor to be used under paragraph (3)(A)(ii). Such factor shall be established in a manner so that the aggregate payments for physicians' services furnished under this part on or after April 1, 1990, and before January 1, 1991, will be the same as the aggregate of payments for such services if this subsection had not ap-

plied. In establishing such a factor, the Secretary shall provide for appropriate adjustments to take into account, in the precise manner specified in Appendix B of the explanation of title IV (Committee on Energy and Commerce) contained in the report of the Committee on the Budget, House of Representatives, to accompany H.R. (the "Omnibus Budget Reconciliation Act of 1989"), 101st Congress, changes in the volume and distribution of physicians' services furnished under this part due to the impact of this subsection.

(6) GEOGRAPHIC ADJUSTMENT FACTORS.—

(A) IN GENERAL.—For purposes of paragraph (3)(A)(iii), for each physicians' service for each fee schedule area there shall be a geographic adjustment factor equal to the sum of the geographic cost-of-practice adjustment factor (specified in subparagraph (B)) and the geographic physician work adjustment factor (specified in subparagraph (C)) for the service and the area.

(B) GEOGRAPHIC COST-OF-PRACTICE ADJUSTMENT FACTOR.—For purposes of subparagraph (A), the "geographic cost-of-practice adjustment factor", for a service for a fee schedule area, is the product of—

(i) the ratio of the relative value of the practice expense component for the service (specified in the Appendix A referred to in paragraph (4)(A)) to the total relative value for the service (as specified in such Appendix), and

(ii) the geographic cost-of-practice index value for the area, based on the relative costs of a mix of goods and services comprising practice expenses in that fee schedule area for a typical physicians' service compared to the national average of such costs for the service, as specified in Apendix C of the explanation of title IV (Committee on Energy and Commerce) contained in the report of the Committee on the Budget, House of Representatives, to accompany H.R. (the "Omnibus Budget Reconciliation Act of 1989").

(C) GEOGRAPHIC PHYSICIAN WORK ADJUSTMENT FACTOR.—For purposes of subparagraph (A), the "geographic physician work adjustment factor", for a service for a fee schedule area, is the product of—

(i) 1, minus the ratio described in subparagraph (B)(i) for the service, and

(ii) the geographic physician work index value for the area, based on ½ of the difference between the relative value of physicians' work effort in that fee schedule area and the national average relative value of such work effort, as specified in Appendix C of the explanation of title IV (Committee on Energy and Commerce) contained in the report of the Committee on the Budget, House of Representatives, to accompany H.R. (the "Omnibus Budget Reconciliation Act of 1989").

(b) APPLICATION IN 1991.—

(1) TO FURTHER ADJUSTMENT OF PREVAILING CHARGES.—

(A) IN GENERAL.—For all physicians' services which are furnished under this part during 1991, the Secretary shall provide for an adjustment in the prevailing charges otherwise applied. Such adjustment shall be equal to an increase or decrease of ¼ of the amount by which the applicable reference fee schedule amount (as determined under paragraph (2)(A)) with respect to each service is greater or less, respectively, than the prevailing charge otherwise applied with respect to the service. The prevailing charge, as so adjusted, for such a service shall be treated, for purposes of this part for all subsequent periods, as the prevailing charge determined under this part for 1991 for the service.

(B) TREATMENT OF EVALUATION AND MANAGEMENT SERVICES.—Subparagraph (B) of subsection (a)(1) shall apply to subparagraph (A) of this paragraph in the same manner as it applies to subsection (a)(1)(A).

(C) COMPUTATION OF PREVAILING CHARGE LEVELS WITHOUT REGARD TO CUSTOMARY CHARGE LEVELS.—Notwithstanding any other provision of this part (other than subparagraph (A)), the prevailing charge levels for physicians' service furnished during 1991 shall be the prevailing charge levels for such services furnished in 1990 increased by the percentage increase in the MEI applicable to 1991, and shall not be recomputed to reflect any change in the customary charges of physicians during any previous period.

(2) ESTABLISHMENT OF REFERENCE FEE SCHEDULE.—

(A) IN GENERAL.— The Secretary shall establish, by October 1, 1990, a reference fee schedule covering each physicians' service. Except as provided in subparagraph (B), the applicable reference fee schedule amounts specified in such schedule with respect to a physicians' service furnished in a fee schedule area shall represent the product of—

(i) the relative value for the service (determined under paragraph (3)),

(ii) the national standard conversion factor (determined under paragraph (4)), and

(iii) the geographic adjustment factor (determined under paragraph (5)(B)) for the service for the fee schedule area.

(B) ANESTHESIA SERVICES.— In establishing a reference fee schedule for anesthesia services for which a relative value guide has been established under section 4048(b) of the Omnibus Budget Reconciliation Act of 1987, instead of the factors described in clauses (i) and (ii) of subparagraph (A), the Secretary shall use, to the extent practicable, such relative value guide, with appropriate adjustment of the conversion factor, in a manner to assure that the reference fee schedule amounts for anesthesia services in fee schedule areas are consistent with the reference fee schedule amounts for other services determined by the Secretary to be of comparable value in those areas. In applying the previous sentence, the Secretary shall adjust the reference fee schedule amounts by geographic adjustment factors in the

same manner as such adjustment is made under subparagraph (A)(iii). The Secretary may provide for an overall percentage adjustment for anesthesia services under paragraph (1)(A) in a manner similar to the overall percentage adjustment provided for evaluation and management services under paragraph (1)(B).

(C) FEE SCHEDULE AREA DEFINED.— In this subsection, the term "fee schedule area" means a locality used for purposes of computing payment amounts for physicians' services under section 1842(b).

(3) DETERMINATION OF RELATIVE VALUES.—

(A) IN GENERAL.—

(i) GENERAL RULE.— The Secretary shall determine, using the best available information and taking into account the recommendations of the Physician Payment Review Commission, a relative value for each physicians' service. Each such relative value shall be the sum of the relative values of the components of each physicians' service, which values are based on the relative resources utilized with respect to each component in furnishing particular physicians' services.

(ii) NO VARIATION FOR SPECIALISTS.— With respect to the computation of the relative value for each component for a service, the Secretary may not vary the relative values, for the same physicians service, based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician.

(B) TREATMENT OF CERTAIN SERVICES.—

(i) RADIOLOGY SERVICES.—In establishing the relative value for radiology services (including radiologist services, as defined in section 1834(b)(6)), the Secretary shall base the relative value on the relative value scale developed under section 1834(b)(1)(A), with approprite modifications of the relative value to assure that the relative value established for radiology services which are similar or related to other physicians' services are consistent with the relative value established for those similar or related services.

(ii) EXTRAPOLATION FOR OTHER SERVICES.—In the case of physicians' services for which specific data are not available, the Secretary may extrapolate relative values based on related services for which data are available and shall specifically take into account recommendations of the Physician Payment Review Commission and the results of consultations with organizations representing physicians who provide such services.

(C) COMPONENTS.—In this subsection, each of the following is a separate "component" with respect to a physicians' service:

(i) PRACTICE EXPENSES.—A component relating to relative practice expenses, based on general categories of expenses (such as office rent, wages of personnel, etc.) comprising practice expenses.

(ii) PHYSICIAN WORK.—A component relating to relative physician work (reflecting such factors as relative time and effort).

With respect to the computation of the relative values for the component for practice expenses described in clause (i), the Secretary shall base such computation on the best, readily available data, such as data from surveys covering such expenses.

(4) NATIONAL STANDARD CONVERSION FACTOR.—The Secretary shall, by not later than October 1, 1990, establish (and report to Congress concerning) the national standard conversion factor to be used under paragraph (2)(A)(ii). Such factor shall be established in a manner so that the aggregate payments for physicians' services under this part during 1991 will be the same as the aggregate of payments for such services if this subsection had not applied. In establishing such a factor, the Secretary shall take into account the recommendations of the Physician Payment Review Commission and the percentage increase in the MEI (as defined in section 1842(i)(3)) and shall provide for appropriate adjustments to increase or decrease the conversion factor, to take into account projected changes in volume and distribution of physicians' services furnished under this part due to the impact of this subsection. The report of the Secretary under this paragraph shall identify and evaluate the components of such changes in the volume and distribution of services and shall explain the basis for any such adjustments.

(5) GEOGRAPHIC ADJUSTMENT FACTORS.—

(A) ESTABLISHMENT OF GEOGRAPHIC INDICES.—

(i) IN GENERAL.—Subject to clause (ii), the Secretary shall establish—

(I) an index which reflects the relative costs of the mix of goods and services comprising practice expenses in the different fee schedule areas compared to the national average of such costs, and

(II) an index which reflects ½ of the difference between the relative value of physicians' work effort in each of the different fee schedule areas and the national average of such work effort.

(ii) CLASS-SPECIFIC GEOGRAPHIC COST-OF-PRACTICE INDICES.—The Secretary may establish more than one index under clause (i)(I) in the case of classes of physicians' services, if, because of differences in the mix of goods and services comprising practice expenses for the different classes of services, the application of a single index to different classes of such services would be substantially inequitable.

(B) COMPUTATION OF GEOGRAPHIC ADJUSTMENT FACTOR.—For purposes of paragraph (2)(A)(iii), for all physicians' services for each fee schedule area the Secretary shall establish a geographic adjustment factor equal to the sum of the geographic cost-of-practice adjustment factor (specified in subparagraph (C)) and the geographic physician work adjustment factor (specified in subparagraph (D)) for the service and the area.

(C) GEOGRAPHIC COST-OF-PRACTICE ADJUSTMENT FACTOR.—For purposes of subparagraph (B), the "geographic cost-of-practice adjustment factor", for a service for a fee schedule area, is the product of—

(i) the ratio of the relative value of the practice expense component for the service (as determined under paragraph (3)(A)) to the total relative value for the service (as determined under such paragraph), and

(ii) the geographic cost-of-practice index value for the area for the service, based on the index established under subparagraph (A)(i)(I) or (A)(ii) (as the case may be).

(D) GEOGRAPHIC PHYSICIAN WORK ADJUSTMENT FACTOR.—For purposes of subparagraph (B), the "geographic physician work adjustment factor", for a service for a fee schedule area, is the product of—

(i) 1, minus the ratio described in subparagraph (C)(i) for the service, and

(ii) the geographic physician work index value for the area, based on the index established under subparagraph (A)(i)(II).

(6) REQUIRING TRANSITIONAL CODING OF BILLS SUBMITTED.—In order to provide for the collection of data required to implement subsection (c)(1)(C), the Secretary may require, for bills submitted for physicians' services furnished during 1991, that the bills indicate the fee schedule area (described in subsection (c)(3)(C)(i)) and the classification and coding (described in subsection (c)(2)) with respect to the services.

(c) APPLICATION IN 1992.—

(1) PAYMENT ON BASIS OF FEE SCHEDULE AMOUNT, SUBJECT TO ADJUSTMENT WITH RESPECT TO PREVAILING CHARGE.—

(A) IN GENERAL.—Notwithstanding any other provision of this part, instead of payment under this part being based on an applicable percent (specified under section 1833 (a) or (b)) of the reasonable charges for the services, for physicians' services furnished in 1992 payment shall be based on such applicable percent of the lesser of—

(i) the actual charge for the services, or

(ii) the fee schedule amount (determined under paragraph (3)(A)) for the service, as adjusted under subparagraph (B).

(B) ADJUSTMENT WITH RESPECT TO PREVAILING CHARGE.—For purposes of subparagraph (A)(ii), the adjustment of a fee schedule amount under this subparagraph for a service shall be an increase or decrease by ½ of the amount by which the prevailing charge level (specified in subparagraph (C)) for the service is greater or less, respectively, than such fee schedule amount.

(C) PREVAILING CHARGE LEVEL.—

(i) IN GENERAL.—In applying subparagraph (B), the prevailing charge level for a service shall be the prevailing charge level for that service furnished in 1991 (taking into account any affect of subsection (b)(1)(C))

increased by the percentage increase in the MEI applicable to 1992.

(ii) ESTABLISHMENT OF PREVAILING CHARGE LEVEL WHERE RECLASSIFICATION OF SERVICE.—In the case of a physicians' service which is reclassified or recoded under paragraph (2) or otherwise and for which specific service a prevailing charge level was not established for 1991, the Secretary shall provide for the construction of such proxy prevailing charge level for 1991 as may be appropriate.

(iii) ESTABLISHMENT OF PREVAILING CHARGE LEVEL FOR NEW FEE SCHEDULE AREAS.—If the fee schedule area in 1992 for a service is different from the fee schedule area in 1991 for that service, the Secretary shall provide for the computation of the prevailing charge level for the service for the new fee schedule area based on the weighted average of the prevailing charge levels that would otherwise have applied in the portions of the old fee schedule areas included in the new fee schedule area.

(D) COMPUTATION OF PREVAILING AND CUSTOMARY CHARGES.—

(i) NO RECOMPUTATION OF CUSTOMARY CHARGES.—The Secretary shall not require carriers to recompute customary charges for physicians' services, for purposes of payment with respect to such services furnished during or after 1992.

(ii) PREVAILING CHARGES.—The Secretary shall not require carriers to recompute prevailing charges for physicians' services, for purposes of payment with respect to such services furnished after 1992.

(2) UNIFORM CLASSIFICATION AND CODING OF SERVICES, GLOBAL SURGICAL CODES, AND CODING OF EVALUATION AND MANAGEMENT SERVICES BY TIME.—The Secretary shall make such changes in classification and coding of physicians' services furnished during or after 1992 as may be required—

(A) to provide for uniform classification and coding of the same physicians' services in all fee schedule areas;

(B) to classify and code, with a surgical procedure, related pre-operative and post-operative physicians' services; and

(C) to take into account, in the classification and coding of evaluation and management services, the time used in providing different evaluation and management services.

(3) FEE SCHEDULE.—

(A) IN GENERAL.—For purposes of this subsection and succeeding subsections for a year, the Secretary shall establish, by not later than October 1 before the year, a fee schedule covering each physicians' services. Except as provided in subparagraph (B), the applicable fee schedule amounts specified in such schedule with respect to a physicians' service furnished in a fee schedule area shall represent the product of—

(i) the relative value for the service (specified under paragraph (4)),

(ii) the national standard conversion factor (specified in paragraph (5)), and

(iii) the geographic adjustment factor for the service for the fee schedule area (specified in paragraph (6)(B)).

(B) ANESTHESIA SERVICES.—In establishing a reference fee schedule for anesthesia services for which a relative value guide has been established under section 4048(b) of the Omnibus Budget Reconciliation Act of 1987, instead of the factors described in clauses (i) and (ii) of subparagraph (A), the Secretary shall use, to the extent practicable, such relative value guide, with appropriate adjustment of the conversion factor, in a manner to assure that the reference fee schedule amounts for anesthesia services in fee schedule areas are consistent with the reference fee schedule amounts for other services determined by the Secretary to be of comparable value in those areas. In applying the previous sentence, the Secretary shall adjust the reference fee schedule amounts by geographic adjustment factors in the same manner as such adjustment is made under subparagraph (A)(iii). In applying the previous sentence, the Secretary may provide for an overall percentage adjustment under paragraph (1)(A) a manner similar to the overall percentage adjustment provided for evaluation and management services under paragraph (1)(B).

(C) FEE SCHEDULE AREAS DEFINED.—

(i) IN GENERAL.—For purposes of this subsection, a "fee schedule area" shall be comprised of either—

(I) each State (in its entirety), or

(II) each metropolitan statistical area (or New England County Metropolitan area or comparable area recognized by the Secretary) and each portion of each State which is outside a metropolitan statistical area (or comparable area).

(ii) RECOMMENDATIONS TO CONGRESS.—The Secretary shall report to Congress, by not later than July 1, 1991, on the Secretary's recommendation on whether fee schedule areas under this subsection should be the areas described in subclause (I) or subsection (II) of clause (i).

(4) RELATIVE VALUES.—

(A) IN GENERAL.—Except as provided in this paragraph, the Secretary shall determine relative values for each physicians' service in the same manner as such determination is made under subsection (b)(3).

(B) COMPONENTS.—In this subsection, each of the following is a separate "component" with respect to a physicians' service:

(i) GENERAL PRACTICE EXPENSES.—A component relating to relative practice expenses (as defined in subseciton (k)(2) (which excludes malpractice expenses)), based on general categories of expenses (such as office rent, wages of personnel, etc.) comprising practice expenses.

(ii) MALPRACTICE EXPENSES.—A component relating to relative malpractice expenses, based on the risk category of the class of services furnished (or the specialty of physicians providing the services).

(iii) PHYSICIAN WORK.— A component relating to relative physician work (reflecting such factors as relative time and effort).

(5) NATIONAL STANDARD CONVERSION FACTOR.—The Secretary shall, by not later than October 1, 1991, establish (and report to Congress concerning) the national standard conversion factor to be used under paragraph (3)(A)(ii). Such factor shall be established in a manner so that the aggregate payments for physicians' services under this part during 1992 will be the same as the aggregate of payments for such services if this section had not applied. In establishing such a factor, the Secretary shall take into account the recommendations of the Physician Payment Review Commission and the percentage increase in the MEI (as defined in section 1842(i)(3)) and shall provide for appropriate adjustments to increase or decrease the conversion factor, to take into account projected changes in volume and distribution of physicians' services furnished under this part due to the impact of this subsection. The report of the Secretary under this paragraph shall identify and evaluate the components of such changes in the volume and distribution of services and shall explain the basis for any such adjustments.

(6) GEOGRAPHIC ADJUSTMENT FACTORS.

(A) ESTABLISHMENT OF GEOGRAPHIC INDICES.—

(i) IN GENERAL.—Subject to clause (ii), the Secretary shall establish—

(I) an index which reflects the relative costs of the mix of goods and services comprising practice expenses (other than malpractice expenses) in the different fee schedule areas compared to the national average of such costs,

(II) an index which reflects the relative costs of malpractice expenses in the different fee schedule area compared to the national average of such costs, and

(III) an index which reflects ½ of the difference between the relative value of physicians' work effort in each of the different fee schedule areas and the national average of such work effort.

(ii) CLASS-SPECIFIC GEOGRAPHIC COST-TO-PRACTICE INDICES.—The Secretary may establish more than one index under clause (i)(I) in the case of classes of physicians' services, if, because of differences in the mix of goods and services comprising practice expenses for the different classes of services, the application of a single index under such clause to different classes of such services would be substantially inequitable.

(B) COMPUTATION OF GEOGRAPHIC ADJUSTMENT FACTOR.—For purposes of paragraph (2)(A)(iii), for all physicians' services for each fee schedule area the Secretary shall establish a geographic adjustment factor equal to the sum of the

geographic cost-of-practice adjustment factor (specified in subparagraph (C)), the geographic malpractice adjustment factor (specified in subparagraph (D)), and the geographic physician work adjustment factor (specified in subparagraph (E)) for the service and the area.

(C) GEOGRAPHIC COST-TO-PRACTICE ADJUSTMENT FACTOR.—For purposes of subparagraph (B), the "geographic cost-of-practice adjustment factor", for a service for a fee schedule area, is the product of—

(i) the ratio of the relative value of the practice expense component for the service (as determined under paragraph (3)(A)) to the total relative value for the service (as determined under such paragraph), and

(ii) the geographic cost-of-practice index value for the area for the service, based on the index established under subparagraph (A)(i)(I) or (A)(ii) (as the case may be).

(D) GEOGRAPHIC MALPRACTICE ADJUSTMENT FACTOR.—For purposes of subparagraph (B), the "geographic malpractice adjustment factor", for a service for a fee schedule area, is the product of—

(i) the ratio of the relative value of the malpractice expense component for the service (as determined under paragraph (3)(A)) to the total relative value for the service (as determined under such paragraph), and

(ii) the geographic malpractice index value for the area, based on the index established under subparagraph (A)(i)(II).

(E) GEOGRAPHIC PHYSICIAN WORK ADJUSTMENT FACTOR.—For purposes of subparagraph (B), the "geographic physician work adjustment factor", for a service for a fee schedule area, is the product of—

(i) 1, minus the sum of the ratios described in subparagraphs (C)(i) and (D)(i) for the service, and

(ii) the geographic physician work index value for the area, based on the index established under subparagraph (A)(i)(III).

(d) APPLICATION IN 1993 AND SUCCEEDING YEARS.—The provisions of subsection (c) shall apply to physicians' services furnished during 1993 and succeeding years in the same manner as they apply to physicians' services furnished during 1992, except as follows:

(1) PAYMENT ON BASIS OF FEE SCHEDULE AMOUNT.—In applying (by reference) subsection (c)(1)(A), there shall be no adjustment made under subparagraph (B) thereof (relating to an adjustment with respect to prevailing charge).

(2) ADJUSTMENTS IN RELATIVE VALUES AND GEOGRAPHIC INDEX FACTORS.—

(A) IN GENERAL.—The Secretary, taking into account recommendations made by the Physician Payment Review Commission and the views of appropriate organizations representing physicians and other interested parties, may provide—

(i) from time to time for the establishment of relative values for physicians' services for which such values have not previously been established, and

(ii) subject to subparagraph (B), annually for such adjustments in the relative values and in the geographic adjustment factors used for purposes of this subsection, as the Secretary determines to be appropriate.

(B) BUDGET NEUTRALITY IN ANNUAL ADJUSTMENTS.—The Secretary may not make adjustments under subparagraph (A)(ii) which are intended or designed to result in an overall increase or decrease in the aggregate amount of payments to be made under this part for physicians' services.

(3) NATIONAL STANDARD CONVERSION FACTOR.—Instead of applying subsection (c)(5) (by reference), the Secretary shall, by not later than August 1 before the year involved, establish (and report to Congress concerning) the national standard conversion factor to be used for the year involved. Such factor for a year shall be the conversion factor established for the previous year adjusted by the projected percentage change, between the midpoint of the previous year and the midpoint of the year involved, in an appropriate index (established by the Secretary) that reflects the value of the resources (including practice expenses, malpractice expenses, and physician work effort) used in furnishing physicians' services. In establishing such index, the Secretary shall take into account the recommendations of the Physician Payment Review Commission and the views of appropriate organizations representing physicians and other interested parties.

(e) [Reserved]

(f) [Reserved]

(g) [Reserved]

(h) [Reserved]

(i) [Reserved]

(j) MISCELLANEOUS PROVISIONS.—

(1) EXPENDITED PROCEDURES FOR INITIAL IMPLEMENTATION.—In order to implement subsections (a) and (b) on a timely basis, the Secretary may provide for publication of regulations on an interim, final basis and chapter 35 of title 44, United States Code, and Executive Order 12291 shall not apply to information and regulations required for purposes of carrying out such subsection.

(2) RESTRICTION ON ADMINISTRATIVE AND JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869 or otherwise of—

(A) the percentage adjustments for evaluation and management services under subsection (a)(1)(B)(i);

(B) the relative values established for physicians' services under this section, including the relative value of components of services;

(C) the national standard conversion factors established under this section;

(D) the geographic indices and adjustment factors established under this section; and

(E) the selection of fee schedule areas under subsection (c)(3)(B).

(k) DEFINITIONS.—In this section:

(1) PHYSICIANS' SERVICES DEFINED.—The term "physicians' services" includes items and services described in paragraphs (3) and (4) of section 1861(s) (other than clinical diagnostic laboratory tests) furnished in connection with other physicians' services.

(2) PRACTICE EXPENSES DEFINED.—

(A) 1990 AND 1991.—Except as provided in subparagraph (B), the term "practice expenses" includes all expenses for furnishing physicians' services, including malpractice expenses, but excluding physician compensation and other physician fringe benefits.

(B) 1992 AND THEREAFTER.—For purposes of subsections other than subsections (a) and (b), the term "practice expenses" does not include malpractice expenses.

PART C—MISCELLANEOUS PROVISIONS

DEFINITIONS OF SERVICES, INSTITUTIONS, ETC.

SEC. 1861. For purposes of this title—

Inpatient Hospital Services

(b) * * *

* * * * * * *

Home Health Services

(m) The term "home health services" means the following items and services furnished to an individual, who is under the care of a physician, by a home health agency or by others under arrangements with them made by such agency, under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician, which items and services are, except as provided in paragraph (7), provided on a visiting basis in a place of residence used as such individual's home—

(1) * * *

* * * * * * *

[(5) medical supplies (other than drugs and biologicals) and durable medical equipment, while under such a plan;] *(5) ostomy supplies (as defined by the Secretary) while under such a plan;*

* * * * * * *

Medical and Other Health Services

(s) The term "medical and other health services" means any of the following items or services:

(1) physicians' services;

(2)(A) * * *

* * * * * * *

(E) rural health clinic services *and Federally qualified health center services;*

* * * * * * *

(H)(i) services furnished pursuant to a contract under section 1876 to a member of an eligible organization by a physician assistant or by a nurse practitioner (as defined in subsection [(aa)(3)] *(aa)(5))* and such services and supplies furnished as an incident to his service to such a member as would otherwise be covered under this part if furnished by a physician or as an incident to a physician's service; and

(ii) services furnished pursuant to a risk-sharing contract under section 1876(g) to a member of an eligible organization by a clinical psychologist (as defined by the Secretary) or by a clinical social worker (as defined in subsection [(hh)] *(hh)(2)),* and such services and supplies furnished as an incident to such clinical psychologist's services or clinical social worker's services to such a member as would otherwise be covered under this part if furnished by a physician or as an incident to a physician's service;

* * * * * * *

(J) covered outpatient drugs (as defined in subsection (t)); [and]

(K)(i) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a physician assistant (as defined in subsection [(aa)(3)] *(aa)(5))* under the supervision of a physician [(as so defined)] *or by a nurse practitioner (as defined in subsection (aa)(5)) working in collaboration (as defined in subsection (aa)(6)) with a physician (as defined in subsection (r)(1))* (I) in a hospital, skilled nursing facility, or nursing facility (as defined in section 1919(a), (II) as an assistant at surgery, or (III) in a rural area (as defined in section 1886(d)(2)(D)) that is designated, under section 332(a)(1)(A) of the Public Health Service Act, as a health manpower shortage area, and which the physician assistant *or nurse practitioner* is legally authorized to perform by the State in which the services are performed, and

(ii) such services and supplies furnished as an incident to such services as would be covered under subparagraph (A) if furnished as an incident to a physician's professional service;

(L) certified nurse-midwife services; [and]

(M) qualified psychologist services; *and*

(N) clinical social worker services;

* * * * * * *

(12) subject to section 4072(e) of the Omnibus Budget Reconciliation Act of 1987, extra-depth shoes with inserts or custom molded shoes for an individual with diabetes, if—

(A) the physician who is managing the individual's diabetic condition (i) documents that the individual has peripheral neuropathy with evidence of callus formation, a history of pre-ulcerative calluses, a history of previous ulceration, foot deformity, or previous amputation, or poor circulation, and (ii) certifies that the individual needs such

shoes under a comprehensive plan of care related to the individual's diabetic condition;

(B) the particular type of shoes are prescribed by a podiatrist or other qualified physician (as established by the Secretary); and

(C) the shoes are fitted and furnished by a podiatrist or other qualified individual (such as a pedorthist or orthotist, as established by the Secretary) who is not the physician described in subparagraph (A) (unless the Secretary finds that the physician is the only such qualified individual in the area); [and]

(13) screening mammography (as defined in subsection [(kk)].]; *and*

(14) screening pap smear.

No diagnostic tests performed in any laboratory which is independent of a physician's office, a laboratory not independent of a physician's office that has a volume of clinical diagnostic laboratory tests exceeding 5,000 per year, a rural health clinic, or a hospital (which, for purposes of this sentence, means an institution considered a hospital for purposes of section 1814(d)) shall be included within paragraph (3) unless such laboratory—

[(14)] *(15)* if situated in any State in which State or applicable local law provides for licensing of establishments of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing establishments of this nature, as meeting the standards established for such licensing; and

[(15)] *(16)* meets such other conditions relating to the health and safety of individuals with respect to whom such tests are performed as the Secretary may find necessary.

* * * * * * *

Reasonable Cost

(v)(1)(A) * * *

* * * * * * *

(S) *(i)* Such regulations shall not include provision for specific recognition of any return on equity capital with respect to hospital outpatient department.

(ii)(I) 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 outpatient hospital services, 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 year 1990.

(II) Subclause (I) shall not apply to payments with respect to the capital-related costs of any hospital that is a sole community hospital (as defined in section 1886(d)(5)(C)(ii)).

* * * * * * *

Rural Health Clinic Services *and Federally Qualified Health Center Services*

(aa)(1) The term "rural health clinic services" means—

(A) physicians' services and such services and supplies as are covered under section 1861(s)(2)(A) if furnished as an incident to a physician's professional service and items and services described in section 1861(s)(10),

(B) such services furnished by a physician assistant or a nurse practitioner (as defined in paragraph [(3)), or] *(5)),* by a clinical psychologist (as defined by the Secretary) *or by a clinical social worker (as defined in subsection (hh)(1))* and such services and supplies furnished as an incident to his service as would otherwise be covered if furnished by a physician or as an incident to a physician's service, and

* * * * * * *

(2) The term "rural health clinic" means a facility which—

(A) * * *

* * * * * * *

(I) has appropriate procedures for review of utilization of clinic services to the extent that the Secretary determines to be necessary and feasible; [and]

(J) has a nurse practitioner, a physician assistant, or a certified nurse-midwife (as defined in subsection (gg)) available to furnish patient care services not less than 50 percent of the time the clinic operates; and

[(J)] *(K)* meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are furnished services by the clinic.

For the purposes of this title, such term includes only a facility which (i) is located in an area that is not an urbanized area (as defined by the Bureau of the Census) and that is [designated by the Secretary] *designated by the chief executive officer of the State and certified by the Secretary as an area with a shortage of personal health services, or that is designated by the Secretary* either (I) as an area with a shortage of personal health services under [section 1302(7) of the Public Health Service Act or] *sections 330(b)(3) or 1302(7) of the Public Health Service Act,* (II) as a health manpower shortage area described in section 332(a)(1)(A) of that Act because of its shortage of primary [medical care manpower,] *medical care manpower, (III) as a high impact area described in section 329(a)(5) of that Act, or (IV) as an area which includes a population group which the Secretary determines has a health manpower shortage under section 332(a)(1)(B) of that Act,* (ii) has filed an agreement with the Secretary by which it agrees not to charge any individual or other person for items or services for which such individual is entitled to have payment made under this title, except for the amount of any deductible or coinsurance amount imposed with respect to such items or services (not in excess of the amount customarily charged for such items and services by such clinic), pursuant to subsections (a) and (b) of section 1833, (iii) employs a physician assistant or nurse practitioner, and (iv) is not a rehabilitation agency or a facility which is primarily for the care and treatment

of mental diseases. A facility that is in operation and qualifies as a rural health clinic under this title or title XIX and that subsequently fails to satisfy the requirement of clause (i) shall be considered, for purposes of this title and title XIX, as still satisfying the requirement of such clause.

(3) The term "Federally qualified health center services" means services of the type described in subparagraphs (A) through (C) of paragraph (1) when furnished to an individual as an outpatient of a Federally qualified health center and, for this purpose, any reference to a rural health clinic or a physician described in paragraph (2)(B) is deemed a reference to a Federally qualified health center or a physician at the center, respectively.

(4) The term "Federally qualified health center" means a facility which—

(A) is receiving a grant under section 329, 330, or 340 of the Public Health Service Act,

(B) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant, or

(C) was treated by the Secretary, for purposes of part B, as a comprehensive Federally funded health center as of January 1, 1989.

[(3)] *(5)* The term "physician assistant" and the term "nurse practitioner" mean, for the purposes of [paragraphs (1) and (2)] *the previous provisions of this subsection,* a physician assistant or nurse practitioner who performs such services as such individual is legally authorized to perform (in the State in which the individual performs such services) in accordance with State law (or the State regulatory mechanism provided by State law), and who meets such training, education, and experience requirements (or any combination thereof) as the Secretary may prescribe in regulations.

(6) The term "collaboration" means a process in which a nurse practitioner works with a physician to deliver health care within the scope of their professional expertise, with medical direction and appropriate supervision as provided for in jointly developed guidelines or other mechanisms as defined by the law of the State in which the services are performed.

* * * * * * *

[Clinical Social Worker]

Clinical Social Worker; Clinical Social Worker Services

(hh) *(1)* The term "clinical social worker" means an individual who—

[(1)] *(A)* possesses a master's or doctor's degree in social work;

[(2)] *(B)* after obtaining such degree has performed at least 2 years of supervised clinical social work; and

[(3)(A)] *(C)(i)* is licensed or certified as a clinical social worker by the State in which the services are performed, or

[(B)] *(ii)* in the case of an individual in a State which does not provide for licensure or certification—

[(i)] *(I)* has completed at least 2 years or 3,000 hours of post-master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate setting (as determined by the Secretary), and

[(ii)] *(II)* meets such other criteria as the Secretary establishes.

(2) The term "clinical social worker services" means services performed by a clinical social worker (as defined in paragraph (1)) for the diagnosis and treatment of mental illnesses which the clinical social worker is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed as would otherwise be covered if furnished by a physician or as an incident to a physician's service.

Qualified Psychologist Services

(ii) The term "qualified psychologist services" means such services and such services and supplies furnished as an incident to his service furnished by a clinical psychologist (as defined by the Secretary) [onsite at a community mental health center (as such term is used in the Public Health Service Act), and such services that are necessarily furnished off-site (other than at an off-site office of such psychologist) as part of a treatment plan because of the inability of the individual furnished such services to travel to the center by reason of physical or mental impairment, because of institutionalization, or because of similar circumstances of the individual,] which the psychologist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) as would othrwise be covered if furnished by a physician or as an incident to a physician's service.

* * * * * * *

Screening Pap Smear

(mm) The term "screening pap smear" means a diagnostic laboratory test consisting of a routine exfoliative cytology test (Papanicolaou test) provided to a woman for the purpose of early detection of cervical cancer and includes a physician's interpretation of the results of the test, if the individual involved has not had such a test during the preceding 3 years (or such shorter period as the Secretary may specify in the case of a woman who is at high risk of developing cervical cancer (as determined pursuant to factors identified by the Secretary)).

EXCLUSIONS FROM COVERAGE

SEC. 1862. (a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

(1)(A) * * *

* * * * * * *

(F) in the case of screening mammography, which is performed more frequently than is covered under section 1834(e)(2) or which does not meet the standards established under section 1834(e)(3), *and, in the case of screening pap smear, which is performed more frequently than is provided under 1861(mm);* and

* * * * * * *

(2) for which the individual furnished such items or services has no legal obligation to pay, and which no other person (by reason of such individual's membership in a prepayment plan or otherwise) has a legal obligation to provide or pay for, *except in the case of Federally qualified health center services;*

(3) which are paid for directly or indirectly by a governmental entity (other than under this Act and other than under a health benefits or insurance plan established for employees of such an entity), except in the case of rural health clinic services, as defined in section 1861(aa)(1), *, in the case of Federally qualified health center services, as defined in section 1861(aa)(3),* and in such other cases as the Secretary may specify;

* * * * * * *

(15) *(A)* which are for services of an assistant at surgery in a cataract operation (including subsequent insertion of an intraocular lens) unless, before the surgery is performed, the appropriate utilization and quality control peer review organization (under part B of title XI) or a carrier under section 1842 has approved of the use of such an assistant in the surgical procedure based on the existence of a complicating medical condition, *or (B) which are for medical direction by a surgeon of a certified registered nurse anesthetist;* or

* * * * * * *

(e)(1) No payment may be made under this title with respect to any item or service (other than an emergency item or service, *not including items or services furnished in an emergency room of a hospital)* furnished—

(A) by an individual or entity during the period when such individual or entity is excluded pursuant to section 1128, 1128A, 1156 or 1842(j)(2) from participation in the program under this title; or

(B) at the medical direction or on the prescription of a physician during the period when he is excluded pursuant to section 1128 or section 1128A from participation in the program under this title and when the person furnishing such item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

* * * * * * *

USE OF STATE AGENCIES TO DETERMINE COMPLIANCE BY PROVIDERS OF SERVICES WITH CONDITIONS OF PARTICIPATION

SEC. 1864. (a) The Secretary shall make an agreement with any State which is able and willing to do so under which the services of the State health agency or other appropriate State agency (or the appropriate local agencies) will be utilized by him for the purpose of determining whether an institution therein is a hospital or skilled nursing facility, or whether an agency therein is a home health agency, or whether an agency is a hospice program or a home intravenous drug therapy provider, or whether a facility therein is a rural health clinic as defined in section 1861(aa)(2) or a comprehensive outpatient rehabilitation facility as defined in section 1861(cc)(2), or whether a laboratory meets the requirements of paragraphs [(14) and (15)] *(15) and (16)* of section 1861(s), or whether a clinic, rehabilitation agency or public health agency meets the requirements of subparagraph (A) or (B), as the case may be, of section 1861(p)(4), or whether an ambulatory surgical center meets the standards specified under section 1832(a)(2)(F)(i), or whether screening mammography meets the standards established under section 1834(e)(3). To the extent that the Secretary finds it appropriate, an institution or agency which such a State (or local) agency certifies is a hospital, skilled nursing facility, rural health clinic, comprehensive outpatient rehabilitation facility, home health agency, hospice program, or home intravenous drug therapy provider (as those terms are defined in section 1861) may be treated as such by the Secretary. Any State agency which has such an agreement may (subject to approval of the Secretary) furnish to a skilled nursing facility, after proper request by such facility, such specialized consultative services (which such agency is able and willing to furnish in a manner satisfactory to the Secretary) as such facility may need to meet one or more of the conditions specified in section 1819(a). Any such services furnished by a State agency shall be deemed to have been furnished pursuant to such agreement. Within 90 days following the completion of each survey of any health care facility, ambulatory surgical center, rural health clinic, comprehensive outpatient rehabilitation facility, laboratory, clinic, agency, or organization by the appropriate State or local agency described in the first sentence of this subsection, the Secretary shall make public in readily available form and place, and require (in the case of skilled nursing facilities) the posting in a place readily accessible to patients (and patients' representatives), the pertinent findings of each such survey relating to the compliance of each such health care facility, ambulatory surgical center, rural health clinic, comprehensive outpatient rehabilitation facility, laboratory, clinic, agency, or organization with (1) the statutory conditions of participation imposed under this title and (2) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such health care facility, ambulatory surgical center, rural health clinic, comprehensive outpatient rehabilitation facility, laboratory, clinic, agency, or organization. Any agreement under this subsection shall provide for the appropriate State or local agency to maintain a toll-free hotline (1) to collect, maintain,

and continually update information on home health agencies located in the State or locality that are certified to participate in the program established under this title (which information shall include any significant deficiencies found with respect to patient care in the most recent certification survey conducted by a State agency or accreditation survey conducted by a private accreditation agency under section 1865 with respect to the home health agency, when that survey was completed, whether corrective actions have been taken or are planned, and the sanctions, if any, imposed under this title with respect to the agency) and (2) to receive complaints (and answer questions) with respect to home health agencies in the State or locality. Any such agreement shall provide for such State or local agency to maintain a unit for investigating such complaints that possesses enforcement authority and has access to survey and certification reports, information gathered by any private accreditation agency utilized by the Secretary under section 1865, and consumer medical records (but only with the consent of the consumer or his or her legal representative).

* * * * * * *

EFFECT OF ACCREDITATION

SEC. 1865. (a) Except as provided in subsection (b) and the second sentence of section 1863, if—

(1) an institution is accredited as a hospital by the Joint Commission on Accreditation of Hospitals, and

(2) such institution (if it is included within survey described in section 1864(c)) authorizes the Commission to release to the Secretary upon his request (or such State agency as the Secretary may designate) a copy of the most current accreditation survey of such institution made by such Commission,

then, such institution shall be deemed to meet the requirements of the numbered paragraphs of section 1861(e); except—

(3) paragraph (6) thereof, and

(4) any standard, promulgated by the Secretary pursuant to paragraph (9) thereof, which is higher than the requirements prescribed for accreditation by such Commission.

If such Commission, as a condition for accreditation of a hospital, requires a utilization review plan (or impose another requirement which serves substantially the same purpose), requires a discharge planning process (or imposes another requirement which serves substantially the same purpose), or imposes a standard which the Secretary determines is at least equivalent to the standard promulgated by the Secretary as described in paragraph (4) of this subsection, the Secretary is authorized to find that all institutions so accredited by such Commission comply also with clause (A) or (B) of section 1861(e)(6) or the standard described in such paragraph (4), as the case may be. In addition, if the Secretary finds that accreditation of an entity by the American Osteopathic Association or any other national accreditation body provides reasonable assurance that any or all of the conditions of section 1832(a)(2)(F)(i), 1834(e)(3), 1861(e), 1861(f), 1861(j), 1861(o), 1861(p)(4)(A) or (B), paragraphs [(14) and (15)] *(15) and (16)* of section 1861(s), section 1861(aa)(2), 1861(cc)(2), or 1861(dd)(2), as the case may be, are met, he may, to

the extent he deems it appropriate, treat such entity as meeting the condition or conditions with respect to which he made such finding. The Secretary may not disclose any accreditation survey (other than a survey with respect to a home health agency) made and released to him by the Joint Commission on Accreditation of Hospitals, the American Osteopathic Association, or any other national accreditation body, of an entity accredited by such body.

* * * * * * *

AGREEMENTS WITH PROVIDERS OF SERVICES

SEC. 1866. (a)(1) Any provider of services (except a fund designated for purposes of section 1814(g) and section 1835(e)) shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

(A) * * *

* * * * * * *

(N) in the case of hospitals—

(i) to make available to its patients the directory or directories of participating physicians (published under section 1842(h)(4)) for the area served by the hospital, and

(ii) is hospital personnel (including staff of any emergency or outpatient department) refer a patient to a nonparticipating physician for further medical care on an outpatient basis, the personnel must inform the patient that the physician is a nonparticipating physician and, whenever practicable, must identify at least one qualified participating physician who is listed in such a directory and from whom the outpatient may receive the necessary services, [and]

(O) in the case of hospitals and skilled nursing facilities, to accept as payment in full for inpatient hospital and extended care services that are covered under this title and are furnished to any individual enrolled with an eligible organization (i) with a risk-sharing contract under section 1876, under section 1876(i)(2)(A) (as in effect before February 1, 1985), under section 402(a) of the Social Security Amendments of 1967, or under section 222(a) of the Social Security Amendments of 1972, and (ii) which does not have a contract establishing payment amounts for services furnished to members of the organization the amounts (in the case of hospitals) or limits (in the case of skilled nursing facilities) that would be made as a payment in full under this title if the individuals were not so enrolled[.] *; and*

(P) in the case of home health agencies which provide home health services to individuals entitled to benefits under this title who require ostomy supplies (described in section 1861(m)(5)), to offer to furnish such supplies to such individual as part of their furnishing of home health services.

* * * * * * *

PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS

SEC. 1876. (a)(1)(A) * * *

* * * * * * *

(C) The annual per capita rate of payment for each such class shall be equal to [95 percent] *100 percent* of the adjusted average per capita cost (as defined in paragraph (4)) for that class.

* * * * * * *

(F)(i) At least 45 days before making the announcement under subparagraph (A) for a year (beginning with the announcement for 1991), the Secretary shall provide for notice to eligible organizations of proposed changes to be made in the methodology or assumptions (including any benefit coverage assumptions), from the methodology and assumptions used in the previous announcement, in making the determinations under such subparagraph with respect to the year and shall provide such organizations an opportunity to comment on such proposed changes.

(ii) In each announcement made under subparagraph (A) for a year (beginning with the announcement for 1991), the Secretary shall include an explanation of the methodology and assumptions (including any benefit coverage assumptions) used in the announcement in sufficient detail so that eligible organizations can compute per capita rates of payment for classes of individuals located in each county (or equivalent area) which is in whole or in part within the service area of such an organization.

* * * * * * *

(j)(a)(A) In the case of physicians' services described in paragraph (2) which are furnished by a participating physician to an individual enrolled with an eligible organization under this section and enrolled under part B, the participation agreement under section 1842(h)(1) is deemed to provide that the physician will accept as payment in full from the eligible organization the amount that would be payable to the physician under part B and from the individual under such part, if the individual were not enrolled with an eligible organization under this section.

(B) In the case of physicians' services described in paragraph (2) which are furnished by a nonparticipating physician, the limitations on actual charges for such services otherwise applicable under part B (to services furnished by individuals not enrolled with an eligible organization under this section) shall apply in the same manner as such limitations apply to services furnished to individuals not enrolled with such an organization.

(2) The physicians' services described in this paragraph are physicians' services which—

(A) are emergency services or out-of-area coverage (described in clauses (iii) and (iv) of subsection (b)(2)(A)), and

(B) are furnished to an enrollee of an eligible organization under this section by a person who is not under a contract with the organization.

* * * * * * *

MEDICARE COVERAGE FOR END STATE RENAL DISEASE PATIENTS

SEC. 1881. (a) * * *
(b)(1) * * *

* * * * * * *

(3) With respect to payments for physicians' services furnished to individuals determined to have end stage renal disease, the Secretary shall pay 80 percent of the amounts calculated for such services—

(A) on a reasonable charge basis (but may, in such case, make payment on the basis of the prevailing charges of other physicians for comparable services) *or, for services furnished on or after January 1, 1992, on the basis described in section 1848)* except that payment may not be made under this subparagraph for routine services furnished during a maintenance dialysis episode, or

* * * * * * *

(7) The Secretary shall provide by regulation for a method (or methods) for determining prospectively the amounts of payments to be made for dialysis services furnished by providers of services and renal dialysis facilities to individuals in a facility and to such individuals at home. Such method (or methods) shall provide for the prospective determination of a rate (or rates) for each mode of care based on a single composite weighted formula (which takes into account the mix of patients who receive dialysis services at a facility or at home and the relative costs of providing such services in such settings) for hospital-based facilities and such a single composite weighted formula for other renal dialysis facilities, or based on such other method or combination of methods which differentiate between hospital-based facilities and other renal dialysis facilities and which the Secretary determines, after detailed analysis, will more effectively encourage the more efficient delivery of dialysis services and will provide greater incentives for increased use of home dialysis than through the single composite weighted formulas, *except that in no case may the amount of a payment made under any method other than a method based on a single composite weighted formula exceed the amount of payment that would have been made under such formula.* The Secretary shall provide for such exceptions to such methods as may be warranted by unusual circumstances (including the special circumstances of sole facilities located in isolated, rural areas and of pediatric facilities). Each application for such an exception shall be deemed to be approved unless the Secretary disapproves it by not later than 60 working days after the date the application is filed. The Secretary may provide that such method will serve in lieu of any target reimbursement rate that would otherwise be established under paragraph (6). The Secretary shall reduce the amount of each composite rate payment under this paragraph for each treatment by 50 cents (subject to such adjustments as may be required to reflect modes of dialysis other than hemodialysis) and provide for payment of such amount to the network administrative organization (designated under subsection (c)(1)(A) for the network area in which the treatment is pro-

vided) for its necessary and proper administrative costs incurred in carrying out its responsibilities under subsection (c)(2).

* * * * * * *

PAYMENT TO HOSPITALS FOR INPATIENT HOSPITAL SERVICES

SEC. 1886. (a) * * *

* * * * * * *

(h) PAYMENTS FOR DIRECT GRADUATE MEDICAL EDUCATION COSTS.—

(1) * * *

(2) DETERMINATION OF HOSPITAL-SPECIFIC APPROVED FTE RESIDENT AMOUNTS.—The Secretary shall determine, for each hospital with an approved medical residency training program, an approved FTE resident amount for each cost reporting period beginning on or after July 1, 1985, as follows:

(A) * * *

* * * * * * *

(D) AMOUNT FOR SUBSEQUENT COST REPORTING PERIODS.—[For each] *Subject to the limit established in subparagraph (F)(ii), for each* subsequent cost reporting period, the approved FTE resident amount for the hospital is equal to the amount determined under this paragraph for the previous cost reporting period updated, through the midpoint of the period, by projecting the estimated percentage change in the consumer price index during the 12-month period ending at that midpoint, with appropriate adjustments to reflect previous under- or over-estimates under this subparagraph in the projected percentage change in the consumer price index

* * * * * * *

(F) LIMITATION ON APROVED FTE RESIDENT ACCOUNTS.—

(i) ESTABLISHMENT OF LIMIT.—For each residency year beginning on or after July 1, 1990, the Secretary shall establish a national payment limit which, when applied to hospitals under clause (ii), is estimated by the Secretary to result in a reduction of payments under this title in the residency year equal to the total additional expenditures under this title in the residency year resulting from the weighting factors for primary care residents and primary care specialty residents under paragraph (4)(C)(ii) being greater than 1.00.

(ii) APPLICATION OF LIMIT TO HOSPITALS.—For each residency year to which clause (i) applies, the approved FTE resident amount for a hospital may not exceed the product of the national payment limit (established under such clause) for the residency year and the primary care coefficient (established under clause (iii)) for the hospital for the residency year.

(iii) COMPUTATION OF PRIMARY CARE COEFFICIENT.—For each hospital for each residency year the Secretary shall estimate a primary care coefficient equal to—

(I) the number of full-time equivalent residents (as determined under paragraph (4), taking into account the weighting factors established under paragraph (4)(C)) expected in the hospital in the residency year, divided by

(II) the total number of full-time-equivalent residents (determined under such paragraph but without applying the weighting factors established under paragraph (4)(C)) expected in the hospital in the residency year.

* * * * * * *

(4) DETERMINATION OF FULL-TIME-EQUIVALENT RESIDENTS.—

(A) * * *

* * * * * * *

(C) WEIGHTING FACTORS FOR CERTAIN RESIDENTS.—Subject to subparagraph (D), such rules shall provide, in calculating the number of full-time-equivalent residents in an approved residency program—

(i) before July 1, 1986, for each resident the weighting factor is 1.00,

(ii) on or after July 1, 1986, for a resident who is in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is 1.00 *or, in the case of a primary care resident (as defined in paragraph (5)(I)(i)), 1.25, or, in the case of a primary care specialty resident (as defined in paragraph (5)(I)(ii)), 1.10.*

* * * * * * *

(5) DEFINITIONS AND SPECIAL RULES.—As used in this subsection:

(A) * * *

* * * * * * *

(I) PRIMARY CARE RESIDENT; PRIMARY CARE SPECIALTY RESIDENT.—

(i) The term "primary care resident" means a resident in family medicine, general internal medicine, or general pediatrics.

(ii) The term "primary care specialty resident" means a resident (other than a primary care resident) in internal medicine, or pediatrics.

* * * * * * *

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * * * *

STATE PLANS FOR MEDICAL ASSITANCE

SEC. 1902. (a) A State plan for medical assistance must—

(1) * * *

* * * * * * *

(5) either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan; or provide for the establishment or designation of a single State agency to administer or to supervise the adminstration of the plan, except that *(A)* the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under title I or XVI (insofar as it relates to the aged) if the State is eligible to participate in the State plan program established under title XVI, or by the agency or agencies administering the supplemental security income program established under title XVI or the State plan approved under part A of title IV if the State is not eligible to participate in the State plan program established under title XVI, *and (B) nothing in this paragraph shall be construed as preventing a State plan from assigning, to a State agency responsible for developmentally disabled individuals, specific management functions under the plan relating to provision of services under the plan to individuals with mental retardation or a related condition;*

* * * * * * *

(9) provide—

(A) * * *

* * * * * *

(C) that any laboratory services paid for under such plan must be provided by a laboratory which meets the applicable requirements of section 1861(e)(9) or [paragraphs (14) and (15)] *paragaphs (15) and (16)* of section 1861(s), or, in the case of a laboratory which is in a rural health clinic, of section 1861(aa)(2)(G);

(10) provide—

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5) and (17) and (18) of section 1905(a), to—

(i) all individuals—

(I) * * *

* * * * * * *

(III) who are qualified pregnant women or children as defined in section 1905(n),

(IV) who are described in subparagraph (A) or (B) of subsection (l)(1) and whose family income does not exceed the minimum income level the State is required to establish under subsection (l)(2)(A) for such a family; [or]

(V) who are qualified family members as defined in section 1905(m)(1)[;] , *or*

(VI) who are described in subparagraph (C) of subsection (l)(1) and whose family income does not

exceed the income level the State is required to establish under subsection (l)(2)(B) for such a family;

(ii) at the option of the State, to any group or groups of individuals described in section 1905(a) (or, in the case of individuals described in section 1905(a)(i), to any reasonable categories of such individuals) who are not individuals described in clause (i) of this subparagraph but—

(I) * * *

* * * * * * *

(V) who are in a medical institution for a period of not less than 30 consecutive days (with eligibility by reason of this subclause beginning on the first day of such period), who meet the resource requirements of the appropriate State plan described in clause (i) or the supplemental security income program, and [whose income does not exceed a separate income standard established by the State which is consistent with the limit established under section 1903(f)(4)(C)] *whose income does not exceed a separate income standard established by the State, which income (as determined under section 1612, but without regard to subsection (b) thereof) does not exceed 300 percent of the supplemental security income benefit rate established by section 1611(b)(1),*

(VI) who would be eligible under the State plan under this title if they were in a medical institution *(applying the resource and income standards applicable under subclause (V)),* with respect to whom there has been a determination that but for the provisions of home or community-based services described in subsection (c), (d), or (e) of section 1915 they would require the level of care provided in a hospital, nursing facility or [intermediate care facility for the mentally retarded] *habitation facility* the cost of which could be reimbursed under the State plan, and who will receive home or community-based services pursuant to a waiver granted by the Secretary under subsection (c), (d), or (e) of section 1915,

(VII) who would be eligible under the State plan under this title if they were in a medical institution *(applying the resource and income standards applicable under subclause (V)),* who are terminally ill, and who will receive hospice care pursuant to a voluntary election described in section 1905(o);

* * * * * * *

(IX) who are described in subsection (l)(1) and are not described in clause (i)(IV) *or clause (i)(VI);*

(X) who are described in subsection (m)(1); [or]

(XI) who receive only an optional State supplementary payment based on need and paid on a regular basis, equal to the difference between the individual's countable income and the income standard used to determine eligibility for such supplementary payment (with countable income being the income remaining after deductions as established by the State pursuant to standards that may be more restrictive than the standards for supplementary security income benefits under title XVI), which are available to all individuals in the State (but which may be based on different income standards by political subdivision according to cost of living differences), and which are paid by a State that does not have an agreement with the Secretary under section 1616 or 1634; *or*

(XII) who are described in subsection (s)(1);

* * * * * * *

(C) that if medical assistance is included for any group of individuals described in section 1905(a) who are not described in subparagraph (A) or (E), then—

(i) * * *

* * * * * * *

(iv) if such medical assistance includes services in institutions for mental diseases or in an [intermediate care facility for the mentally retarded] *habilitation facility* (or both) for any such group, it also must include for all groups covered at least the care and services listed in paragraphs (1) through (5) and (17) *and (18)* of section 1905(a) or the care and services listed in any 7 of the paragraphs numbered (1) [through (20)] *through (24)* of such section;

* * * * * * *

(E)*(i)* for making medical assistance available for medicare cost-sharing (as defined in section 1905(p)(3)) for qualified medicare beneficiaries described in section 1905(p)(1); except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1905(a) to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under part B of title XVIII to individuals eligible therefor (either pursuant to an agreement entered into under section 1843 or by reason of the payment of premiums under such title by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of title XVIII for individuals eligible for benefits under such part, shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of serv-

ices of the same amount, duration, and scope, to any other individuals, (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals approved by the Secretary with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A), (IV) the imposition of a deductible, cost sharing, or similar charge for any item or service furnished to an individual not eligible for the exemption under section 1916(a)(2) or (b)(2) shall not require the imposition of a deductible, cost sharing, or similar charge for the same item or service furnished to an individual who is eligible for such exemption, (V) the making available to pregnant women covered under the plan of services relating to pregnancy (including prenatal, delivery, and postpartum services) or to any other condition which may complicate pregnancy shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any other individuals, provided such services are made available (in the same amount, duration, and scope) to all pregnant women covered under the State plan, (VI) with respect to the making available of medical assistance for hospice care to terminally ill individuals who have made a voluntary election described in section 1905(o) to receive hospice care instead of medical assistance for certain other services, such assistance may not be made available in an amount, duration, or scope less than that provided under title XVIII, and the making available of such assistance shall not, by reason of this paragraph (10), require the making available of medical assistance for hospice care to other individuals or the making available of medical assistance for services waived by such terminally ill individuals, (VII) the medical assistance made available to an individual described in subsection (l)(1)(A) who is eligible for medical assistance only because of subparagraph (A)(i)(IV) or (A)(ii)(IX) shall be limited to medical assistance for services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions which may complicate pregnancy, (VIII) the medical assistance made available to a qualified medicare beneficiary described in section 1905(p)(1) who is only entitled to medical assistance because the individual is such a beneficiary shall be limited to medical assistance for medicare cost-sharing (described in section 1905(p)(3)), subject to the provisions of subsection (n) and section 1916(b), (IX) the making available of respiratory care services in accordance with subsection (e)(9) shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any individuals not included under subsection (e)(9)(A), provid-

ed such services are made available (in the same amount, duration, and scope) to all individuals described in such subsection, and (X) if the plan provides for any fixed durational limit on medical assistance for inpatient hospital services (whether or not such a limit varies by medical condition or diagnosis), the plan must establish exceptions to such a limit for medically necessary inpatient hospital services furnished with respect to individuals [under one year of age] *under 18 years of age* in a hospital defined under the State plan, pursuant to section 1923(a)(1)(A), as a disproportionate share hospital and subparagraph (B) (relating to comparability) shall not be construed as requiring such an exception for other individuals, services, or hospitals, *and*

(ii) for making medical assistance available for payment of medicare cost-sharing described in section 1905(p)(3)(A) for qualified disabled and working individuals described in section 1905(t);

(11)(A) provde for entering into cooperative arrangements with the State agencies responsible for administering or supervising the administration of health services and vocational rehabilitation services in the State looking toward maximum utilization of such services in the State looking toward maximum utilization of such services in the provision of medical assistance under the plan, [and] (B) effective July 1, 1969, provide, to the extent prescribed by the Secretary, for entering into agreements, with any agency, institution, or organization receiving payments under (or through an allotment under) title V, (i) providing for utilizing such agency, institution, or organization in furnishing care and services which are available under such title or allotment and which are included in the State plan approved under this section and (ii) making such provision as may be appropriate for reimbursing such agency, institution, or organization for the cost of any such care and services furnished any individual for which payment would otherwise be made to the State with respect to him under section 1903, *and (C) provide for coordination of the operations under this title with the State's operations under the special supplemental food program for women, infants, and children under section 17 of the Child Nutrition Act of 1966;*

* * * * * * *

(13) provide—

(A) for payment (except where the State agency is subject to an order under section 1914) of the hospital services, nursing facility services, and services in an [intermediate care facility for the mentally retarded] *habilitation facility* provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State *which, in the case of habilitation facilities, take into account the costs of complying with subsections (b) (other than paragraph (4)(D)), (c), and (d) of section 1928,* which, in the case of nursing facilities, take into account the costs *(including the costs of services required to attain or maintain the highest practicable physical,*

mental, and psychosocial well-being of each resident eligible for benefits under this title) of complying with subsections (b) (other than paragraph (3)(F) thereof), (c), and (d) of section 1919 and provide (in the case of a nursing facility with a waiver under section 1919(b)(4)(C)(ii)) for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care, and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs and provide, in the case of hospital patients receiving services at an inappropriate level of care (under conditions similar to those described in section 1861(v)(1)(G)), for lower reimbursement rates reflecting the level of care actually received (in a manner consistent with section 1861(v)(1)(G))) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality; and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital, nursing facility, and [intermediate care facility for the mentally retarded] *habilitation facility* and periodic audits by the State of such reports;

* * * * * * *

(C) that the State shall provide assurances satisfactory to the Secretary that the valuation of capital assets, for purposes of determining payment rates for nursing facilities and for [intermediate care facilities for the mentally retarded] *habilitation facilities,* will not be increased (as measured from the date of acquisition by the seller to the date of the change of ownership), solely as a result of a change of ownership, by more than the lesser of—

(i) one-half of the percentage increase (as measured over the same period of time, or, if necessary, as extrapolated retrospectively by the Secretary) in the Dodge Construction Systems Costs for Nursing Homes, applied in the aggregate with respect to those facilities which have undergone a change of ownership during the fiscal year, or

(ii) one-half of the percentage increase (as measured over the same period of time) in the Consumer Price Index for All Urban Consumers (United States city average);

(D) for payment for hospice care [in the same amounts, and using the same methodology, as used] *in amounts no lower than the amounts, using the same methodology used* under part A of title XVIII and for payment of amounts

under section 1905(o)(3); except that [a separate rate may be paid for] *in the case of* hospice care which is furnished to an individual who is a resident of a nursing facility or [intermediate care facilities for the mentally retarded] *habilitation facilities,* and who would be eligible under the plan for nursing facility services or services in an [intermediate care facilities for the mentally retarded] *habilitation facilities,* if he had not elected to receive hospice care, [to take into account the room and board furnished by such facility; and] *there shall be paid an additional amount, to take into account the room and board furnished by the facility, equal to at least 95 percent of the rate that would have been paid by the State under the plan for facility services in that facility for that individual;*

(E) for payment for services described in section 1905(a)(2)(B) provided by a rural health clinic under the plan, *and for payment for services described in section 1905(a)(2)(C) under the plan,* of 100 percent of costs which are reasonable and related to the cost of furnishing such services or based on such other tests of reasonableness, as the Secretary may prescribe in regulations under section 1833(a)(3), or, in the case of services to which those regulations do not apply, on such tests of reasonableness as the Secretary may prescribe in regulations under this subparagraph;

(F) for payment—

(i) for community habitation and supportive services (as defined in section 1927(a)) through rates which are reasonable and adequate (and which may not be established on a capitation basis or any other risk basis) to meet the costs of providing services, efficiently and economically, in conformity with applicable State and Federal laws, regulations, and quality and safety standards (including those described in section 1927(f)(1)(B)),

(ii) for habilitation facility services through rates which are reasonable and adequate (and which may not be established on a capitation basis or any other risk basis) to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards, and

(iii) for services described in clause (i) or (ii) through methodologies which do not distinguish between State-operated providers and other providers; and

(G) for payment for community care (as defined in sectionf 1929(a) and provided under such section) through rates which are reasonable and adequate (and which may not be established on a capitation basis or any other risk basis) to meet the costs of providing care, efficiently and economically, in conformity with applicable State and Fed-

eral Laws, regulations, and quality and safety standards (including those described in section 1928(f)(1)(B));

* * * * * * *

(17) except as provided in subsections (1)(3), (m)(3), [and (m)(4)] *(m)(4), and (s)(1),* include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under title I, X, XIV, Or XVI, or part A of title IV, and with respect to whom supplemental security income benefits are not being paid under title XVI, based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this title, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or to have paid with respect to him supplemental security income benefits under title XVI) as would not be disregarded (or set aside for future needs) in determining his elibility for such aid, assistance, or benefits, (C) provide for reasonable evalaution of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under title XVI), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1614 (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standrds with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums or otherwise and regardless of whether such costs are reimbursed under another public program of the state or political subdivision thereof) incurred for medical care or for any other type of remedial care recognized under State alw;

* * * * * * *

(28) provide—

(A) * * *

* * * * * * *

(C) for procedures to make available to the public the data and methodology used in establishing payment rates for nursing facilities under this title; [and]

(D) for compliance (by the date specified in the respective sections) with the requirements of—

(i) section 1919(e);

(ii) section 1919(g) (relating to responsibility for survey and certification of nursing facilities); and

(iii) sections 1919(h)(2)(B) and 1919(h)(2)(D) (relating to establishment and application of remedies);

(E) that any habilitation facility receiving payments under such plan must satisfy all the requirements of subsections (b) through (d) of section 1928 as they apply to such facilities; and

(F) for compliance (by the date specified in the respective sections) with the requirements of—

(i) section 1928(e) (relating to preadmission screening and client review);

(ii) section 1928(g) (relating to responsibility for survey and certification of habilitation facilities); and

(iii) sections 1928(h)(2)(B) and 1928(h)(2)(D) (relating to establishment and application of remedies);

[(29) include a State program which meets the requirements set forth in section 1908, for the licensing of administrators of nursing homes;]

(30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care *and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area;*

(B) provide, under the program described in subparagraph (A), that—

(i) each admission to a hospital [,intermediate care facility for the mentally retarded,] or hospital for mental diseases is reviewed or screened in accordance with criteria established by medical and other professional personnel who are not themselves directly responsible for the care of the patient involved, and who do not have a significant financial interest in any such institution and are not, except in the case of a hospital, employed by the institution providing the care involved, and

(ii) the information developed from such review or screening, along with the data obtained from prior reviews of the necessity for admission and continued stay of patients by such professional personnel, shall be used as the basis for establishing the size and composition of the sample of admissions to be subject to review and evaluation by such personnel, and any such sample may be of any size up to 100 percent of all admissions and must be of sufficient size to serve the purpose of (I) identifying the patterns of care being provided and the changes occurring over time in such patterns so that the need for modification may be ascertained, and (II) subjecting admissions to early or more extensive review where information indi-

cates that such consideration is warranted to a hospital [, intermediate care facility for the mentally retarded,] or hospital for mental diseases; and

* * * * * * *

[(31) with respect to services in an intermediate care facility for the mentally retarded (where the State plan includes medical assistance for such services) provide—

[(A) with respect to each patient receiving such services, for a written plan of care, prior to admission to or authorization of benefits in such facility, in accordance with regulations of the Secretary, and for a regular program of independent professional review (including medical evaluation) which shall periodically review his need for such services;

[(B) with respect to each intermediate care facility for the mentally retarded within the State, for periodic onsite inspections of the care being provided to each person receiving medical assistance, by one of more independent professional review teams (composed of a physician or registered nurse and other appropriate health and social service personnel), including with respect to each such person (i) the adequacy of the services available to meet his current health needs and promote his maximum physical well-being, (ii) the necessity and desirability of his continued placement in the facility, and (iii) the feasibility of meeting his health care needs through alternative institutional or noninstitutional services; and

[(C) for full reports to the State agency by each independent professional review team of the findings of each inspection under subparagraph (B), together with any recommendations;]

* * * * * * *

(33) provide—

(A) * * *

(B) that, except as provided in [section 1919(g)] *section 1919 and section 1928,* the State or local agency utilized by the Secretary for the purpose specified in the first sentence of section 1864(a), or, if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for such licensing, will perform for the State agency administering or supervising the administration of the plan approved under this title the function of determining whether institutions and agencies meet the requirements for participation in the program under such plan, except that, if the Secretary has cause to question the adequacy of such determinations, the Secretary is authorized to validate State determinations and, on that basis, make independent and binding determinations concerning the extent to which individual institutions and agencies meet the requirements for participation;

* * * * * * *

(43) provide for—

(A) informing all persons in the State who are under the age of 21 and who have been determined to be eligible for medical assistance including services described in section 1905(a)(4)(B), of the availability of early and periodic screening, diagnostic, [and treatment services as described in section 1905(a)(4)(B)] *as described in section 1905(r), and treatment services*

(B) providing or arranging for the provision of such screening services in all cases where they are requested, [and]

(C) arranging for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screeing services[;], *and*

(D) reporting to the Secretary (in a uniform form and manner established by the Secretary, by age group and by basis of eligibility for medical assistance, and by not later than April 1 after the end of each fiscal year, beginning with fiscal year 1990) the following information relating to early and periodic screening, diagnostic, and treatment services provided under the plan during each fiscal year:

(i) the number of children provided child health screening services,

(ii) the number of children referred for corrective treatment (the need for which is disclosed by such child health screening services), and

(iii) the number of children receiving dental services;

(44) in each case for which payment for inpatient hospital services[, services in an intermediate care facility for the mentally retarded,] or inpatient mental hospital services is made under the State plan—

(A) a physician [(or, in the case of skilled nursing facility services or intermediate care facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician)] certifies at the time of admission, or, if later, the time the individual applies for medical assistance under the State plan (and a physician, a physican assistant under the supervision of a physician, [or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is an employee of the facility but is working in collaboration with a physician,] recertifies, where such services are furnished over a period of time, in such cases, at least as often as required under section 1903(g)(6) [or, in the case of services that are services provided in an intermediate care facility for the mentally retarded, every year)], and accompanied by such supporting material, appropriate to the case involved, as may be provided in regulations of the Secretary), that such services are or were required to be given on an inpatient basis because the individual needs or needed such services, and

(B) such services were furnished under a plan established and periodically reviewed and evaluated by a physician, [or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician];

* * * * * * *

(51)(A) meet the requirements of section 1924 (relating to protection of community spouses), and (B) meet the requirement of section 1917(c) (relating to transfer of assets); [and]

(52) meet the requirements of section 1925 (relating to extension of eligibility for medical assistance)[.]; *(53) provide—*

(A) for notifying in a timely manner all individuals in the State who are determined to be eligible for medical assistance and who are pregnant women, breastfeeding or postpartum women (as defined in section 17 of the Child Nutrition Act of 1966), or children below the age of 5, of the availability of benefits furnished by the special supplemental food program under such section, and

(B) for referring any such individual to the State agency responsible for administering such program; and

((54) provide for receipt and initial processing of applications of individuals for medical assistance under subsections (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), or (a)(10)(A)(ii)(IX)—

(A) at locations which include locations (such as hospitals or clinics providing covered services to such individuals, without discrimination based on whether the hospital or clinic is public or private) which are other than those used for the receipt and processing of applications for aid under part A of title IV, and

(B) using applications which are other than those used for applications for aid under such part.

Nothwithstanding paragraph (5), if on January 1, 1965, and on the date on which a State submits its plan for approval under this title, the State agency which administered or supervised the administration of the plan of such State approved under title X (or title XVI, insofar as it relates to the blind) was different from the State agency which administered or supervised the administration of the State plan approved under title I (or title XVI, insofar as it relates to the blind) may be designed to administer or supervise the administration of the portion of the State plan for medical assistance which relates to blind individuals and a different State agency may be established or designated to administer or supervise the administration of the rest of the State plan for medical assistance; and in such case the part of the plan which such agency administers, or the administration of which such agency supervises, shall be regarded as a separate plan for purposes of this title (except for purposes of paragraph (10)). The provisions of paragraphs [(9)(A), (31), and (33)] *(9)(A) and (31)* and of section 1903(i)(4) shall not apply to a Christian Science sanatorium operated, or listed and

certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

* * * * * * *

(e)(1) * * *

(2)(A) In the case of an individual who is enrolled with a qualified health maintenance organization (as defined in title XIII of the Public Health Service Act) or with an entity described in paragraph (2)(B)(iii), (2)(E), (2)(G), or (6) of section 1903(m) under a contract described in section 1903(m)(2)(A) *or with an eligible organization with a contract under section 1876* and who would (but for this paragraph) lose eligibility for benefits under this title before the end of the minimum enrollment period (defined in subparagraph (B)), the State plan may provide, notwithstanding any other provision of this title, that the individual shall be deemed to continue to be eligible for such benefits until the end of such minimum period, but, except for benefits furnished under section 1905(a)(4)(C), only with respect to such benefits provided to the individual as an enrollee of such organization or entity.

* * * * * * *

(3) At the option of the State, any individual who—

(A) is 18 years of age or younger and qualifies as a disabled individual under section 1614(a);

(B) with respect to whom there has been a determination by the State that—

(i) the individual requires a level of care provided in a hospital, nursing facility, or [intermediate care facility for the mentally retarded] *habilitation facility,*

* * * * * * *

(9)(A) At the option of the State, the plan may include as medical assistance respiratory care services for any individual who—

(i) is medically dependent on a ventilator for life support at least six hours per day;

(ii) has been so dependent for at least 30 consecutive days (or the maximum number of days authorized under the State plan, whichever is less) as an inpatient;

(iii) but for the availability of respiratory care services, would require respiratory care as an inpatient in a hospital[, nursing facility, or intermediate care facility for the mentally retarded] *or nursing facility* and would be eligible to have payment made for such inpatient care under the State plan;

* * * * * * *

(B) The requirements of subparagraph (A)(ii) may be satisfied by a continuous stay in one or more hospitals[, nursing facilities, or intermediate care facilities for the mentally retarded] *or nursing facilities.*

* * * * * * *

(11) With respect to an individual who has not attained the age of 18, who is receiving medical assistance under this title, and who is determined to be no longer eligible for such assistance, the State may not discontinue such assistance until the State has determined

that the individual is not eligible for assistance under this title on any basis.

(f)(1) Notwithstanding any other provision of this title, except as provided in [subsection (e) and section 1619(b)(3)] *paragraph (2) of this subsection and subsections (e) and (r)(2) and section 1619(b)(3) and section 1924 and except with respect to qualified medicare beneficiaries, qualified severely impaired individuals, and individuals described in subsection (m)(1),* no State not eligible to participate in the State plan program established under title XVI shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of title XVI) for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this title and in effect on January 1, 1972, been in effect in such month, except that for this purpose any such individual shall be deemed eligible for medical assistance under such State plan if (in addition to meeting such other requirements as are or may be imposed under the State plan) the income of any such individual as determined in accordance with section 1903(f) (after deducting any supplemental security income payment and State supplementary payment made with respect to such individual, and incurred expenses for medical care as recognized under State law regardless of whether such expenses are reimbursed under another public program of the State or political subdivision thereof) is not in excess of the standard for medical assistance established under the State plan as in effect on January 1, 1972. In States which provide medical assistance to individuals pursuant to paragraph (10)(C) of subsection (a) of this section, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under paragraph (10)(A) of that subsection of that individual is, or is eligible to be [(1)] *(A)* an individual with respect to whom there is payable a State supplementary payment on the basis of which similarly situated individuals are eligible to receive medical assistance equal in amount, duration, and scope to that provided to individuals eligible under paragraph (10)(A), or [(2)] *(B)* an eligible individual or eligible spouse, as defined in title XVI, with respect to whom supplemental security income benefits are payable; otherwise that individual shall be considered to be an individual eligible for medical assistance under paragraph (1)(C) of that subsection. In States which do not provide medical assistance to individuals pursuant to paragraph (10)(C) of that subsection, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under paragraph (10)(A) of that subsection.

(2) A State shall provide medical assistance to any individual under 18 years of age with respect to whom supplemental security income benefits are payable under title XVI.

* * * * * * *

(h) Nothing in this title (including subsections (a)(13) and (a)(30) of this section) shall be construed as authorizing the Secretary to limit the amount of payment adjustments *(including pass-through payments for capital costs)* that may be made under a plan under this title with respect to hospitals that serve a disproportionate number of low-income patients with special needs *or to limit the amount of payment that may be made under a plan under this title for community care.*

[(i)(1) In addition to any other authority under State law, where a State determines that a intermediate care facility for the mentally retarded which is certified for participation under its paln 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 patients, the State shall provide for the termination of the facility's certification for participation under the plan and may provide, or

[(B) do not immediately jeopardize the health and safety of its patients, the State may, in lieu of providing for terminating the facility's certification for participation under the plan, provide

that no payment will be made under the State plan with respect to any individual admitted to such facility after a date specified by the State.

[(2) The State 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 this title [111], to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

[(3) The State'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 State, and its effectiveness shall terminate (A) when the State 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 [112], 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 State shall terminate such facility's certification for participation under the plan effective with the first day of the first month following the month specified in such clause.]

(i)(1) In addition to any other authority under State law, where a State determines that a psychiatric hospital which is certified for participation under its plan no longer meets the requirements for a psychiatric hospital (referred to in section 1905(h)) and further finds that the hospital's deficiencies—

(A) immediately jeopardize the health and safety of its patients, the State shall terminate the hospital's participation under the State plan; or

(B) do not immediately jeopardize the health and safety of its patients, the State may terminate the hospital's participation under the State plan, or provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding, or both.

(2) Except as provided in paragraph (3), if a psychiatric hospital described in paragraph (1)(B) has not complied with the requirements for a psychiatric hospital under this title—

(A) within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period, or

(B) within 6 months after the date the hospital is found to be out of compliance with such requirements, no Federal financial paricipation shall be provided under section 1903(a) with respect to further services provided in the hospital until the State finds that the hospital is in compliance with the requirements of this title.

(3) The Secretary may continue payments, over a period of not longer than 6 months from the date the hospital is found to be out of compliance with such requirements, if—

(A) the State finds that it is more appropriate to take alternative action to assure compliance of the hospital with the requirements than to terminate the certification of the hospital,

(B) the State has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action, and

(C) the State agrees to repay to the Federal Government payments received under this paragraph if the corrective action is not taken in accordance with the approved plan and timetable.

(j) Notwithstanding any other requirement of this title, the Secretary may waive or modify any requirement of this title with respect to the medical assistance program in American Samoa and the Northern Mariana Islands, other than a waiver of the Federal medical assistance percentage, the limitation in section 1108(c), or the requirement that payment may be made for medical assistance only with respect to amounts expended by American Samoa or the Northern Mariana Islands for care and services described in paragraphs (1) through [(21)] *(25)* of section 1905(a).

* * * * * * *

(l)(1) Individuals described in this paragraph are—

(A) women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy),

(B) infants under one year of age, and

[(C) at the option of the State, children born after September 30, 1983, who have attained one year of age but have not attained 2, 3, 4, 5, 6, 7, or 8 years of age (as selected by the State),]

(C) children born after September 30, 1983, who have attained one year of age but have not attained 18 years of age,

who are not described in any of subclauses (I) through (III) of subsection (a)(10)(A)(i) and whose family income does not exceed the

income level established by the State under paragraph (2) for a family size equal to the size of the family, including the woman, infant, or child.

(2)(A)(i) For purposes of paragraph (1) with respect to individuals described in subparagraph (A) or (B) of that paragraph, the State shall establish an income level which is a percentage (not less than the percentage provided under clause (ii) and not more than 185 percent) of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

(ii) The percentage provided under this clause, with respect to eligibility for medical assistance on or after—

(I) July 1, 1989, is 75 percent, or, if greater, the percentage provided under clause (iii), [and

[(II) July 1, 1990, is 100 percent.]

(II) April 1, 1990, 130 percent, or, if greater, the percentage provided under clause (iv),

(III) July 1, 1992, 150 percent, or, if greater, the percentage provided under clause (iv), and

(IV) July 1, 1993, 185 percent.

* * * * * * *

(iv) In the case of a State which, as of the date of the enactment of this clause, has established under clause (i), or has enacted legislation authorizing, or appropriating funds, to provide for, a percentage (of the income official poverty line) that is greater than 130 percent, the percentage provided under clause (ii) for medical assistance on or after April 1, 1990, shall not be less than—

(I) the percentage specified by the State in an amendment to its State plan (whether approved or not) as of the date of the enactment of this clause, or

(II) if no such percentage is specified as of the date of the enactment of this clause, the percentage established under the State's authorizing legislation or provided for under the State's appropriations.

[(B) If a State elects, under subsection (a)(10)(A)(ii)(IX), to cover individuals not described in subparagraph (A) or (B) of paragraph (1), for purposes of that paragraph and with respect to individuals not described in such subparagraphs the State shall estabish an income level which is a percentage (not more than 100 percent, or, if less, the percentage established under subparagraph (A)) of the income official poverty line described in subparagraph (A).]

(B) For purposes of paragraph (1) with respect to individuals described in subparagraph (C) of that paragraph, the State shall establish an income level which is equal to the minimum percentage provided under subclause (I) or (II) of subparagraph (A)(ii) of the income official poverty line described in subparagraph (A) applicable to a family of the size involved.

(3) Notwithstanding subsection (a)(17), for individuals who are eligible for medical assistance because of subsection (a)(10)(A)(i)(IV), *(a)(10)(A)(i)(VI),* or (a)(10(A)(ii)(IX)—

[(A) application of a resource standard shall be at the option of the State;]

(A)(i) no resource standard or methodology shall be applied to individuals who are eligible for medical assistance because of subsection (a)(10)(A)(i)(IV) or (VI), and (ii) application of a resource standard or methodology for individuals who are eligible for medical assistance because of subsection (a)(10)(A)(ii)(IX) shall be at the option of the State, but any such resource standard or methodology may not be more restrictive than the corresponding standards or methodology that is applied under the State plan under part A of title IV;

[(B) any resource standard or methodology that is applied with respect to an individual described in subparagraph (A) of paragraph (1) may not be more restrictive than the resource standard or methodology that is applied under title XVI;

[(C) any resource standard or methodology that is applied with respect to an individual described in subparagraph (B) or (C) of paragraph (1) may not be more restrictive than the corresponding methodology that is applied under the State plan under part A of title IV;]

[(D) *(B)* the income standard to be applied is the appropriate income standard established under paragraph (2); and

[(E)] *(E)(i) with respect to an individual described in subparagraph (A) or (B) of paragraph (1), family income shall be determined in accordance with a methodology which is no more restrictive than the methodology employed under the State plan under part A or E of title IV (except to the extent such methodology is inconsistent with clause (D) of subsection (a)(17) and except that there shall be disregarded costs for such child care as is necessary for the employment of the pregnant woman or the caretaker of the infant), and costs incurred for medical care or for any other type of remedial care shall not be taken into account, and*

(ii) with respect to an individual described in paragraph (1)(C), family income shall be determined in accordance with [the methodology employed] *a methodology which is no more restrictive than the methodology employed* under the State plan under part A or E of title IV (except to the extent such methodology is inconsistent with clause (D) of subsection (a)(17) *and except that there shall be disregarded costs for such child care as is necessary for the employment of the pregnant woman or the caretaker relative of the child),* and costs incurred for medical care or for any other type of remedial care shall not be taken into account.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17), require or permit such treatment for other individuals.

(4)(A) In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the Secretary shall require the State to provide medical assistance for pregnant women and infants under age 1 described in subsection (a)(10)(A)(i)(IV) *and for children described in subsection (a)(10)(A)(i)(VI)* in the same manner as the State would be required to provide such assistance for such individuals if the State had in effect a plan approved under this title.

(B) In the case of a State which is not one of the 50 States or the District of Columbia, the State need not meet the requirement of subsection (a)(10)(A)(i)(IV) *or (a)(10)(A)(i)(VI)* and, for purposes of paragraph (2)(A), the State may substitute for the percentage provided under clause (ii) of such paragraph any percentage.

* * * * * * *

(r)(1) * * *

(2)(A) The methodology to be employed in determining income and resource eligibility for individuals under subsection (a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), *(a)(10)(A)(i)(VI),* (a)(10)(A)(ii), (a)(10)(C)(i)(III), or (f) or under section 1905(p) may be less restrictive, and shall be no more restrictive, than the methodology—

* * * * * * *

(s)(1) Individuals described in this paragraph are individuals for whom a public agency assumes full or partial financial responsibility—

(A) who have not attained the age of 18,

(B) who reside in a foster home, group home, or private institution, and

(C) whose incomes do not exceed 100 percent of the income official poverty line (as defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of one.

(2) Notwithstanding subsection (a)(17), for individuals who are eligible for medical assistance because of subsection (a)(10)(A)(ii)(XII)—

(A) no resource standard or methodology shall be applied,

(B) the income standard to be applied is the income standard described in paragraph (1)(C), and

(C) income for these individuals shall be determined in accordance with a methodology which is no more restrictive than the methodology employed under the State plan under part E of title IV.

(t)(1)(A) Subject to subparagraphs (B) and (C), financial participation described in subsection (a)(2) may include the application of private funds donated by hospitals to, and subject to the unrestricted control of, the State.

(B) Financial participation may not include—

(i) donations to the extent their aggregate amount exceeds in any Federal fiscal year 10 percent of the non-Federal portion of expenditures under the plan in the year, or

(ii) donations made by, or on behalf of, or with respect to, any particular hospital, to the extent that their aggregate amount in an annual cost reporting period exceeds 10 percent of the gross revenues of the hospital (not taking into account any Federal revenues under this title or under title V or title XVIII).

(C) For purposes of this paragraph, the fact that a hospital may receive some benefit from a transfer of funds to a State shall not prevent the transfer from being treated as the donation of funds, unless the amount of benefit to the hospital is directly related, in timing and amount, to the timing and amount of the transfer.

(2) Nothing in this title (including sections 1903(a) and 1905(a)) shall be construed as authorizing the Secretary to deny or limit payments to a State for expenditures, for medical assistance for items or services, attributable to taxes (whether or not of general applicability) imposed with respect to the provision of such items or services.

PAYMENT TO STATES

SEC. 1903. (a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966—

(1) * * *

(2)(A) an amount equal to 75 per centum of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to compensation or training of skilled professional medical personnel, and staff directly supporting such personnel, of the State agency or any other public agency *and are not attributable to community care for functionally disabled elderly individuals;* plus

(B) notwithstanding paragraph (1) or subparagraph (A), with respect to amounts expended for nursing aide training and competency evaluation programs, and competency evaluation programs, described in section 1919(e)(1) *(including the costs for nurse aides to complete such competency evaluation programs),* regardless of whether the programs are provided in or outside nursing facilities or of the skill of the personnel involved in such programs, an amount equal to 50 percent *(or, for calendar quarters beginning on or after July 1, 1988, and before July 1, 1990, the lesser of 90 percent or the Federal medical assistance percentage plus 25 percentage points* of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to such programs; plus

* * * * * *

(7) subject to section 1919(g)(3)(B) *and section 1927(g)(4),* an amount equal to 50 per centum of the remainder of the amounts expended during such quarter as found necessary by the Secretary for the proper and efficent administration of the State plan.

Payment shall be made available under paragraph (7) for amounts expended for reasonable administrative expenses of a State agency described in section 1902(a)(5)(B) in carrying out activities described in that section in the same manner as they are available for similar reasonable administrative expenses of the single State agency described in section 1902(a)(5).

(b)(1) * * *

* * * * * * *

(4) Federal reimbursement is available under subsection (a)(7) for reasonable expenses associated with training and retraining pro-

grams for habilitation facility employees pursuant to section 1928(j)(1)(E).

(f)(1) * * *

* * * * * * *

(4) The limitations on payment imposed by the preceding provisions of this subsection [shall not apply with respect to any amount expended by a State as medical assistance for any individual described in section 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(ii)(IX), 1902(a)(10)(A)(ii)(X), or 1905(p)(1) or for any individual—

(A) who is receiving aid or assistance under any plan of the State approved under title I, X, XIV or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, or

(B) who is not receiving such aid or assistance, and with respect to whom such benefits are not being paid, but (i) is eligible to receive such aid or assistance, or to have such benefits paid with respect to him, or (ii) would be eligible to receive such aid or assistance, or to have such benefits paid with respect to him if he were not in a medical institution, or

(C) with respect to whom there is being paid, or who is eligible, or would be eligible if he were not in a medical institution, to have paid with respect to him, a State supplementary payment and is eligible for medical assistance equal in amount, duration and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A), but only if the income of such individual (as determined under section 1612, but without regard to subsection (b) thereof) does not exceed 300 percent of the supplemental security income benefit rate established by section 1611(b)(1),

at the time of the provision of the medical assistance giving rise to such expenditure.] *shall only apply with respect to any amount expended by a State as medical assistance for an individual who is only eligible for such assistance as an individual described in section 1902(a)(10)(C) at the time of the provision of the medical assistance giving rise to such expenditure.*

(g)(1) Subject to paragraph (3), with respect to amounts paid for the following services furnished under the State plan after June 30, 1973 (other than services furnished pursuant to a contract with a health maintenance organization as defined in section 1876 or which is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act)), the Federal medical assistance percentage shall be decreased as follows: After an individual has received inpatient hospital services [or services in an intermediate care facility for the mentally retarded] for 60 days or inpatient mental hospital services for 90 days (whether or not such days are consecutive), during any fiscal year, the Federal medical assistance percentage with respect to amounts paid for any such care furnished thereafter to such individual shall be decreased by a per centum thereof (determined under paragraph (5)) unless the State agency responsible for the administration of the plan makes a showing satisfactory to the Secretary that, with respect to each calendar quarter for which the State submits a request for payment at the full Federal medical assistance percentage for amounts

paid for inpatient hospital serivces [of services in an intermediate care facility for the mentally retarded] furnished beyond 60 days (or inpatient mental hospital services furnished beyond 90 days), such State has an effective program of medical review of the care of patients in mental hospitals [and intermediate care facilities for the mentally retarded] pursuant to *paragraphs (26) and (31) paragrah (26)* of section 1902(a) whereby the professional management of each case is reviewed and evaluated at least annually by independent professional review teams. In determining the number of days on which an individual has received services described in this subsection, there shall not be counted any days with respect to which such individual is entitled to have payments made (in whole or in part) on his behalf under section 1812.

* * * * * * *

(4)(A) The Secretary may not find the showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory if the showing is submitted to the Secretary later than the 30th day after the last day of the calendar quarter, unless the State demonstrates to the satisfaction of the Secretary good cause for not meeting such deadline.

(B) The Secretary shall find a showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory under such paragraph with respect to the requirement that the State conduct annual onsite inspections in mental hospitals [and intermediate care facilities for the mentally retarded] under [paragraphs (26) and (31)] *paragraph 26* of section 1902(a), if the showing demonstrates that the State has conducted such an onsite inspection during the 12-month period ending on the last date of the calendar quarter—

(i) in each of not less than 98 per centum of the number of such hospitals [and facilities] requiring such inspection, and

(ii) in every such hospital [or facility] which has 200 or more beds,

and that, with respect to such hospitals [and facilities] not inspected within such period, the State has exercised good faith and due diligence in attempting to conduct such inspection, or if the State demonstrates to the satisfaction of the Secretary that it would have made such a showing but for failings of a technical nature only.

(5) In the case of a State's unsatisfactory or invalid showing made with respect to a type of [facility or institutional] *inpatient hospital* services in a calendar quarter, the per centum amount of the reduction of the State's Federal medical assistance percentage for that type of services under paragraph (1) is equal to 33⅓ per centum multiplied by a fraction, the denominator of which is equal to the total number of patients receiving that type of services in that quarter under the State plan in [facilities or institutions] *hospitals* for which a showing was required to be made under this subsection, and the numerator of which is equal to the number of such patients receiving such type of services in that quarter in those [facilities or institutions] *hospitals* for which a satisfactory and valid showing was not made for that calendar quarter.

(6)(A) Recertifications required under section 1902(a)(44) shall be conducted at least every 60 days in the case of inpatient hospital services.

[(B) Such recertifications in the case of services in an intermediate care facility for the mentally retarded shall be conducted at least—

[(i) 60 days after the date of the initial certification,

[(ii) 180 days after the date of the initial certification,

[(iii) 12 months after the date of the initial certification,

[(iv) 18 months after the date of the initial certification,

[(v) 24 months after the date of the initial certification, and

[(vi) every 12 months thereafter.

[(C)] *(B)* For purposes of determining compliance with the schedule established by this paragraph, a recertification shall be considered to have been done on a timely basis if it was performed not later than 10 days after the date the recertification was otherwise required and the State establishes good cause why the physician or other person making such recertification did not meet such schedule.

(h)(1) As a condition for the receipt of payment under subsection (a) with respect to medical assistance provided by a State for community habilitation and supportive services (other than under a waiver under section 1915(c)), the State shall report to the Secretary, with respect to each Federal fiscal year (beginning with fiscal year 1989) and in a format developed or approved by the Secretary, the amount of non-Federal funds obligated by the State (including funds obligated by localities in the State) with respect to the provision of such services (other than under such a waiver) for individuals with mental retardation or a related condition in that fiscal year.

(2) In applying subsection (a)(1) with respect to the total amount expended by a State for calendar quarters in a fiscal year (beginning with fiscal year 1990) for community habilitation and supportive services for individuals with mental retardation or a related condition (other than under a waiver under section 1915(c)), such expenditures shall be reduced by the amount reported under paragraph (1) with respect to fiscal year 1989.

(i) Payment under the preceding provisions of this section shall not be made—

(1) * * *

(2) with respect to any amount expended for an item or service (other than an emergency item or service *,not including items or services furnished in an emergency room of a hospital)* furnished—

(A) under the plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, or XX or under this title pursuant to section 1128, 1128A, 1156, or 1842(j)(2), or

(B) at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX or under this title pursuant to section 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew or had reason to know of the exclusion (after

a reasonable time period after reasonable notice has been furnished to the person).

* * * * * * *

(8) with respect to any amount expended for medical assistance *(A)* for nursing facility services to reimburse (or otherwise compensate) a nursing facility for payment of a civil money penalty imposed under section 1919(h) *,(B) for community habilitation and supportive services or habilitation facility services to reimburse (or otherwise compensate) a provider of such services or habilitation facility for payment of a civil money penalty imposed under this title or title XI, or (C) for community care to reimburse (or otherwise compensate) a provider of such care for payment of a civil money penalty imposed under this title or title XI or for legal expenses in defense of an exclusion or civil money penalty under this title or title XI if there is no reasonable legal ground for the provider's case;* [*or*]

(9) with respect to any amount of medical assistance for pregnant women and children described in section 1902(a)(10)(A)(ii)(IX), if the State has in effect, under its plan established under part A of title IV, payment levels that are less than the payment levels in effect under such plan on July 1, 1987[*.*]*; or*

(10) for community care under sections 1905(a)(21) and 1929—

(A) which does not meet the applicable requirements published or developed under section 1929(j),

(B) which is furnished in a community care setting—

(i) if a survey under section 1929(h)(3)(A) indicates that such setting is substandard,

(ii) on or after January 1, 1992, with respect to which State has not applied the protocols and methods developed under section 1929(j)(2)(B), or

(iii) that does not meet the applicable requirements of paragraphs (2) and (3) of section 1929(g),

(C) which is provided to a functionally disabled elderly individual by members of the family of such individual, or

(D) to the extent payment is made for such care other than under this title.

Nothing in paragraph (1) shall be construed as permitting a State to provide services under its plan under this title that are not reasonable in amount, duration, and scope to achieve their purpose. *Clauses (i) and (iii) of paragraph (10)(B) shall not apply once, and only once, in the case of a setting found to be substandard or not to meet applicable requirements if the setting is changed within 3 months of the findings to no longer be substandard and to meet applicable requirements.*

* * * * * * *

(m)(1) * * *

(2)(A) Except as provided in subparagraphs (B), (C), and (G), no payment shall be made under this title to a State with respect to expenditures incurred by it for payment (determined under a prepaid capitation basis or under any other risk basis) for services provided by any entity (including a health insuring organization)

which is responsible for the provision (directly or through arrangements with providers of services) of inpatient hospital services and any other service described in paragraph (2), (3), (4), (5), or (7) of section 1905(a) or for the provision of any three or more of the services described in such paragraphs unless—

(i) the Secretary [(or the State as authorized by paragraph (3))] has determined that the entity is a health maintenance organization as defined in paragraph (1);

* * * * * * *

(D) In the case of a health maintenance organization that is a public entity, the Secretary may modify or waive the requirement described in subparagraph (A)(ii) but only if the Secretary determines that [(i) special circumstances warrant such modification or waiver, and (ii)] The organization has taken and is taking reasonable efforts to enroll individuals who are not entitled to benefits under the State plan approved under this title or under title XVIII.

* * * * * * *

(F) In the case of—

(i) a contract with an entity described in subparagraph (E) or [(G) or] *(G),* with a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) which meets the requirement of subparagraph (A)(ii), *or with an eligible organization with a contract under section 1876 which meets the requirement of subparagraph (A)(ii),* or

* * * * * * *

(ii) a program pursuant to an undertaking described in paragraph (6) in which at least 25 percent of the membership enrolled on a prepaid basis are individuals who (I) are not insured for benefits under part B of title XVIII or eligible for benefits under this title, and (II) (in the case of such individuals whose prepayments are made in whole or in part by any government entity) had the opportunity at the time of enrollment in the program to elect other coverage of health care costs that would have been paid in whole or in part by any government entity,

a State plan may restrict the period in which requests for termination of enrollment without cause under subparagraph (A)(vi)(I) are permitted to the first month of each period of enrollment, each such period of enrollment not to exceed six months in duration, but only if the State provides notification, at least twice per year, to individuals enrolled with such entity or organization of the right to terminate such enrollment and the restriction on the exercise of this right. Such restriction shall not apply to requests for termination of enrollment for cause.

* * * * * * *

(H) In the case of an individual who—

(i) in a month is eligible for benefits under this title and enrolled with a health maintenance organization with a contract under this paragraph,

(ii) in the next month (or in the next 2 months) is not eligible for such benefits, but

(iii) in the succeeding month is again eligible for such benefits,

the State plan, subject to subparagraph (A)(vi), may enroll the individual for that succeeding month with the health maintenance organization described in clause (i) if the organization continues to have a contract under this paragraph with the State.

[(3) A State may, in the case of an entity which has submitted an application to the Secretary for determination that it is a health maintenance organization within the meaning of paragraph (1) and for which no such determination has been made within 90 days of the submission of the application, make a provisional determination for the purposes of this title that such entity is such a health maintenance organization. Such provisional determination shall remain in force until such time as the Secretary makes a determination regarding the entity's qualification under paragraph (1).]

* * * * * * *

(u)(1)(A) * * *

* * * * * * *

(D)(i) * * *

* * * * * * *

(vi) In determining the amount of erroneous excess payments for quarters beginning on or after July 1, 1990, there shall not be included any erroneous payments which are attributable to individuals described in section 1902(e)(11) who are determined to be no longer eligible for assistance but whose assistance has not been discontinued because a determination on other bases for such assistance has not been made.

* * * * * * *

DEFINITIONS

SEC. 1905. For purposes of this title—

(a) The term "medical assistance" means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance or, in the case of medicare cost-sharing with respect to a qualified medicare beneficiary described in subsection (p)(1), if provided after the month in which the individual becomes such a beneficiary) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A)) not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom supplemental security income benefits are not being paid under title XVI, who are—

(i) * * *

* * * * * * *

but whose income and resources are insufficient to meet all of such cost—

(1) inpatient hospital services (other than services in an institution for mental diseases);

(2)(A) outpatient hospital services, [and] (B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (1)) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (1)) and which are otherwise included in the plan, *and (C) ambulatory services offered by a health center receiving funds under section 329, 330, or 340 of the Public Health Service Act to a pregnant woman or individual under 18 years of age*;

* * * * * * *

(4)(A) nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older; [(B) effective July 1, 1969, such early and periodic screening and diagnosis of individuals who are eligible under the plan and are under the age of 21 to ascertain their physical or mental defects, and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby, as may be provided in regulations of the Secretary; and] *(B) early and periodic screening, diagnostic, and treatment services (as defined in subsection (r)) for individuals who are eligible under the plan and are under the age of 21; and* (C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies;

* * * * * * *

(13) other diagnostic, screening, preventive, and rehabilitative services, *including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;*

* * * * * * *

(15) services in an [intermediate care facility for the mentally retarded] *habilitation facility* (other than in an institution for mental diseases) [for individuals who are determined, in accordance with section 1902(a)(31)(A), to be in need of such care];

* * * * * * *

(20) respiratory care services (as defined in section 1902(e)(9)(C)); [and]

(21) prenatal home visitation services for high-risk pregnant women, postpartum home visitation services with respect to

high-risk infants unde 1 year of age, or both (as specified by the State), as precribed by a physician;

(22) community habilitation and supportive services (as defined in section 1927(a) and including at least the services described in paragraph (2) thereof) for individuals with mental retardation or a related condition (as defined in subsection (s)) without regard to whether or not individuals who receive such services have been discharged from a nursing facility or habilitation facility;

(23) community care (as defined in section 1929(a)) for functionally disabled elderly individuals;

(24) personal care services (as defined in section (u); and

[21] *(25)* any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary; except as otherwise provided in paragraph (16), such term does not include—

* * * * * * *

[(d) The term "intermediate care facility for the mentally retarded" means an institution (or distinct part thereof) for the mentally retarded or persons with related conditions if—

[(1) the primary purpose of such institution (or distinct part thereof) is to provide health or rehabilitative services for mentally retarded individuals and the institution meets such standards as may be prescribed by the Secretary;

[(2) the mentally retarded individual with respect to whom a request for payment is made under a plan approved under this title is receiving active treatment under such a program; and

[(3) in the case of a public institution, the State or political subdivision responsible for the operation of such institution has agreed that the non-Federal expenditures in any calendar quarter prior to January 1, 1975, with respect to services furnished to patients in such institution (or distinct part thereof) in the State will not, because of payments made under this title, be reduced below the average amount expended for such services in such institution in the four quarters immediately proceding the quarter in which the State in which such institution is located elected to make such services available under its plan approved under this title.]

(d) For definition of term "habilitation facility", see section 1928(a).

* * * * * * *

(h)(1) For purposes of paragraph (16) of subsection (a), the term "inpatient psychiatric hospital services for individuals under age 21" includes only—

(A) inpatient services which are provided in an institution (or distinct part thereof) which is a psychiatric hospital as defined in section 1861(f) *or in another inpatient setting that the Secretary has specified in regulations;*

* * * * * * *

(n) The term "qualified pregnant woman or child" means—

(1) a pregnant woman who—

(A) * * *

* * * * * * *

(2) a child who has not attained the [age of 7 (or any age designated by the State that exceeds 7 but does not exceed 8], *) age of 18* who was born after September 30, 1983 (or such earlier date as the State may designate), and who meets the income and resources requirements of the State plan under part A of title IV.

(o)(1)(A) Subject to subparagraph (B), the term "hospice care" means the care described in section 1861(dd)(1) furnished by a hospice program (as defined in section 1861(dd)(2)) to a terminally ill individual who has voluntarily elected (in accordance with paragraph (2)) to have payment made for hospice care instead of having payment made for certain benefits described in section 1812(d)(2)(A) *and for which payment may otherwise be made under title XVIII* and intermediate care facility services under the plan. For purposes of such election, hospice care may be provided to an individual while such individual is a resident of a skilled nursing facility or intermediate care facility, but the only payment made under the State plan shall be for the hospice care.

* * * * * * *

(3) In the case of [a State which elects not to provide medical assistance for hospice care, but provides medical assistance for skilled nursing or intermediate care facility services with respect to] an individual—

(A) who is residing in a skilled nursing or intermediate care facility and is receiving medical assistance for services in such facility under the plan,

(B) who is entitled to benefits under part A of title XVIII and has elected, under section 1812(d), to receive hospice care under such part, and

(C) with respect to whom the hospice program under such title and the skilled nursing or intermediate care facility have entered into a written agreement under which the program takes full responsibility for the professional management of the individual's hospice care and the facility agrees to provide room and board to the individual,

instead of any payment otherwise made under the plan with respect to the facility's services, the State shall provide for payment to the hospice program of an amount equal to [the amounts allocated under the plan for room and board in the facility, in accordance with the rates established under section 1902(a)(13),] *the additional amount described in section 1902(a)(13)(D)* and, if the individual is an individual described in section 1902(a)(10)(A), shall provide for payment of any coinsurance amounts imposed under section 1813(a)(4). [For purposes of this paragraph and section 1902(a)(13)(D), the term "room and board" includes performance of personal care services, including assistance in activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervising and assisting in the use of durable medical equipment and prescribed therapies.]

(p)(1) The term "qualified medicare beneficiary" means an individual—

(A) who is entitled to hospital insurance benefits under part A of title XVIII (including an individual entitled to such benefits pursuant to an enrollment under section 1818 , *but not including an individual entitled to such benefits only pursuant to an enrollment under section 1818A),*

* * * * * * *

(3) The term "medicare cost-sharing" means the following costs incurred with respect to a qualified medicare beneficiary *(or, with respect to a qualified disabled and working individual, only the premiums described in subparagraph (A)),* without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan.

(A) Premiums under title XVIII (including under part B and, if applicable, under [section 1818] *section 1818 or 1818A).*

(B) Coinsurance under title XVIII (including coinsurance described in section 1813).

(C) Subject to paragraph (4), deductibles established under title XVIII (including those described in section 1813, section 1833(b), and section 1834(c)(1)).

(D) The difference between the amount that is paid under section 1833(a) and the amount that would be paid under such section if any reference to "80 percent" therein were deemed a reference to "100 percent".

Such term also may include, at the option of a State, premiums for enrollment of a qualified medicare beneficiary with an eligible organization under section 1876.

* * * * * * *

(r) The term "early and periodic screening, diagnostic, and treatment services" means the following items and services:

(1) Screening services—

(A) which are provided—

(i) at intervals which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions; and

(B) which shall at a minimum include—

(i) a comprehensive health and developmental history (including assessment of both physical and mental health development),

(ii) a comprehensive unclothed physical exam,

(iii) appropriate immunizations according to age and health history,

(iv) laboratory tests (including lead blood level assessment appropriate for age and risk factors), and

(v) health education (including anticipatory guidance).

(2) Vision services—

(A) which are provided—

(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include diagnosis and treatment for defects in vision, including eyeglasses.

(3) Dental services—

(A) which are provided—

(i) at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.

(4) Hearing services—

(A) which are provided—

(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include diagnosis and treatment for defects in hearing, including hearing aids.

Nothing in this title shall be construed as limiting providers of early and periodic screening, diagnostic, and treatment services to providers who are qualified to provide all of the items and services described in the previous sentence or as preventing a provider that is qualified under the plan to furnish one or more (but not all) of such items or services from being qualified to provide such items and services as part of early and periodic screening, diagnostic, and treatment services.

(s) The term "individual with mental retardation or a related condition" means an individual with mental retardation or an individual who has a severe, chronic disability that—

(1) is attributable—

(A) to cerebral palsy or epilepsy,

(B) to any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with mental retardation, and requires treatment or services similar to those required for these individuals;

(2) is manifested before the individual reaches age 22;

(3) is likely to continue indefinitely; and

(4) results in substantial functional limitations in 3 or more of the following areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.

(t) The term "qualified disabled and working individual" means an individual—

(1) who is entitled to enroll for hospital insurance benefits under part A of title XVIII under section 1818A (as added by title X of the Omnibus Budget Reconciliation Act of 1989);

(2) whose income (as determined under section 1612 for purposes of the supplemental security income program) does not exceed 200 percent of the official poverty line (as defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconcilation Act of 1981) applicable to a family of the size involved; and

(3) who is not otherwise eligible for medical assistance under this title.

((t) Only for purposes of subsection (a)(24), the term "personal care services" means services—

(1) prescribed by a physician for an individual in accordance with a plan of treatment,

(2) provided by a person who is qualified to provide such services and who is not a member of the individual's family,

(3) supervised by a registered nurse, and

(4) furnished in a home or other location;

but does not include such services furnished to an inpatient or resident of a hospital or nursing facility.

* * * * * * *

STATE PROGRAMS FOR LICENSING OF ADMINISTRATORS OF NURSING HOMES

[SEC. 1908. (a) For purposes of section 1902(a)(29), a "State program for the licensing of administrators of nursing homes" is a program which provides that no nursing home within the State may operate except under the supervision of an administrator licensed in the manner provided in this section.

[(b) Licensing of nursing home administrators shall be carried out by the agency of the State responsible for licensing under the healing arts licensing act of the State, or, in the absence of such act or such an agency, a board representative of the professions and institutions concerned with care of chronically ill and infirm aged patients and established to carry out the purposes of this section.

[(c) It shall be the function and duty of such agency or board to—

[(1) develop, impose, and enforce standards which must be met by individuals in order to receive a license as a nursing home administrator, which standards shall be designed to insure that nursing home administrators will be individuals who are of good character and are otherwise suitable, and who, by training or experience in the field of institutional administration, are qualified to serve as nursing home administrators;

[(2) develop and apply appropriate techniques, including examinations and investigations, for determining whether an individual meets such standards;

[(3) issue licenses to individuals determined, after the application of such techniques, to meet such standards, and revoke or suspend licenses previously issued by the board in any case where the individual holding any such license is determined substantially to have failed to conform to the requirements of such standards;

[(4) establish and carry out procedures designed to insure that individuals licensed as nursing home administrators will, during any period that they serve as such, comply with the requirements of such standards;

[(5) receive, investigate, and take appropriate action with respect to, any charge or complaint filed with the board to the effect that any individual licensed as a nursing home administrator has failed to comply with the requirements of such standards; and

[(6) conduct a continuing study and investigation of nursing homes and administrators of nursing homes within the State with a view to the improvement of the standards imposed for the licensing of such administrators and of procedures and methods for the enforcement of such standards with respect to administrators of nursing homes who have been licensed as such.

[(d) No State shall be considered to have failed to comply with the provisions of section 1902(s)(29) because the agency or board of such State (established pursuant to subsection (b)) shall have granted any waiver, with respect to any individual who, during all of the three calendar years immediately preceding the calendar year in which the requirements prescribed in section 1902(a)(29) are first met by the State, has served as a nursing home administrator, of any of the standards developed, imposed, and enforced by such agency or board pursuant to subsection (c).

[(e) As used in this section, the term—

[(1) "nursing home" means any institution or facility defined as such for licensing purposes under State law, or, if State law does not employ the term nursing home, the equivalent term or terms as determined by the Secretary, but does not include a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts; and

[(2) "nursing home administrator" means any individual who is charged with the general administrator" means any individual who is charged with the general administration of a nursing home whether or not such individual has an ownership interest in such home and whether or not his functions and duties are shared with one or more other individuals.]

CERTIFICATION AND APPROVAL OF RURAL HEALTH CLINICS

SEC. 1910. [(a)(1)] *(a)* Whenever the Secretary certifies a facility in a State to be qualified as a rural health clinic under title XVIII, such facility shall be deemed to meet the standards

for certification as a rural health clinic for purposes of providing rural health clinic services under this title.

[(2)] *(b)* The Secretary shall notify the State agency administering the medical assistance plan of his approval or disapproval of any facility in that State which has applied for certification by him as a qualified rural health clinic.

[(b)(1) The Secretary may cancel approval of any skilled nursing or intermediate care facility at any time if he finds on the basis of a determination made by him as provided in section 1902(a)(33)(B) that a facility fails to meet the requirements contained in section 1902(a)(28) or section 1919 or section 1905(c), or if he finds grounds for termination of his agreement with the facility pursuant to section 1866(b). In that event the Secretary shall notify the State agency and the skilled nursing facility or intermediate care facility that approval of eligibility of the facility to participate in the programs established by this title and title XVIII shall be terminated at a time specified by the Secretary. The approval of eligibility of any such facility to participate in such programs may not be reinstated unless the Secretary finds that the reason for termination has been removed and there is reasonable assurance that it will not recur.

[(2) Any skilled nursing facility or intermediate care facility which is dissatisfied with a determination by the Secretary that it no longer qualifies as a skilled nursing facility or intermediate care facility for purposes of this title, shall be entitled to a hearing by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g). Any agreement between such facility and the State agency shall remain in effect until the period for filing a request for a hearing has expired or, if a request has been filed, until a decision has been made by the Secretary; except that the agreement shall not be extended if the Secretary makes a written determination, specifying the reasons therefore, that the continuation of provider status constitutes an immediate and serious threat to the health and safety of patients, and the Secretary certifies that the facility has been notified of its deficiencies and has failed to crrect them.]

* * * * * * *

ASSIGNMENT OF RIGHTS OF PAYMENT

SEC. 1912. (a) For the purpose of assisting in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance under the State plan approved under this title, a State plan for medical assistance shall—

(1) provide that, as a condition of eligiblity for medical assistance under the State plan to an individual who has the legal capacity to execute as assignment for himself, the individual is required—

(A) to assign the State any rights, of the individual or of any other person who is eligible for medical assistance under this title and on whose behalf the individual has the legal authority to execute an assignment of such rights, to support (specified as support for the purpose of medical

care by a court or administrative order) and to payment for medical care for any third party;

(B) to cooperate with the State (i) in establishing the paternity of such person (referred to in subparagraph (A)) if the person is a child born out of wedlock, and (ii) in obtaining support and payments (described in subparagraph (A)) for himself and for such person, unless (in either case) *the individual is described in section 1902(l)(1)(A) or* the individual is found to have good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the individuals involved; and

* * * * * * *

PROVISIONS RESPECTING INAPPLICABILITY AND WAIVER OF CERTAIN REQUIREMENTS OF THIS TITLE

SEC. 1915. (a) A State shall not be deemed to be out of compliance with the requirements of paragraphs (1), (10), or (23) of section 1902(a) solely by reason of the fact that the State (or any political subdivision thereof)—

(1) has entered into—

(A) a contract with an organization which has agreed to provide care and services in addition to those offered under the State plan to individuals eligible for medical assistance who reside in the geographic area served by such organization and who elect to obtain such care and services from such organization, or by reason of the fact that the plan provides for payment for rural health clinic services only if those services are provided by a rural health clinic; or

(B) arrangements through a competitive bidding process or otherwise for the purchase of laboratory services referred to in section 1905(a)(3) or medical devices if the Secretary has found that—

(i) adequate services or devices will be available under such arrangements, and

(ii) any such laboratory services will be provided only through laboratories—

(I) which meet the applicable requirements of section 1861(e)(9) or paragraphs [(14) and (15)] *(15) and (16)* of section 1861(s), and such additional requirements as the Secretary may require, and

* * * * * * *

(b) The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this title, may waive such requirements of section 1902 as may be necessary for a State—

(1) * * *

* * * * * * *

(4) to restrict the provider from (or through) whom an individual (eligible for medical assistance under this title) can

obtain services (other than in emergency circumstances) to providers or practitioners who undertake to provide such services and who meet, accept, and comply with the reimbursement, quality, and utilization standards under the State plan, which standards *shall be consistent with the requirements of section 1923 and* are consistent with access, quality, and efficient and economic provision of covered care and services, if such restriction does not discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing those services.

No waiver under this subsection may restrict the choice of the individual in receiving services under section 1905(a)(4)(C) *and if providers under such restriction are paid on a timely basis in the same manner as health care practitioners must be paid under section 1902(a)(37)(A).*

(c)(1) The Secretary may by waiver provide that a State plan approved under this title may include as "medical assistance" under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or [intermediate care facilities for the mentally retarded] *habilitation facilities,* the cost of which could be reimbursed under the State plan. *For purposes of this subsection, the term "room and board" shall not include the portion of costs of rent and food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of such caregiver, would require admission to a hospital, nursing facility, or intermediate care facility for the mentally retarded.*

(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—

(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;

(B) the State will provide, with respect to individuals who—

(i) are entitled to medical assistance for inpatient hospital services, nursing facility services, or [services in an intermediate care facilities for the mentally retarded] *habilitation facilities services* under the State plan,

(ii) may require such services, and

(iii) may be eligible for such home or community-based care under such waiver,

for an evaluation of the need for inpatient hospital services, nursing facility services, or [services in an intermediate care facilities for the mentally retarded] *habilitation facilities services*;

(C) such individuals who are determined to be likely to require the level of care provided in a hospital, nursing facility, or [intermediate care facilities for the mentally retarded] *habilitation facilities* are informed of the feasible alternatives, if available under the waiver, at the choice of such individuals, to the provision of in-

patient hospital services, nursing facility services, or services in an [intermediate care facility for the mentally retarded] *habilitation facilities;*

* * * * * * *

(4) A waiver granted under this subsection may, consistent with paragraph (2)—

(A) limit the individuals provided benefits under such waiver to individuals with respect to whom the State has determined that there is a reasonable expectation that the amount of medical assistance provided with respect to the individual under such waiver will not exceed the amount of such medical assistance provided for such individual if the waiver did not apply, and

(B) provide medical assistance to individuals (to the extent consistent with written plans of care, which are subject to the approval of the State) for case management services, homemaker/home health aide services and personal care services, adult day health services, [habilitation] *community habilitation and supportive* services, respite care, and such other services requested by the State as the Secretary may approve and for day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility: for individuals with chronic mental illness. *Except as provided under paragraph (2)(D), the Secretary may not restrict the number of hours or days of respite care in any period which a State may provide under a waiver under this subsection.*

[(5) For purposes of paragraph (4)(B), the term "habilitation services", with respect to individuals who receive such services after discharge from a nursing facility or intermediate care facility for the mentally retarded—

[(A) means services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings; and

[(B) includes (except as provided in subparagraph (C)) prevocational, educational, and supported employment services; but

[(C) does not include—

[(i) special education and related services (as defined in section 602(16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401(16), (17)) which otherwise are available to the individual through a local educational agency; and

[(ii) vocational rehabilitation services which otherwise are available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).]

* * * * * * *

(7)(A) In making estimates under paragraph (2)(D) in the case of a waiver that applies only to individuals with a particular illness or condition who are inpatients in, or who would require the level of care provided in, hospitals, nursing facilities, or [intermediate

care facilities for the mentally retarded] *habilitation facilities,* the State may determine the average per capita expenditure that would have been made in a fiscal year for those individuals under the State plan separately from the expenditures for other individuals who are inpatients in, or who would require the level of care provided in, those respective facilities.

(B) In making estimates under paragraph (2)(D) in the case of a waiver that applies only to individuals with developmental disabilities who are inpatients in a nursing facility and whom the State has determined, on the basis of an evaluation under paragraph (2)(B), to need the level of services provided by an [intermediate care facility for the mentally retarded] *habilitation facility,* the State may determine the average per capita expenditures that would have been made in a fiscal year for those individuals under the State plan on the basis of the average per capita expenditures under the State plan for services to individuals who are inpatients in an [intermediate care facility for the mentally retarded] *habilitation facility,* without regard to the availability of beds for such inpatients.

(C) In making estimates under paragraph (2)(D) in the case of a waiver to the extent that it applies to individuals with mental retardation or a related condition who are resident in an intermediate care facility for the mentally retarded the participation of which under the State plan is terminated, the State may determine the average per capita expenditures that would have been made in a fiscal year for those individuals without regard to any such termination.

* * * * * * *

(d)(1) Subject to paragraph (2), the Secretary shall grant a waiver to provide that a State plan approved under this title shall include as "medical assistance" under such plan payment for part or all of the cost of home or community-based services (other than room and board) which are provided pursuant to a written plan of care to individuals 65 years of age or older with respect to whom there has been a determination that but for the provision of such services the individuals would be likely to require the level of care provided in a skilled nursing facility or intermediate care facility the cost of which could be reimbursed under the State plan. *For purposes of this subsection, the term "room and board" shall not include the portion of costs of rent and food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of such caregiver, would require admission to a hospital, nursing facility, or intermediate care facility for the mentally retarded.*

* * * * * * *

USE OF ENROLLMENT FEES, PREMIUMS, DEDUCTIONS, COST SHARING, AND SIMILAR CHARGES

SEC. 1916. (a) The State plan shall provide that in the case of individuals described in subparagraph (A) or [(E)] *(E)(i)* of section 1902(a)(10) who are eligible under the plan—

(1) no enrollment fee, premium, or similar charge will be imposed under the plan (except for a premium imposed under subsection (c));

(2) no deduction, cost sharing or similar charge will be imposed under the plan with respect to—

(A) services furnished to individuals under 18 years of age (and, at the option of the State, individuals under 21, 20, or 19 years of age, or any reasonable category of individuals 18 years of age or over),

(B) services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy (or, at the option of the State, any services furnished to pregnant women),

(C) services furnished to any individual who is an inpatient in a hospital, nursing facility, [intermediate care facility for the mentally retarded] *habilitation facility,* or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs,

* * * * * * *

(b) The State plan shall provide that in the case of individuals other than those described in subparagraph (A) or (E) of section 1902(a)(10) who are eligible under the plan—

(1) there may be imposed an enrollment fee, premium, or similar charge, which (as determined in accordance with standards prescribed by the Secretary) is related to the individual's income,

(2) no deduction, cost sharing, or similar charge will be imposed under the plan with respect to—

(A) services furnished to individuals under 18 years of age (and, at the option of the State, individuals under 21, 20, or 19 years of age, or any reasonable category of individuals 18 years of age or over),

(B) services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy (or, at the option of the State, any services furnished to pregnant women),

(C) services furnished to any individual who is an inpatient in a hospital, nursing facility, [intermediate care facility for the mentally retarded] *habilitation facility,* or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs,

* * * * * * *

(d) With respect to a qualified disabled and working individual described in section 1905(t) whose income (as determined under

paragraph (3) of that section) exceeds 150 percent of the official poverty line referred to in that paragraph, the State plan of a State may provide for the charging of a premium (expressed as a percentage of the medicare cost-sharing described in section 1905(p)(3)(A) provided with respect to the individual) according to a sliding scale under which such percentage increases from 0 percent to 100 percent, in reasonable increments, as the individual's income increases from 150 percent of such poverty line to 200 percent of such poverty line.

[(d)] *(e)* The State plan shall require that no provider participating under the State plan may deny care or services to an individual eligible for such care or services under the plan on account of such individual's inability to pay a deduction, cost sharing, or similar charge. The requirements of this subsection shall not extinguish the liability of the individual to whom the care or services were furnished for payment of the deduction, cost sharing, or similar charge.

[(e)] *(f)* No deduction, cost sharing, or similar charge may be imposed under any waiver authority of the Secretary, except as provided in subsections (a)(3) and (b)(3), unless such waiver is for a demonstration project which the Secretary finds after public notice and opportunity for comment—

(1) will test a unique and previously untested use of copayments,

(2) is limited to a period of not more than two years,

(3) will provide benefits to recipients of medical assistance which can reasonably be expected to be equivalent to the risks to the recipients,

(4) is based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar recipients of medical assistance in the area, and

(5) is voluntary, or makes provision for assumption of liability for preventable damage to the health of recipients of medical assistance resulting from involuntary participation.

LIENS, ADJUSTMENTS AND RECOVERIES, AND TRANSFERS OF ASSETS

SEC. 1917. (a)(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except—

(A) pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual, or

(B) in the case of the real property of an individual—

(i) who is an inpatient in a nursing facility, [intermediate care facility for the mentally retarded] *habilitation facility,* or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs, and

* * * * * * *

(c)(1) In order to meet the requirements of this subsection (for purposes of section 1902(a)(51)(B)), the State plan must provide for a

period of ineligibility for nuring facility services and for a level of care in a medical institution equivalent to that of nursing facility services and for services under section 1915(c) in the case of an institutionalized individual (as defined in paragraph (3)) who, *or whose spouse,* at any time during or after the 30-month period immediately before the date the individual becomes an institutionalized individual (if the individual is entitled to medical assistance under the State plan on such date) or, if the individual is not so entitled, the date the individual applies for such assistance while an institutionalized indiviudal, disposed of resources for less than fair market value. The period of ineligibility shall begin with the month in which such resources were transferred and the number of months in such period shall be equal to the lesser of—

(A) 30 months, or

(B)(i) the total uncompensated vlaue of the resources so transferred, divided by (ii) the average costs, to a private patient at the time of the application, of nursing facility services in the State or, at State option, in the community in which the individual is institutionalized.

(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that—

(A) * * *

(B) the resources were transferred [(i) to (or to another for the sole benefit of) the community spouse, as defined in section 1924(h)(2)] (i) to or from (or to another for the sole benefit of) the individual's spouse, or (ii) to the individual's child described in subparagraph (A)(ii)(II) [, or (iii) to (or to another for the sole benefit of) the individual's spouse if such does not transfer such resources to another person other than the spouse for less than fair market value];

* * * * * * *

REQUIREMENTS FOR NURING FACILITES

SEC. 1919. (a) * * *

(b) REQUIREMENTS RELATING TO PROVISION OF SERVICES.—

(1) QUALITY OF LIFE.—

(A) IN GENERAL.—A nursing facility must care for its reidents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.

(B) QUALITY ASSESSMENT AND ASSURANCE.—A nursing facility must maintain a quality assessment and assurance committee, consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff, which (i) meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and (ii) develops and implements appropriate plans of action to correct identified quality deficiencies. *A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the*

compliance of such committee with the requirements of this subparagraph.

* * * * * * *

(3) RESIDENTS' ASSESSMENT.—
A * * *

* * * * * * *

(C) FREQUENCY.—
(i) IN GENERAL.—Such an assessment must be conducted—
(I) promptly upon (but no later than [4 days] *14 days* after the date of) admission for each individual admitted on or after October 1, 1990, and by not later than October 1, 1991, for each resident of the facility on that date;

* * * * * * *

(F) REQUIREMENTS RELATING TO PREADMISSION SCREENING FOR MENTALLY ILL AND MENTALLY RETARDED INDIVIDUALS.—[A nursing facility] *Except as provided in clauses (ii) and (iii) of subsection (e)(7)(A), a nursing facility* must not admit, on or after January 1, 1989, any new resident who—
(i) is mentally ill (as defined in subsection (e)(7)(G)(i)) unless the State mental health authority has determined (based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority) prior to admission that, because of the physical and mental condition of the individual, the individual requires the level of services provide by a nursing facility, and, if the individual requires such level of services, whether the individual requires [active treatment] *specialized services* for mental illness, or
(ii) is mentally retarded (as defined in subsection (e)(7)(G)(ii)) unless the State mental retardation or developmental disability authority has determined prior to admission that, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility, and, if the individual requires such level of services, whether the individual requires [active treatment] *specialized services* for mental retardation. *A State mental health authority and a State mental retardation or developmental disability authority may not delegate (by subcontract or otherwise) their responsibilities under this subparagraph to a nursing facility (or to an entity that has a direct or indirect affiliation or relationship with such a facility).*

(4) PROVISION OF SERVICES AND ACTIVITIES.—
(A) IN GENERAL.—To the extent needed to fulfill all plans of care described in paragraph (2), a nursing facility must provide (or arrange for the provision of)—

(i) * * *

* * * * * * *

(v) an on-going program, directed by a qualified professional, of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident; [and]

(vi) routine dental services (to the extent covered under the State plan) and emergency dental services to meet the needs of each resident.*; and*

(vii) treatment and services required by mentally ill and mentally retarded residents not otherwise provided or arranged for (or required to be provided or arranged for) by the State.

(5) REQUIRED TRAINING OF NURSE AIDES.—

(A) IN GENERAL.—A nursing facility must not use (on a full-time, temporary, per diem, or other basis) any individual as a nurse aide in the facility on or after [January 1, 1990, for more than 4 months] *October 1, 1990,* unless the individual—

(i) has completed a training and competency evaluation program, or a competency evaluation program, approved by the State under subsection (e)(1)(A), and

(ii) is competent to provide nursing or nursing-related services]*; except that such requirement shall not apply to an individual who has been used (on a full-time, temporary, per diem, or other basis) as a nurse aide for less than 90 days in any nursing facility.*

(B) OFFERING COMPETENCY EVALUATION PROGRAMS FOR CURRENT EMPLOYEES.—A nursing facility must provide for individuals used as a nurse aide by the facility as of [July 1, 1989] *January 1, 1990,* for a competency evaluation program approved by the State under subsection (e)(1) and such preparation as may be necessary for the individual to complete such a program by [January 1, 1990] *October 1, 1990.*

* * * * * * *

(6) PHYSICIAN SUPERVISION AND CLINICAL RECORDS.—A nursing facility must—

(A) require that the health care of every resident be provided under the supervision of a physician *(or, at the option of a State, under the supervision of a nurse practitioner or clinical nurse specialist who is not an employee of the facility but who is working in collaboration with a physician);*

* * * * * * *

(c) REQUIREMENTS RELATING TO RESIDENTS' RIGHTS.—

(1) GENERAL RIGHTS.—

(A) SPECIFIED RIGHTS.—A nursing facility must protect and promote the rights of each resident, including each of the following rights:

(i) * * *

(ii) FREE FROM RESTRAINTS.—The right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed—

(I) to ensure the physical safety of the resident or other residents, and

(II) only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances specified by the [Secretary)] *Secretary* until such an order could reasonably be [obtained] *obtained*).

* * * * * * *

(iv) CONFIDENTIALITY.—The right to confidentiality of personal and clinical records *and to access to current clincial records of the resident promptly upon request by the resident.*

(v) ACCOMMODATION OF NEEDS.—The right—

(I) to reside and receive services with reasonable [accommodations] *accommodation* of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered, and

* * * * * * *

(x) REFUSAL OF CERTAIN TRANSFERS.—The right to refuse a transfer to another room within the facility, if a purpose of the transfer is to relocate the resident from a portion of the facility that is not a skilled nursing facility (for purposes of title XVIII) to a portion of the facility that is such a skilled nursing facility.

[(x)] *(xi)* OTHER RIGHTS.—Any other right established by the Secretary.

Clause (iii) shall not be construed as requiring the provision of a private room. *A resident's exercise of a right to refuse transfer under clause (x) shall not affect the resident's eligibility or entitlement to medical assistance under this title or a State's entitlement to Federal medical assistance under this title with respect to services furnished to such a resident.*

(B) NOTICE OF RIGHTS.—A nursing facility must—

(i) * * *

(ii) make available to each resident, upon reasonable request, a written statement of such rights (which statement is updated upon changes in such rights) *including the notice (if any) of the State developed under subsection (e)(6);*

* * * * * * *

(7) LIMITATION ON CHARGES IN CASE OF MEDICAID-ELIGIBLE INDIVIDUALS.—

(A) IN GENERAL.—A nursing facility may not impose charges, for certain medicaid-eligible individuals for nursing facility services covered by the State under its plan under this title, that exceed the payment amounts established by the State for such services under this title.

(B) CERTAIN MEDICAID INDIVIDUALS DEFINED.—In subparagraph (A), the term "certain medicaid-eligible individual" means an individual who is entitled to medical assistance for nursing facility services in the facility under this title but with respect to whom such benefits are not being paid because, in determining the amount of the individual's income to be applied monthly to payment for the costs of such services, the amount of such income exceeds the payment amounts established by the State for such services under this title.

[(7)] *(8)* POSTING OF SURVEY RESULTS.—A nursing facility must post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility, conducted under subsection (g).

* * * * * * *

(e) STATE REQUIREMENTS RELATING TO NURSING FACILITY REQUIREMENTS.—As a condition of approval of its plan under this title, a State must provide for the following:

(1) * * *

* * * * * * *

(7) STATE REQUIREMENTS FOR PREADMISSION SCREENING AND RESIDENT REVIEW.—

(A) PREADMISSION SCREENING.—

(i) *IN GENERAL.*—Effective January 1, 1989, *except as provided in clause (iv),* the State must have in effect a preadmission screening program, for making determinations (using any criteria developed under subsection (f)(8)) described in subsection (b)(3)(F) for mentally ill and mentally retarded individuals (as defined in subparagraph (G)) who are admitted to nursing facilities on or after January 1, 1989. The failure of the Secretary to develop minimum criteria under subsection (f)(8) shall not relieve any State of its responsibility to have a preadmission screening program under this subparagraph or to perform resident reviews under subparagraph (B).

(ii) CLARIFICATION WITH RESPECT TO CERTAIN READMISSIONS.—The preadmission screening program under clause (i) need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.

(iii) EXCEPTION FOR CERTAIN HOSPITAL DISCHARGES.—The preadmission screening program under clause (i) shall not apply to the admission to a nursing facility of an individual—

(I) who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,

(II) who requires nursing facility services for the condition for which the individual received care in the hospital, and

(III) whose attending physician has certified, before admission to the facility, that the individual is likely to require less than 30 days of nursing facility services.

(iv) DELAY IN APPLICATION OF PREADMISSION SCREENING FOR PRIVATE PAY RESIDENTS.—In the case of an individual who, at the time of admission to a nursing facility, is not entitled to benefits under this title, the preadmission screening requirements of this subparagraph shall not apply until such time as the resident is so entitled and, in such case, the preadmission screening requirements shall apply as of the end of the day following the date on which the individual is determined to be so entitled. The previous sentence shall not be construed as prohibiting a State from imposing such a preadmission screening requirement with respect to individuals not so entitled at the time of admission.

(B) STATE REQUIREMENT FOR ANNUAL RESIDENT REVIEW.—

(i) FOR MENTALLY ILL RESIDENTS.—As of April 1, 1990, *except as provided in clause (iv),* in the case of each resident of a nursing facility who is mentally ill, the State mental health authority must review and determine (using any criteria developed under subsection (f)(8) and based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority)—

(I) whether or not the resident, because of the resident's physical and mental condition, requires the level of services provided by a nursing facility or requires the level of services of an inpatient psychiatric hospital for individuals under age 21 (as described in section 1905(h)) or of an institution for mental diseases providing medical assistance to individuals 65 years of age or older; and

(II) whether or not the resident requires [active treatment] *specialized services* for mental illness.

(ii) FOR MENTALLY RETARDED RESIDENTS.—As of April 1, 1990, *except as provided in clause (iv),* in the case of each resident of a nursing facility who is mentally retarded, the State mental retardation or developmental disability authority must review and determine (using any criteria developed under subsection (f)(8))—

(I) whether or not the resident, because of the resident's physical and mental condition, requires the level of services provided by a nursing facility or requires the level of services of an intermediate care facility described under section 1905(d); and

(II) whether or not the resident requires [active treatment] *specialized services* for mental retardation.

(iii) FREQUENCY OF REVIEWS.—

(I) ANNUAL.—Except as provided in subclauses (II) and (III), the reviews and determinations under clauses (i) and (ii) must be conducted with respect to each mentally ill or mentally retarded resident not less often than annually.

(II) PREADMISSION REVIEW CASES.—In the case of a resident subject to a preadmission review under subsection (b)(3)(F), the review and determination under clause (i) or (ii) need not be done until the resident has resided in the nursing facility for 1 year.

(III) INITIAL REVIEW.—The reviews and determinations under clauses (i) and (ii) must first be conducted (for each resident not subject to preadmission review under subsection (b)(3)(F)) by not later than April 1, 1990, *except as provided in clause (iv).*

(iv) DELAY IN APPLICATION OF ANNUAL RESIDENT REVIEW FOR PRIVATE PAY RESIDENTS.—In the case of an individual who, at the time of admission to a nursing facility, is not entitled to benefits under this title, the annual resident review requirements of this subparagraph shall not apply until such time as the resident is so entitled. The previous sentence shall not be construed as prohibiting a State from imposing such an annual resident review requirement with respect to individuals not so entitled at the time of admission.

(v) PROHIBITION OF DELEGATION.—A State mental health authority, a State mental retardation or developmental disability authority, and a State may not delegate (by subcontract or otherwise) their responsibilities under this subparagraph to a nursing facility (or to an entity that has a direct or indirect affiliation or relationship with such a facility).

(C) RESPONSE TO PREADMISSION SCREENING AND RESIDENT REVIEW.—As of April 1, 1990, the State must meet the following requirements:

(i) LONG-TERM RESIDENTS NOT REQUIRING NURSING FACILITY SERVICES, BUT REQUIRING [ACTIVE TREATMENT] *SPECIALIZED SERVICES.*—In the case of a resident who is determined, under subparagraph (B), not to require the level of services provided by a nursing facility, but to require [active treatment] *specialized services* for mental illness or mental retardation, and who has continuously resided in a nursing facility for at least 30 months before the date of the determination, the State must, in consultation with the resident's family or legal representative and care-givers—

(I) inform the resident of the institutional and noninstitutional alternatives covered under the State plan for the resident,

(II) offer the resident the choice of remaining in the facility or of receiving covered services in an alternative appropriate institutional or noninstitutional setting,

(III) clarify the effect on eligibility for services under the State plan if the resident chooses to leave the facility (including its effect on readmission to the facility), and

(IV) regardless of the resident's choice, provide for (or arrange for the provision of) such [active treatment] *specialized services* for the mental illness or mental retardation.

A State shall not be denied payment under this title for nursing facility services for a resident described in this clause because the resident does not require the level of services provided by such a facility, if the resident chooses to remain in such a facility.

(ii) OTHER RESIDENTS NOT REQUIRING NURSING FACILITY SERVICES, BUT REQUIRING [ACTIVE TREATMENT] *SPECIALIZED SERVICES.*—In the case of a resident who is determined, under subparagraph (B), not to require the level of services provided by a nursing facility, but to require [active treatment] *specialized services* for mental illness or mental retardation, and who has not continuously resided in a nursing facility for at least 30 months before the date of the determination, the State must, in consultation with the resident's family or legal representative and care-givers—

(I) arrange for the safe and orderly discharge of the resident from the facility, consistent with the requirements of subsection (c)(2),

(II) prepare and orient the resident for such discharge, and

(III) provide for (or arrange for the provision of) such [active treatment] *specialized services* for the mental illness or mental retardation.

(iii) RESIDENTS NOT REQUIRING NURSING FACILITY SERVICES AND NOT REQUIRING [ACTIVE TREATMENT] *SPECIALIZED SERVICES.*—In the case of a resident who is determined, under subparagraph (B), not to require the level of services provided by a nursing facility and not to require [active treatment] *specialized services* for mental illness or mental retardation, the State must—

(I) arrange for the safe and orderly discharge of the resident from the facility, consistent with the requirements of subsection (c)(2), and

(II) prepare and orient the resident for such discharge.

(iv) ANNUAL REPORT.—Each State shall report to the Secretary annually concerning the number of disposi-

tion of residents described in each of clauses (ii) and (iii).

(D) DENIAL OF PAYMENT [WHERE FAILURE TO CONDUCT PREADMISSION SCREENING].—

(i) FOR FAILURE TO CONDUCT PREADMISSION SCREENING OR ANNUAL REVIEW.—No payment may be made under section 1903(a) with respect to nursing facility services furnished to an individual for whom a determination is required under subsection (b)(3)(F) or subparagraph (B) but for whom the determination is not made.

(ii) FOR CERTAIN RESIDENTS NOT REQUIRING NURSING FACILITY LEVEL OR SERVICES.—No payment may be made under section 1903(a) with respect to nursing facility services furnished to an individual (other than an individual described in subparagraph (C)(i)) who does not require the level of services provided by a nursing facility.

(E) PERMITTING ALTERNATIVE DISPOSITION PLANS.—With respect to residents of a nursing facility who are mentally retarded or mentally ill and who are determined under subparagraph (B) not to require the level of services of such a facility, but who require [active treatment] *specialized services* for mental illness or mental retardation, a State and the nursing facility shall be considered to be in compliance with the [requirement of this paragraph] *requirements of subparagraphs (A) through (C) of this paragraph* if, before April 1, 1989, the State and the Secretary have entered into an agreement relating to the disposition of such residents of the facility and the State is in compliance with such agreement. Such an agreement may provide for the disposition of the residents after the date specified in subparagraph (C). *The State may revise such an agreement, subject to the approval of the Secretary, before October 1, 1990, but only if, under the revised agreement, all residents subject to the agreement who do not require the level of services of such a facility are discharged from the facility by not later than April 1, 1994.*

* * * * * * *

(G) DEFINITIONS.—In this paragraph and in subsection (b)(3)(F):

(i) An individual is considered to be "mentally ill" if the individual has a [primary or secondary diagnosis of mental disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition)] *serious mental illness (as defined by the Secretary)* and does not have a primary diagnosis of dementia (including Alzheimer's disease or a related disorder).

(ii) An individual is considered to be "mentally retarded" if the individual is [mentally retarded or a person with a related condition (as described in section 1905(d)).] *an individual with mental retardation or a related condition.*

(iii) The term [“active treatment”] *“specialized services”* has the meaning given such term by the Secretary in regulations, but does not include, in the case of a resident of a nursing facility, services within the scope of services which the facility must provide or arrange for its residents under subsection (b)(4).

(f) RESPONSIBILITIES OF SECRETARY RELATING TO NURSING FACILITY REQUIREMENTS.—

(1) * * *

(2) REQUIREMENTS FOR NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS AND FOR NURSE AIDE COMPETENCY EVALUATION PROGRAMS.—

(A) IN GENERAL.—For purposes of subsections (b)(5) and (e)(1)(A), the Secretary shall establish, by not later than September 1, 1988—

(i) requirements for the approval of nurse aide training and competency evaluation programs, including requirements relating to (I) the areas to be covered in such a program (including at least basic nursing skills, personal care skills, recognition of mental health and social service needs, *care of cognitively impaired residents,* basic restorative services, and residents' rights)[, content of the curriculum] *and content of the curriculum,* (II) minimum hours of initial and ongoing training and retraining (including not less than 75 hours in the case of initial training), (III) qualifications of instructors, and (IV) procedures for determination of competency;

(ii) requirements for the approval of nurse aide competency evaluation programs, including requirement relating to the areas to be covered in such a program, including at least basic nursing skills, personal care skills, [cognitive, behavioral and social care] *recognition of mental health and social service needs, care of cognitively impaired residents,* basic restorative services, and residents' rights, and procedures for determination of competency;

(iii) requirements respecting the minimum frequency and methodology to be used by a State in reviewing such programs' compliance with the requirements for such programs[.] *; and*

(iv) requirements, under both such programs, that—

(I) provide procedures for determining competency that permit a nurse aide, at the nurse aide's option, to establish competency through procedures or methods other than the passing of a written examination and to have the competency evaluation conducted at the nursing facility at which the aide is (or will be) employed (unless the facility is described in subparagraph (B)(iii)(I)), and

(II) prohibit the imposition on a nurse aide of any charges (including any charges for textbooks and other required course materials and any

charges for the competency evaluation) for either such program.

(B) APPROVAL OF CERTAIN PROGRAMS.—Such requirements—

(i) may permit approval of programs offered by or in facilities, as well as outside facilities (including employee organizations), and of programs in effect on the date of the enactment of this section;

(ii) shall permit a State to find that an individual who has completed (before [January 1, 1989] *July 1, 1989*) a nurse aide training and competency evaluation program shall be deemed to have completed such a program approved under subsection (b)(5) if the State determines that, at the time the program was offered, the program met the requirements for approval under such paragraph; and

(iii) shall prohibit approval of such a program—

(I) offered by or in a nursing facility which has been determined to be out of compliance with the requirements of subsection (b), (c), or (d), within the previous 2 years, or

(II) offered by or in a nursing facility unless the State makes the determination, upon an individual's completion of the program, that the individual is competent to provide nursing and nursing-related services in nursing facilities.

A State may not delegate *(through subcontract or otherwise)* its responsibility under clause (iii)(II) to the nursing facility.

* * * * * * *

(g) SURVEY AND CERTIFICATION PROCESS.—

(1) STATE AND FEDERAL RESPONSIBILITY.—

(A) * * *

* * * * * * *

(C) INVESTIGATION OF ALLEGATIONS OF RESIDENT NEGLECT AND ABUSE AND MISAPPROPRIATION OF RESIDENT PROPERTY.—The State shall provide, through the agency responsible for surveys and certification of nursing facilities under this subsection, for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility in providing services to such a resident. The State shall, after notice to the individual involved and a reasonable opportunity for a hearing for the individual to rebut allegations, make a finding as to the accuracy of the allegations. If the State finds that a nurse aide has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the nurse aide and the registry of such finding. If the State finds that any other individual used by the facility has neglected or abused a resident or misappropriated resident property in

a facility, the State shall notify the appropriate licensure authority. *A State shall not make a finding that an individual has neglected a resident if the individual demonstrates that such neglect was caused by factors beyond the control of the individual.*

* * * * * * *

(5) DISCLOSURE OF RESULTS OF INSPECTIONS AND ACTIVITIES.—

(A) PUBLIC INFORMATION.—Each State, and the Secretary, shall make available to the public—

(i) information respecting all surveys and certifications made respecting nursing facilities, including statements of deficiencies and plans of correction, *within 14 calendar days after such information is made available to those facilities,*

* * * * * * *

(h) ENFORCEMENT PROCESS.—

(1) * * *

* * * * * * *

(3) SECRETARIAL AUTHORITY.—

* * * * * * *

(D) CONTINUATION OF PAYMENTS PENDING REMEDIATION.—The Secretary may continue payments, over a period of not longer than 6 months *after the effective date of the findings*, under this title with respect to a nursing facility not in compliance with a requirement of subsection (b), (c), or (d), if—

(i) the State survey agency finds that it is more appropriate to take alternative action, to assure compliance of the facility with the requirements than to terminate the certification of the facility,

(ii) the State has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action, and

(iii) the State agrees to repay to the Federal Government payments received under this subparagraph if the corrective action is not taken in accordance with the approved plan and timetable.

The Secretary shall establish guidelines for approval of corrective actions requested by States under this subparagraph.

* * * * * * *

(8) CONSTRUCTION.—The remedies provided under this subsection are in addition to those otherwise available under State or Federal law and shall not be construed as limiting such other remedies, including any remedy available to an individual at common law. The remedies described in clauses (i), (iii), and (iv) of paragraph (2)(A) may be imposed during the pendency of any hearing. *The provisions of this subsection shall apply to a nursing facility (or portion thereof) notwithstanding that the fa-*

cility (or portion thereof) also is a skilled nursing facility for purposes of title, XVIII.

* * * * * * *

PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN

SEC. 1920. (a) * * *

(b) For purposes of this section—

(1) the term "presumptive eligibility period" means, with respect to a pregnant woman, the period that—

(A) begins with the date on which a qualified provider determines, on the basis of preliminary information, that the family income of the woman does not exceed the applicable income level of eligibility under the State plan, and

(B) ends with (and includes) the earlier of—

(i) the day on which a determination is made with respect to the eligibility of the woman for medical assistance under the State plan, *or*

[(ii) the day that is 45 days after the date on which the provider makes the determination referred to in subparagraph (A), or]

[(iii) in the case of a woman who does not file an application for medical assistance within 14 calendar days after the date on which the provider makes the determination referred to in subparagraph (A), the fourteenth calendar day after such determination is made; and] *(ii) in the case of a woman who does not file an application by the last day of the month following the month during which the provider makes the determination referred to in subparagraph (A), such last day; and*

* * * * * * *

(c)(1) The State agency shall provide qualified providers with—

(A) such forms as are necessary for a pregnant woman to make application for medical assistance under the State plan, and

(B) information on how to assist such women in completing and filing such forms.

(2) A qualified provider that determines under subsection (b)(1)(A) that a pregnant woman is presumptively eligible for medical assistance under a State plan shall—

(A) notify the State agency of the determination within 5 working days after the date on which determination is made, and

(B) inform the woman at the time the determination is made that she is required to make application for medical assistance under the State plan [within 14 calendar days after the date on which] *by not later than the last day of the month following the month during which* the determination is made.

(3) A pregnant woman who is determined by a qualified provider to be presumptively eligible for medical assistance under a State plan shall make application for medical assistance under such plan [within 14 calendar days after the date on which] *by not later*

than the last day of the month following the month during which the determination is made, *which application may be the application used for the receipt of medical assistance by individuals described in section 1902(l)(1)(A).*

CORRECTION AND REDUCTION PLANS FOR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

[SEC. 1922. (a) If the Secretary finds that an intermediate care facility for the mentally retarded has substantial deficiencies which do not pose an immediate threat to the health and safety of residents (including failure to provide active treatment) the State may elect, subject to the limitations in this section, to—

[(1) submit, within the number of days specified by the Secretary in regulations which apply to submission of compliance plans with respect to deficiencies of such type, a written plan of correction which details the extent of the facility's current compliance with the standards promulgated by the Secretary, including all deficiencies identified during a validation survey, and which provides for a timetable for completion of necessary steps to correct all staffing deficiencies within 6 months, and a timetable for rectifying all physical plant deficiencies within 6 months; or

[(2) submit, within a time period consisting of the number of days specified for submissions under paragraph (1) plus 35 days, a written plan for permanently reducing the number of certified beds, within a maximum of 36 months, in order to permit any noncomplying buildings (or distinct parts thereof) to be vacated and any staffing deficiencies to be corrected (hereinafter in this section referred to as a "reduction plan").

[(b) As conditions of approval of any reduction plan submitted pursuant to subsection (a)(2), the State must—

[(1) provide for a hearing to be held at the affected facility at least 35 days prior to submission of the reduction plan, with reasonable notice thereof to the staff and residents of the facility, responsible members of the residents' families, and the general public;

[(2) demonstrate that the State has successfully provided home and community services similar to the services proposed to be provided under the reduction plan for similar individuals eligible for medical assistance; and

[(3) provide assurances that the requirements of subsection (c) shall be met with respect to the reduction plan.

[(c) The reduction plan must—

[(1) identify the number and service needs of existing facility residents to be provided home or community services and the timetable for providing such services, in 6-month intervals, within the 36-month period;

[(2) describe the methods to be used to select such residents for home and community services and to develop the alternative home and community services to meet their needs effectively;

[(3) describe the necessary safeguards that will be applied to protect the health and welfare of the former residents of the

facility who are to receive home or community services, including adequate standards for consumer and provider participation and assurances that applicable State licensure and applicable State and Federal certification requirements will be met in providing such home or community services;

[(4) provide that residents of the affected facility who are eligible for medical assistance while in the facility shall, at their option, be placed in another setting (or another part of the affected facility) so as to retain their eligibility for medical assistance;

[(5) specify the actions which will be taken to protect the health and safety of, and to provide active treatment for, the residents who remain in the affected facility while the reduction plan is in effect;

[(6) provide that the ratio of qualified staff to residents at the affected facility (or the part thereof) which is subject to the reduction plan will be the higher of—

[(A) the ratio which the Secretary determines is necessary in order to assure the health and safety of the residents of such facility (or part thereof); or

[(B) the ratio which was in effect at the time that the finding of substantial deficiencies (referred to in subsection (a)) was made; and

[(7) provide for the protection of the interests of employees affected by actions under the reduction plan, including—

[(A) arrangements to preserve employee rights and benefits;

[(B) training and retraining of such employees where necessary;

[(C) redeployment of such employees to community settings under the reduction plan; and

[(D) making maximum efforts to guarantee the employment of such employees (but this requirement shall not be construed to guarantee the employment of any employee).

[(d)(1) The Secretary must provide for a period of not less than 30 days after the submission of a reduction plan by a State, during which comments on such reduction plan may be submitted to the Secretary, before the Secretary approves or disapproves such reduction plan.

[(2) If the Secretary approves more than 15 reduction plans under this section in any fiscal year, any reduction plans approved in addition to the first 15 such plans approved, must be for a facility (or part thereof) for which the costs of correcting the substantial deficiencies (referred to in subsection (a)) are $2,000,000 or greater (as demonstrated by the State to the satisfaction of the Secretary).

[(e)(1) If the Secretary, at the conclusion of the 6-month plan of correction described in subsection (a)(1), determines that the State has substantially failed to correct the deficiencies described in subsection (a), the Secretary may terminate the facility's provider agreement in accordance with the provisions of section 1910(b).

[(2) In the case of a reduction plan described in subsection (a)(2), if the Secretary determines, at the conclusion of the initial 6-month period or any 6-month interval thereafter, that the State has sub-

stantially failed to meet the requirements of subsection (c), the Secretary shall—

[(A) terminate the facility's provider agreement in accordance with the provisions of section 1910(b); or

[(B) if the State has failed to meet such requirements despite good faith efforts, disallow, for purposes of Federal financial participation, an amount equal to 5 percent of the cost of care for all eligible individuals in the facility for each month for which the State fails to meet such requirements.

[(f) The provisions of this section shall apply only to plans of correction and reduction plans approved by the Secretary by January 1, 1990.]

ADJUSTMENT IN PAYMENT FOR INPATIENT HOSPITAL SERVICES FURNISHED BY DISPROPORTATIONATE SHARE HOSPITALS

SEC. 1923. (a) IMPLEMENTATION OF REQUIREMENT.—

(1) * * *

(2)(A) * * *

* * * * * * *

(D) If a State plan under this title provides for payments for inpatient hospital services on a prospective basis (whether per diem, per case, or otherwise), in order for the plan to be considered to have met such requirement of section 1902(a)(13)(A) as of July 1, 1990, the State must submit to the Secretary by not later than April 1, 1990, a State plan amendment that provides, in the case of hospitals defined by the State as disproportionate share hospitals under paragraph (1)(A), for an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1990, involving exceptionally high costs or exceptionally long lengths of stay for individuals one year of age or older, but under 18 years of age.

* * * * * * *

(b) HOSPITALS DEEMED DISPROPORTIONATE SHARE.—

(1) * * *

(2) For purposes of paragraph (1)(A), the term "mediciad inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for the medical assistance under a State plan approved under this title in a period, and the denominator of which is the total number of the hospital's inpatient days in that period. *In this paragraph, the term "inpatient day" includes each days in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.*

* * * * * * *

(e) SPECIAL RULE.—(1) A State plan shall be considered to meet the requirement of section 1902(a)(13)(A) (insofar as it requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with

special needs) without regard to the requirement of subsection (a) if *(A)(i)* the plan provided for payment adjustments based on a pooling arrangement involving a majority of the hospitals participating under the plan for disproportionate share hospitals as of January 1, 1984, [and if] *or (ii) the plan as of January 1, 1987, provided for payment adjustments based on a statewide pooling arrangement involving all acute care hospitals and the arrangement provides for reimbursement of the total amount of uncompensated care provided by each participating hospital, and (B)* the aggregate amount of the payment of adjustments under the plan for such hospitals is not less than the aggregate amount of such adjustments otherwise required to be made under such subsection.

TREATMENT OF INCOME AND RESOURCES FOR CERTAIN INSTITUTIONALIZED SPOUSES

SEC. 1924. (a) * * *

* * * * * * *

(c) RULES FOR TREATMENT OF RESOURCES.—

(1) COMPUTATION OF SPOUSAL SHARE AT TIME OF INSTITUTIONALIZATION.—

(A) TOTAL JOINT RESOURCES.—There shall be computed (as of [the beginning of a continuous period of institutionalization of the institutionalized spouse] *the beginning of the first continuous period of institutionalization (beginning on or after September 30, 1989) of the institutionalized spouse*—

(i) the total value of the resources to the extent either the institutionalized spouse or the community spouse has an ownership interest, and

(ii) a spousal share which is equal to ½ of such total value.

(B) ASSESSMENT.—At the request of an institutionalized spouse or community spouse, at [the beginning of a continuous period of institutionalization of the institutionalized spouse *the beginning of the first continuous period of institutionalization (beginning on or after September 30, 1989) of the institutionalized spouse*—and upon the receipt of relevant documentation of resources, the State shall promptly assess and document the total value described in subparagraph (A)(i) and shall provide a copy of such assessment and documentation to each spouse and shall retain a copy of the assessment for use under this section. If the request is not part of an application for medical assistance under this title, the State may, at its option as a condition of providing the assessment, require payment of a fee not exceeding the reasonable expenses of providing and documenting the assessment. At the time of providing the copy of the assessment, the State shall include a notice indicating that the spouse will have a right to a fair hearing under subsection (e)(2).

* * * * * * *

EXTENSION OF ELIGIBILITY FOR MEDICAL ASSISTANCE

SEC. 1925. (a) INITIAL 6-MONTH EXTENSION.—
(1) * * *

* * * * * * *

(3) TERMINATION OF EXTENSION.—
(A) NO DEPENDENT CHILD.—Subject to subparagraphs (B) and (C), extension of assistance during the 6-month period described in paragraph (1) to a family shall terminate (during such period) at the close of the first month in which the family ceases to include a child [who is], *whether or not the child is* (or would if needy be) a dependent child under part A of title IV.

* * * * * * *

(C) CONTINUATION IN CERTAIN CASES UNTIL REDETERMINATION.—With respect to a child who would cease to receive medical assistance because of subparagraph (A) but who may be eligible for assistance under the State plan because the child is described in clause (i) [or (v) of section 1905(a)] *of section 1905(a) or clause (i)(IV), (i)(VI), or (ii)(IX) of section 1902(a)(10)(A),* the State may not discontinue such assistance under such subparagraph until the State has determined that the child is not eligible for assistance under the plan.

* * * * * * *

(b) ADDITIONAL [6-MONTH] EXTENSION.—
(1) REQUIREMENT.—Notwithstanding any other provision of this title, each State plan approved under this title shall provide that the State shall offer to each family, which has received assistance during the entire 6-month period under subsection (a) and which meets the requirement of paragraph (2)(B)(i), in the last month of the period the option of extending coverage under this subsection for [the succeeding 6-month period], *the succeeding period of 6 months (or, at the State option as specified by the State, of 9 months, 12 months, 15 months, or 18 months),* subject to paragraph (3).
(2) NOTICE AND REPORTING REQUIREMENTS.—
(A) NOTICES.—
(i) * * *
(ii) NOTICE DURING ADDITIONAL EXTENSION PERIOD OF REPORTING REQUIREMENTS AND PREMIUMS.—Each State, during the 3rd month *(and, if applicable, 6th, 9th, 12th, and 15th month)* of any additional extended assistance furnished to a family under this subsection, shall notify the family of the reporting requirement under subparagraph (B)(ii) and a statement of the amount of any premium required for such extended assistance for the succeeding 3 months.
(B) REPORTING REQUIREMENTS.—
(i) * * *
(ii) DURING ADDITIONAL EXTENSION PERIOD.—Each State shall require that a family receiving extended

assistance under this subsection report to the State, not later than the 21st day of the 1st month and of the 4th month *(and, if applicable, 7th, 10th, 13th, and 16th month)* in the period of additional extended assistance under this subsection, on the family's gross monthly earnings and on the family's costs for such child care as is necessary for the employment of the caretaker relative in each of the 3 preceding months.

(3) TERMINATION OF EXTENSION.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), extension of assistance during the [6-month] period described in paragraph (1) to a family shall terminate (during the period) as follows:

(i) NO DEPENDENT CHILD.—The extension shall terminate at the close of the first month in which the family ceases to include a child [who is], *whether or not the child is* (or would if needy be) a dependent child under part A of title IV.

* * * * * * *

(iii) QUARTERLY INCOME REPORTING AND TEST.—The extension under this subsection shall terminate at the close of the 1st or 4th month [of the 6-month period] *(or, if applicable, the 7th, 10th, 13th, or 16th month) of the period* if—

(I) the family fails to report to the State, by the 21st day of such month, the information required under paragraph (2)(B)(ii), unless the family has established, to the satisfaction of the State, good cause for the failure to report on a timely basis;

(C) CONTINUATION IN CERTAIN CASES UNTIL REDETERMINATION.—

(i) DEPENDENT CHILDREN.—With respect to a child who would cease to receive medical assistance because of subparagraph (A)(i) but who may be eligible for assistance under the State plan because the child is described in clause (i) [or (v) of section 1905(a)], *of section 1905(a) or clause (i)(IV), (VI), or (ii) (IX) of section 1902(a)(10)(A),* the State may not discontinue such assistance under such subparagraph until the State has determined that the child is not eligible for assistance under the plan.

* * * * * * *

(5) PREMIUM.—

(A) * * *

* * * * * * *

(D) DEFINITIONS.—In this paragraph:

(i) A "premium payment period" described in this clause is a 3-month period beginning with the 1st or 4th month [of the 6-month additional extension period] *(or, if applicable, the 7th, 10th, 13th, or 16th*

month) of the additional extension period provided under this subsection.

* * * * * * *

[(f) SUNSET.—This section shall not apply with respect to families that cease to be eligible for aid under part A of title IV after September 30, 1988.]

ASSURING ADEQUATE PAYMENT LEVELS FOR OBSTETRICAL AND PEDIATRIC SERVICES

SEC. 1926. (a)(1) A State plan under this title shall not be considered to meet the requirement of section 1902(a)(30)(A) with respect to obstetrical services (as defined in paragraph (4)(A)), as of July 1 of each year (beginning with 1990), unless, by not later than April 1 of such year, the State submits to the Secretary an amendment to the plan that specifies the payment rates to be used for such services under the plan in the succeeding period and includes in such submission such additional data as will assist the Secretary in evaluating the State's compliance with such requirement, including data relating to how rates established for payments to health maintenance organizations under section 1903(m) take into account such payment rates.

(2) A State plan under this title shall not be considered to meet the requirement of section 1902(a)(30)(A) with respect to pediatric services (as defined in paragraph (4)(B)), as of July 1 of each year (beginning with 1990), unless, by not later than April 1 of such year, the State submits to the Secretary an amendment to the plan that specifies, by pediatric procedure, the payment rates to be used for such services under the plan in the succeeding period and includes in such submission such additional data as will assist the Secretary in evaluating the State's compliance with such requirement, including data relating to how rates established for payments to health maintenance organizations under section 1903(m) take into account such payment rates.

(3) The Secretary, by not later than 90 days after the date of submission of a plan amendment under paragraph (1) or (2), shall—

(A) review each such amendment for compliance with the requirement of section 1902(a)(30)(A), and

(B) approve or disapprove each such amendment.

If the Secretary disapproves such an amendment, the State shall immediately submit a revised amendment which meets such requirement.

(4) In this section:

(A) The term "obstetrical services" means services relating to pregnancy covered under the State plan provided by an obstetrician, obstetrician-gynecologist, family practitioner, certified nurse midwife, or centered family nurse practitioner and does not include inpatient or outpatient hospital services or other institutional services.

(B) The term "pediatric services" means services covered under the State plan provided by a pediatrician, family practitioner, or certified pediatric nurse practitioner to children under 18 years of age and does not include inpatient or outpatient hospital services or other institutional services.

(b) For amendments submitted under subsection (a)(1) in 1992 and thereafter, the data submitted under such subsection must include, for the second previous year, at least the statewide average payment rates under the State plan for obstetrical services furnished by obstetricians, obstetrician-gynecologists, family practitioners, certified family nurse practitioners, and certified nurse midwives, by procedure. Such information shall be provided separately for providers located in each metropolitan statistical area (or similar area) in the State and in the remainder of the State.

(c) For amendments submitted under subsection (a)(2) in 1992 and thereafter, the data submitted under such subsection must include, for the second previous year, at least the statewide average payment rates under the State plan for pediatric services furnished by pediatricians, family practitioners, and certified pediatric nurse practitioners by procedure. Such information shall be provided separately for providers located in each metropolitan statistical area (or similar area) in the State and in the remainder of the State.

(d) Nothing in this title (including section 1902(a)(30)(A)) shall be construed as preventing a State from establishing payment levels for obstetrical or pediatric services that are higher for those services furnished in rural areas than those furnished in metropolitan statistical areas.

COMMUNITY HABILITATION AND SUPPORTIVE SERVICES

SEC. 1927. (a) COMMUNITY HABILITATION AND SUPPORTIVE SERVICES DEFINED.—In this title, the term "community habilitation and supportive services"—

(1) means services designed—

(A) to assist individuals in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to function successfully in a home or community-based setting, or

(B) to assist individuals in participating in community or other activities;

(2) includes (except as provided in paragraphs (4), (5), and (6))—

(A) case management services (furnished by entities that, in the case of nonpublic organizations, are not providers of other community habilitation and supportive services and do not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides other community habilitation and supportive services),

(B) respite care services, and

(C) personal attendant care;

(3) may, at a State's option, also include (except as provided in paragraphs (4), (5), and (6))—

(A) prevocational services,

(B) education services,

(C) supported employment services,

(D) day habilitation and related services,

(E) transportation,

(F) assistive technologies or devices used to increase, maintain, or improve functional capabilities of individuals with mental retardation or a related condition, and

(G) other supportive services, including services to assist an individual to achieve the objectives of independence, productivity, and integration into the community; but

(4) does not include—

(A) special education and related services (as defined in section 602 (16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401 (16), (17)) which otherwise are available to the individual through a local educational agency, and

(B) vocational rehabilitation services which otherwise are available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730);

(5) does not include room and board, consisting of non-personnel costs directly attributable to—

(A) the purchase of food on behalf of clients,

(B) the cost of property,

(C) the purchase of household supplies not otherwise employed in the provision of covered services,

(D) utility expenses, and

(E) costs of facility maintenance, upkeep, and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents or to meet the requirements of the applicable life safety code; and

(6) does not include payments made, directly or indirectly, to members of the family of the individual receiving such services.

(b) INDEPENDENCE, PRODUCTIVITY, AND INTEGRATION.—

(1) IN GENERAL.—The objectives of community habilitation and supportive services are to expand opportunities for independence, productivity, and integration into the community for individuals with mental retardation or a related condition.

(2) APPLICATION TO CERTAIN WAIVERS.—

(A) SECTION 1915(C).—The provisions of this section apply to community habilitation and supportive services provided under a waiver approved under section 1915(c), but such provisions do not apply to such a waiver in effect before July 1, 1990, until the date the next renewal of such a waiver takes effect or, if later, the end of the 30-day period beginning on the date the Secretary promulgates interim regulations described in subsection (j)(1).

(B) SECTION 1115.—In the case of any State which is providing medical assistance under a waiver granted under section 1115(a) with respect to community rehabilitation and supportive services, the Secretary shall require the State to meet the requirements of this section in the same manner as the State would be required to meet such requirements if the State had in effect a plan approved under this title.

(3) DEFINITIONS.—In this section and section 1928:

(A) INDEPENDENCE.—The term "independence" means the extent to which individuals with mental retardation or a related condition exert control and choice over their own lives.

(B) PRODUCTIVITY.—The term "productivity" means engagement by an individual with mental retardation or a related condition in income-producing work or work that contributes to a household or community.

(C) INTEGRATION INTO THE COMMUNITY.—The term "integration into the community" means, with respect to an individual with mental retardation or a related condition, the use of common facilities, participation in activities, and regular contact with other residents (who are not individuals with mental retardation or a related condition) of the community in which such individual resides.

(c) INDIVIDUAL HABILITATION PLANS.—

(1) REQUIREMENT.—Community habilitation and supportive services must be provided in accordance with an individual habilitation plan (in this section referred to as an "IHP") which states specific objectives necessary to meet some or all of the client's needs, as identified in the comprehensive functional assessment conducted under subsection (d). In addition, the IHP shall include a description of the medical care service needs of the client, as identified by the client's physician. Nothing in this paragraph shall be construed as requiring a State to make available medical assistance under this title for all types or elements of community habilitation and supportive services. If a State provides such medical assistance for some or all such types or elements and an IHP identifies such types or elements with respect to a client, the medical assistance shall be made available under this title for those types and elements for that client under the IHP.

(2) PREPARATION.—Each IHP for a client shall be prepared, before the date community habilitation and supportive services are first provided to the client under this title, by an appropriate interdisciplinary team and shall be periodically reviewed and revised by such a team after each assessment under subsection (d). In preparing an IHP the team shall provide the client, the client's parents (if the client is a minor), and the client's legal guardian (if any) with notice of the rights described in subsection (e)(2).

(3) REQUIRED PARTICIPATION IN DEVELOPMENT OF IHP.—In developing an IHP for a client, the team shall notify, and provide for and encourage the participation of, the client, the client's parents (if the client is a minor), and the client's legal guardian (if any) and the client's case manager.

(4) PERMISSIVE PARTICIPATION OF PARENTS OF ADULT CLIENTS.—A parent (if the client is not a minor) who is not a legal guardian of the client may participate in developing the IHP unless the client has objected to the parent's participation.

(5) AVAILABILITY.—A copy of each IHP must, consistent with the client's right to confidentiality described in subsection (e)(2)(D), be made accessible to all relevant providers, including other providers who work with the client, to the client's legal

guardian (if any), and, unless the client objects, to the client's parents.

(d) COMPREHENSIVE FUNCTIONAL ASSESSMENT.—

(1) REQUIREMENT.—The State must provide that each individual who receives community habilitation and supportive services under the State plan under this title must have had a comprehensive functional assessment and must have such an assessment periodically reviewed. Such an assessment and review must be conducted by an interdisciplinary team. Such an assessment and review must identify each client's developmental and behavioral abilities and management needs. In the case of a client with a seizure disorder, the assessment must include a determination, by a professional with expertise in the diagnosis and treatment of such disorders, of the classification of the disorder in accordance with the most recent version of the International Classification of Epileptic Seizures.

(2) FREQUENCY.—

(A) ASSESSMENTS.—Such an assessment must be conducted before the receipt of community habilitation and supportive services under this title.

(B) REVIEWS.—A review of each such assessment shall be performed in no case less often than once every 12 months.

(3) USE.—The results of such an assessment or review shall be used in developing, reviewing, and revising the client's IHP under subsection (c).

(e) MINIMUM REQUIREMENTS FOR SERVICES.—

(1) IN GENERAL.—Community habilitation and supportive services provided under this title must meet such requirements for the protection of health, safety, and welfare of clients, consistent with the objectives described in subsection (b), as are published or developed by the Secretary under subsection (j). Such requirements shall include—

(A) minimum qualifications for individuals providing such services,

(B) guidelines for such minimum compensation for personnel as will assure the availability and continuity of qualified personnel to provide such services for clients of various levels of impairment, and

(C) the requirement that a provider of community habilitation and supportive services must protect and promote the rights of each client, including the rights specified in paragraph (2).

(2) SPECIFIED RIGHTS.—The rights specified in this paragraph are as follows:

(A) FREE FROM ABUSE.—The right to be free from physical, verbal, sexual, or psychological abuse, corporal or psychological punishment, aversive stimuli, and involuntary seclusion. Nothing in the previous sentence shall be construed to prohibit the use of "time-out" rooms for periods of less than one hour, if the use of such a room is subject to review by the interdisciplinary team (described in subsection (c)(2)) to ensure the use of the least restrictive and most positive behavior management intervention and consistency with the objectives of the client's IHP.

(B) FREE FROM RESTRAINTS.—The right to be free from any physical restraints or medications imposed for purposes of discipline or convenience of the provider or as a substitute for active treatment and not required to treat the client's medical symptoms. Any such imposition of such physical restraints or medications must be subject to review by the interdisciplinary team (described in subsection (c)(2)) to ensure protection of this right and consistency with the objectives of the client's IHP.

(C) PRIVACY.—The right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and friends and of client groups.

(D) CONFIDENTIALITY.—The right to confidentiality of personal and clinical records.

(E) DIGNITY.—The right to be treated with dignity in a manner consistent with the client's chronological age.

(F) GRIEVANCES.—The right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal (or threat of discrimination or reprisal) for voicing the grievances and the right to prompt efforts by the provider to resolve grievances the client may have, including those with respect to the behavior of other clients.

(G) FREE CHOICE WITH RESPECT TO MEDICAL CARE AND TREATMENT.—The right to choose the provider of community habilitation and supportive services from which to receive such services, to be fully informed in advance about care and treatment, to be fully informed in advance of any changes in care or treatment that may affect the client's well-being, and to participate in planning care and treatment or changes in such care and treatment.

(H) USE OF PSYCHOPHARMACOLOGIC DRUGS.—Psychopharmacologic drugs may be administered only on the orders of a physician and only as an integral part of a plan (included in the IHP) designed to eliminate or modify the symptoms or behaviors for which the drugs are prescribed and only if, at least annually, an independent, external consultant trained in the administration and interaction of psychopharmacologic drugs reviews the appropriateness of the drug plan of each client receiving such drugs.

(I) OTHER RIGHTS.—Any other right established by the Secretary.

(3) RIGHTS OF INCOMPETENT CLIENTS.—In the case of a client adjudged incompetent under this laws of a State, the rights of the client under the title shall devolve upon, and, to the extent judged necessary by a court of competent jurisdiction, be exercised by, a person appointed under State law to act on the client's behalf. For purposes of the previous sentence, the term "person" includes an organization which is independent of a provider of community habilitation and supportive services.

(f) MINIMUM REQUIREMENTS FOR RESIDENTIAL SETTINGS.—A residential setting in which one or more community habilitation or supportive services are provided must meet the following requirements,

in order to protect the health, safety, and welfare of clients residing in such settings:

(1) CLIENTS' RIGHTS.—A setting must meet the requirements of section 1928(c)(1) (relating to clients rights) in the same manner as such requirements apply to habilitation facilities under such section.

(2) ADMINISTRATION.—A setting must meet the requirements of section 1928(d) (relating to administration and other matters), other than paragraph (2)(B) thereof, in the same manner as such requirements apply to habilitation facilities under such section.

(3) LIFE SAFETY CODE.—A setting must meet such provisions of such edition (as specified by the Secretary in regulation) of the Life Safety Code of the National Fire Protection Association as are applicable and appropriate to the residential setting; except that—

(A) the Secretary may waive, for such periods as he deems appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a setting, but only if such waiver would not adversely affect the health and safety of clients or personnel, and

(B) the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects clients of and personnel in residential settings.

(4) DISCLOSURE OF OWNERSHIP AND CONTROL INTERESTS AND EXCLUSION OF REPEATED VIOLATORS.—A residential setting—

(A) must disclose persons with an ownership or control interest (including such persons as defined in section 1124 (a)(3)) in the setting, and

(B) may not have, as a person with an ownership or control interest in the setting, any individual or person who has been excluded from participation in the program under this title or who has had such an ownership or control interest in one or more residential settings which have been found repeatedly to have provided care of substandard quality in the setting.

(5) CONTINUATION OF ACTIVE TREATMENT FOR CERTAIN CLIENTS UPON CONVERSION FROM A HABILITATION FACILITY.—If part or all of a facility converts from an habilitation facility to a residential setting, each client who was a resident of the portion of the facility so converted at the time of the conversion and who, under the client's individual program plan at such time, required continuous active treatment (as defined in section 1928(b)(2)(B)), the residential setting must continue to provide for (or arrange for the provision of) continuous active treatment (as so defined) so long as such client resides in the setting and continues to require such active treatment. Nothing in section 1902(a)(10)(B) shall be construed as requiring medical assistance made available under the previous sentence to be made available to individuals not described in such sentence.

(6) DOCUMENTATION OF RECEIPT OF MEDICAL CARE SERVICES.—A residential setting must include, in the clinical records of

each client, documentation of the provision of medical care services to the client. Nothing in this paragraph shall be construed as requiring a State to make available medical assistance under this title for all types or elements of medical care services for such clients.

In this section, the term "residential setting" does not include a setting in which fewer than 3 unrelated adults reside.

(g) STATE QUALITY ASSURANCE PROGRAM FOR SERVICES.—

(1) IN GENERAL.—Each State which elects to cover community habilitation and supportive services under this title shall establish a program for assuring the quality of community habilitation and supportive services provided, and for protecting and promoting the rights of clients receiving such services, under this title, consistent with the objectives described in subsection (b).

(2) ELEMENTS OF PROGRAM.—A program under this subsection shall provide, in a manner specified by the State—

(A) for identifying a State agency responsible for implementing the program;

(B) for the publication of standards, relating to the quality of community habilitation and supportive services and relating to clients' rights, which are consistent with the objectives of independence, productivity, and integration into the community described in subsection (b);

(C) for a system of periodic monitoring (through onsite, unannounced reviews and including measurement of client satisfaction) of compliance with standards, of investigation of compliants of violations of standards, and of public disclosure of results of such monitoring and investigations;

(D) for a system of enforcement of standards, including specified remedies;

((E) for public participation in the development of the program; and

(F) for educational programs for providers of community habilitation and supportive services, clients, parents, and legal guardians, respecting the quality assurance program.

A State's program under this subsection may include incentives to reward, through public recognition, incentive payments, or both, providers of community habilitation and supportive services that provide the highest quality care to clients under this title.

(3) NO SECRETARIAL REVIEW.—Nothing in this subsection shall be construed as authorizing the Secretary to review or approve a State quality assurance program established to meet the requirements of this subsection if the program, on its face, meets such requirements.

(4) NO MATCHING PAYMENT AVAILABLE.—Notwithstanding section 1903, no Federal financial participation shall be available under section 1903(a) to a state with respect to its expenditures in establishing or carrying out its quality assurance program under this subsection.

(h) SURVEY AND CERTIFICATION PROCESS.—

(1) RESPONSIBILITIES OF THE STATE.—

(A) IN GENERAL.—Subject to paragraph (2), under each State plan under this title, the State shall be responsible for certifying the compliance of providers of community habilitation and supportive services, and of residential settings in which such services are provided, with the requirements of subsections (e) and (f).

(B) EDUCATIONAL PROGRAM.—Each State shall conduct periodic educational programs for the staff and clients in residential settings in which community habilitation and supportive services are provided, and the parents (if the client is a minor) and legal guardians (if any) of such clients, in order to present current regulations, procedures, and policies under this section.

(C) INVESTIGATION OF ALLEGATIONS OF CLIENT NEGLECT AND ABUSE AND MISAPPROPRIATION OF CLIENT PROPERTY.—The State shall provide, through the agency responsible for surveys and certification of providers of community habilitation and supportive services and residential settings under this subsection, for a process for the receipt, review, and investigation of allegations of client neglect and abuse (including injuries of unknown source) by individuals providing such services and of misappropriation of client property by such individuals. The State shall, after notice to the individual involved and a reasonable opportunity for hearing for the individual to rebut allegations, make a finding as to the accuracy of the allegations. If the State finds that an individual has neglected or abused a client receiving community habilitation and supportive services or misappropriated such client's property, the State shall notify the individual against whom the finding is made. A State shall not make a finding that an individual has neglected a client if the individual demonstrates that such neglect was caused by factors beyond the control of the individual. The State shall provide for public disclosure of findings under this subparagraph upon request and for inclusion, in any such disclosure of such findings, of any brief statement (or of a clear and accurate summary thereof) of the individual disputing such findings. The findings relating to such allegations shall be made available, on request, to the State protection and advocacy system established under part C of the Developmental Disabilities Assistance and Bill of Rights Act and to other appropriate agency or agencies with whom a client, parent, or guardian may file a complaint respecting client abuse and neglect and misapproriation of client property.

(D) CONSTRUCTION.—The failure of the Secretary to issue regulations to carry out this subsection shall not relieve a State of its responsibility under this subsection.

(2) RESPONSIBILITIES OF THE SECRETARY.—The Secretary shall be responsible for certifying the compliance of State providers of community habilitation and supportive services, and of State residential settings in which such services are provided, with the requirements of subsections (e) and (f).

(3) FREQUENCY OF CERTIFICATIONS.—Certification of providers and settings under this subsection shall occur no less frequently than once every 12 months.

(4) SURVEYS AND REVIEWS.—

(A) SURVEYS OF RESIDENTIAL SETTINGS.—The certification under this subsection with respect to a setting must be based on a survey. Such survey for a residential setting must be conducted without prior notice to the setting. Any individual who notifies (or causes to be notified) a residential setting of the time or date on which such a survey is scheduled to be conducted is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). The Secretary shall review each State's procedures for scheduling and conducting such surveys to assure that the State has taken all reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.

(B) SURVEY PROTOCOL.—Surveys under this paragraph shall be conducted based upon a protocol which the Secretary has provided for under subsection (j).

(C) PROHIBITION OF CONFLICT OF INTEREST IN SURVEY TEAM MEMBERSHIP.—A State and the Secretary may not use as a member of a survey team under this paragraph an individual who is serving (or has served within the previous 2 years) as a member of the staff of, or as a consultant to, the provider of residential setting being surveyed (or the person responsible for such setting) respecting compliance with the requirements of subsections (e) and (f) or who has a personal or familial financial interest in the provider or setting being surveyed.

(D) TRAINING REQUIRED.—No individual shall serve on or after January 1, 1992, as a member of a survey team under this paragraph or paragraph (5) unless the individual has successfully completed a training and testing program in survey and certification techniques that has been approved by the Secretary under subsection (j)(3).

(E) REVIEWS OF PROVIDERS.—The certification under this subsection with respect to a provider (other than with respect to a residential setting) must be based on a periodic review of the provider's performance.

(5) VALIDATION SURVEYS AND REVIEWS.—

(A) IN GENERAL.—The Secretary shall conduct onsite surveys of a representative sample of residential settings in each State, within 2 months of the date of surveys conducted under paragraph (4) by the State, in a sufficient number to allow inferences about the adequacies of each State's surveys conducted under paragraph (4). In conducting such surveys, the Secretary shall use the same survey protocols as the State is required to use under paragraph (4). If the State has determined that an individual setting meets the requirements of subsection (e) and (f), but the Secretary de-

termines that the setting does not meet such requirements, the Secretary's determination as to the setting's noncompliance with such requirements is binding and supersedes that of the State survey.

(B) SPECIAL SURVEYS AND REVIEWS OF COMPLIANCE.—Where the Secretary has reason to question the compliance of a provider or setting with any of the requirements of subsections (e) and (f), the Secretary may conduct a survey of the setting or a review of the provider and, on the basis of that survey or review, make independent and binding determinations concerning the extent to which the setting or provider meets such requirements.

(6) INVESTIGATION OF COMPLAINTS AND MONITORING.—Each State and the Secretary shall maintain procedures and adequate staff to investigate complaints of violations of requirements by providers of community habilitation and supportive services or by residential settings in which such services are provided.

(7) DISCLOSURE OF RESULTS OF INSPECTIONS AND ACTIVITIES.—

(A) PUBLIC INFORMATION.—Each State, and the Secretary, shall make available to the public—

(i) information respecting all surveys, reviews, and certifications made under this subsection respecting providers and settings, including statements of deficiencies and plans of correction,

(ii) copies of cost reports (if any) of such providers and settings filed under this title,

(iii) copies of statements of ownership under section 1124, and

(iv) information disclosed under section 1126.

(B) NOTICE TO PROTECTION AND ADVOCACY SYSTEM.—Each State shall notify the agency responsible for the protection and advocacy system for developmentally disabled individuals established under part C of the Developmental Disabilities Assistance and Bill of Rights Act of the State's findings of noncompliance with any of the requirements of subsections (e) and (f) with respect to a provider or setting in the State.

(C) ACCESS TO FRAUD CONTROL UNITS.—Each State shall provide its State medicaid fraud and abuse control unit (established under section 1903(q)) with access to all information of the State agency responsible for surveys, reviews, and certifications under this subsection.

(D) NOTICE TO FAMILY.—If a State finds that a provider or setting has provided services of substandard quality, the State shall notify the parent (if the client is a minor), or legal guardian (if any) of each client with respect to which such finding is made.

(i) ENFORCEMENT PROCESS.—

(1) IN GENERAL.—If a State finds, on the basis of a survey or review under subsection (f)(2) or otherwise, that a provider of community habilitation and supportive services or a residential setting in which such services are provided no longer meets the requirements of this section (other than standards developed by

the State under subsection (g)), and further finds that the provider's or setting's deficiencies—

(A) immediately jeopardize the health or safety of its clients, the State shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in paragraph (2)(A)(iii), or terminate the provider's or setting's participation under the State plan and may provide, in addition, for one or more of the other remedies described in paragraph (2); or

(B) do not immediately jeopardize the health or safety of its clients, the State may—

(i) terminate the provider's or setting's participation under the State plan,

(ii) provide for one or more of the remedies described in paragraph (2), or

(iii) do both;

but in any case in which the Secretary has not provided for a civil money penalty under paragraph (3)(C)(i), the State shall provide for a civil money penalty under paragraph (2)(A)(i) for each day in which the State finds that the provider or setting was not in compliance with such requirements. Nothing in this paragraph shall be construed as restricting the remedies available to a State to remedy a provider's or setting's deficiencies. If the State finds that a provider or setting meets such requirements but, as of a previous period, did not meet such requirements, the State shall provide for a civil money penalty under paragraph (2)(A)(ii) for the days on which it finds that the provider or setting was not in compliance with such requirements.

(2) SPECIFIED REMEDIES.—

(A) LISTING.—Each State shall establish by law (whether statute or regulation) at least the following remedies:

(i) Denial of payment under the State plan with respect to any individual admitted to a residential setting involved after such notice to the public and to the setting as may be provided for by the State.

(ii) A civil money penalty assessed and collected, with interest, for each day in which the provider or setting is or was out of compliance with a requirement of this section. Funds collected by a State as a result of imposition of such a penalty (or as a result of the imposition by the State of a civil money penalty for activities described in subsection (h)(4)(A)) shall be applied to the protection of the health or property of clients of providers of community habilitation and supportive services that the State or the Secretary finds deficient, including payment for the costs of relocation of clients, maintenance of operation of a provider pending correction of deficiencies or closure, and reimbursement of clients for personal funds lost.

(iii) The appointment of temporary management to oversee the operation of a residential setting and to assure the health and safety of the setting's clients, where there is a need for temporary management while—

(I) there is an orderly closure of the setting, or

(II) improvements are made in order to bring the setting into compliance with all the requirements of this section.

The temporary management uiider this clause shall not be terminated under subclause (II) until the State has determined that the setting has the management capability to ensure continued compliance with all the requirements of this seciton.

(iv) The authority, in the case of an emergency, to close a residential seting, to transfer clients in that setting to other settings, or both.

The State also shall specify criteria, as to when and how each of such remedies is to be applied, the amounts of any fines, and the severity of each of these remedies, to be used in the imposition of such remedies. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the remedies and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies. In addition, the State may provide for other specified remedies.

(B) DEADLINE AND GUIDANCE.—As a condition for approval of a State plan for calendar quarters in which the State plan provides for coverage of community habilitation and supportive services (including under a waiver approved under section 1915(c), pursuant to subsection (b)(2)(A)), each State shall have in effect the remedies described in clauses (i) through (iv) of subparagraph (A). The Secretary whall provide, through regulations or otherwise by not later than July 1, 1990, guidance to States in establishing such remedies; but the failure of the Secretary to provide such guidance shall not relieve a State of the responsibility for establishing such remedies.

(C) ASSURING PROMPT COMPLIANCE.—If a residential setting has not complied with any of the requirements of this section within 3 months after the date the setting is found to be out of compliance with such requirements, the State shall impose the remedy describe din subparagraph (A)(i) for all individuals who are admitted to the setting after such date.

(D) FUNDING.—The reasonable expenditures of a State to provide for temporary management and other expenses associated with implementing the remedies described in clauses (iii) and (iv) of subparagraph (A) shall be considered, for purposes of section 1903(a)(7), to be necessary for the proper and efficient administration of the State plan.

(3) SECRETARIAL AUTHORITY.—

(A) FOR STATE PROVIDERS AND SETTINGS.—With respect to a State provider of community habilitation and supportive services and a State residential setting in which such services are provided, the Secretary shall have the authority and duties of a State under this subsection, including the authority to impose the remedies described in clauses (i) and (ii) of paragraph (2)(A), except that the remedy de-

scribed in subparagraph (C)(i) shall be substituted for the remedy described in paragrpah (2)(A)(ii).

(B) OTHER PROVIDERS AND SETTINGS.—With respect to any other provider of community habilitation and supportive services and any other residential setting in which such services are provided in a State, if the Secretary finds that a provider or setting no longer meets a requirement of this section (other than a standard developed by the State under subsection (g)) and further finds that the provider's or setting's deficiencies—

(i) immediately jeopardizes the health or safety of its clients, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in subparagraph (C)(ii), or terminate the provider's or setting's participation under the State plan and may provide, in addition, for the remedy described in subparagraph (C)(i); or

(ii) do not immediately jeopardize the health or safety of its clients, the Secretary may impose either or both of the remedies described in subparagraph (C);

but in any case the Secretary shall provide for a civil money penalty under paragraph (2)(A)(i) for each day in which the Secretary finds that the provider or setting was not in compliance with such requirements. Nothing in this subparagraph shall be construed as restricting the remedies available to the Secretary to remedy a provider's or setting's deficiencies. If the Secretary finds that a provider or setting meets such requirement but, as of a previous period, did not meet such requirements, the Secretary shall provide for a civil money penalty under subparagraph (C)(i) for the days on which he finds that the provider or setting was not in compliance with such requirements.

(C) SPECIFIED REMEDIES.—If the Secretary finds that a provider or setting has not met an applicable requirement:

(i) AUTHORITY WITH RESPECT TO CIVIL MONEY PENALTIES.—The Secretary shall impose a civil money penalty in an amount not to exceed $10,000 for each day of noncompliance. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same amount as such provisions apply to a penalty or proceeding under section 1128A(a).

(ii) APPOINTMENT OF TEMPORARY MANAGEMENT.—In consultation with the State, the Secretary may appoint temporary management to oversee the operation of a residential setting and to assure the health and safety of the setting's clients, where there is a need for temporary management while—

(I) there is an orderly closure of the setting, or

(II) improvements are made in order to bring the setting into compliance with all the requirements of this section.

The temporary management under this clause shall not be terminated under subclause (II) until the Secretary has de-

termined that the setting has the mangement capability to ensure continued compliance with all the requirements of this section

The Secretary shall specify criteria, as to when and how each of such remedies is to be applied, the amounts of any fines, and the severity of each of these remedies, to be used in the imposition of such remedies. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the remedies and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies.

(4) EFFECTIVE PERIOD OF DENIAL OF PAYMENT.—A finding to deny payment under this subsection shall terminate when the State or Secretary (or both, as the case may be) finds that the provider or setting is in compliance with all the requirements of this section.

(j) SECRETARIAL RESPONSIBILITIES.—

(1) PUBLICATION OF INTERIM AND FINAL REQUIREMENTS.—

(A) IN GENERAL.—The Secretary shall publish, by July 1, 1990, an interim regulation, and by October 1, 1991, a final regulation, that sets forth interim and final requirements, respectively, consistent with subparagraph (B), to protect the health, safety, and welfare of clients receiving community habilitation and supportive services, including—

(i) the requirements of subsection (e) (relating to providers of community habilitation and supportive services) and subsection (f) (relating to residential settings), and

(ii) survey protocols for residential settings and guidelines for reviews of providers (for use under subsection (h)) which relate to such requirements.

In developing such protocols for residential settings, the Secretary shall take into account the type of residential setting.

(B) MINIMUM PROTECTIONS.—Interim and final requirements under subparagraph (A) shall assure, through methods other than reliance on State licensure processes or the State quality assurance programs under subsection (g), that—

(i) individuals receiving community habilitation and supportive services are protected from neglect, physical and sexual abuse, and financial exploitation;

(ii) a provider of community habilitation and supportive services and a residential setting may not use individuals who have been convicted of child or client abuse, neglect, or mistreatment or of a felony involving physical harm to an individual and shall take all reasonable steps to determine whether applicants for employment by the provider or in the setting have histories indicating involvement in child or client abuse, neglect, or mistreatment or a criminal record involving physical harm to an individual;

(iii) individuals or entities delivering such services are not unjustly enriched as a result of abusive financial arrangements (such as owner lease-backs); and

(vi) individuals or entities delivering such services to clients, or relatives of such individuals, are prohibited from being named beneficiaries of life insurance policies purchased by (or on behalf of) such clients.

(C) CONSTRUCTION.—Nothing in this paragraph shall be construed as authorizing the Secretary to develop standards relating to the quality of community habilitation and supportive services beyond the scope of the minimum requirements for the protection of the health, safety, and welfare of clients under subsections (e) and (f).

(2) TECHNICAL ASSISTANCE.—The Secretary shall make available to States, providers of community habilitation and supportive services, and clients (and their representatives) technical assistance with respect to the implementation of this section, including, upon request of a State, such assistance with respect to the development and operation of State quality assurance programs under subsection (g).

(3) APPROVAL OF TRAINING PROGRAMS.—The Secretary shall provide, by not later than Ocbober 1, 1990, for the approval of comprehensive training programs of State and Federal surveyors in the conduct of surveys under paragraphs (4) and (5) of subsection (h).

(4) NO DELEGATION TO STATES.—The Secretary's authority under this subsection shall not be delegated to States.

(5) NO PREVENTION OF MORE STRINGENT REQUIREMENTS BY STATES.—Nothing in this section shall be construed as preventing States from imposing requirements that are more stringent than the requirements published or developed by the Secretary under this subsection.

(k) DENIAL OF PAYMENT FOR SERVICES OR SETTINGS FAILING TO MEET MINIMUM REQUIREMENTS.—No payment may be made under section 1903(a) for community habilitation and supportive services furnished on and after October 1, 1991, including such services furnished under section 1915(c) or 1905(a)(22, if the services, or the residential settings (if any) in which the services are provided, do not meet the minimum requirements described in subsections (e) and (f).

(l) NONDUPLICATION OF PAYMENTS.—Payments made to a habilitation facility for providing community habilitation or supportive services shall not include payment for any services for which payment is otherwise made under this title to such facility.

REQUIREMENTS FOR HABILITATION FACILITIES

SEC. 1928. (a) DEFINITIONS AND APPLICATION OF SECTION.—

(1) DEFINITIONS.—

(A) HABILITATION FACILITY.—In this title, the term "habilitation facility" means an institution (or a distinct part of an institution) which—

(i) is primarily engaged in providing health or habilitation services to individuals with mental retarda-

tion or a related condition and is not primarily for the care and treatment of mental diseases; and

(ii) meets the requirements for an habilitation facility described in subsections (b), (c), and (d) of this section.

(B) CLIENT.—In this section, the term "client" means, with respect to an habilitation facility, an individual with mental retardation or a related condition who is admitted to the facility.

(2) APPLICATION TO WAIVERS UNDER SECTION 1115.—In the case of any State which is providing medical assistance under a waiver granted under section 1115(a) with respect to habilitation facility services, the Secretary shall require the State to meet the requirements of this section in the same manner as the State would be required to meet such requirements if the State had in effect a plan approved under this title.

(b) REQUIREMENTS RELATING TO PROVISION OF SERVICES.—

(1) QUALITY OF LIFE.—An habilitation facility must care for its clients in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life, independence, productivity, and integration into the community of each client.

(2) SCOPE OF SERVICES AND ACTIVITIES UNDER INDIVIDUAL PROGRAM PLAN.—

(A) IN GENERAL.—An habilitation facility must provide each client, in accordance with an individual program plan, with continuous active treatment (as defined in subparagraph (B)) which is coordinated and monitored by a qualified mental retardation professional.

(B) ACTIVE TREATMENT DEFINED.—In this section, the term "active treatment" means services directed towards—

(i) the acquisition of behaviors and skills necessary for the client to function with as much self determination, independence, productivity, and integration into the community as possible, and

(ii) the prevention or deceleration of regression or loss of current optimal functional status.

Such term includes aggressive, consistent implementation of a program of specialized and generic training, treatment, and health services. Such term does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.

(3) INDIVIDUAL PROGRAM PLAN.—

(A) DEVELOPMENT OF IPPS.—

(i) IN GENERAL.—An habilitation facility must develop (or provide for the development of), not later than 30 days after the date of admission of each client, an individual program plan (in this section referred to as an "IPP") which states specific objectives necessary to meet the client's needs, as identified in the comprehensive functional assessment conducted under paragraph (4).

(ii) PREPARATION BY AN INTERDISCIPLINARY TEAM.—Each IPP shall be prepared by an appropriate interdisciplinary team and shall be periodically reviewed and revised by such a team after each assessment under paragraph (4). Such team shall include, in the case of a client who has a seizure disorder, a professional with expertise in the diagnosis and treatment of seizure disorders. Such team shall include, in the case of an IPP which provides for physical or chemical restraints, a person who has expertise in positive behavioral interventions.

(iii) REQUIRED PARTICIPATION IN DEVELOPMENT OF IPP.—in developing an IPP for a client, the facility shall notify, and provide for and encourage the participation of, the client, the client's parents (if the client is a minor), and the client's legal guardian (if any).

(iv) PERMISSIVE PARTICIPATION OF PARENTS OF ADULT CLIENTS.—A parent (if the client is not a minor) who is not a legal guardian of the client may participate in developing the IPP unless the client objects to the parent's participation.

(B) AVAILABILITY.—A copy of each IPP must, consistent with subsection (c)(1)(A)(iv), be made accessible to all relevant staff, including staffs of other agencies who work with the client, the client's legal guardian (if any), and, unless the client objects, to the client's parents.

(C) MEDICAL CARE PLAN.—The IPP shall include a formalized plan for the provision of physician, licensed nursing care, and related medical care services (including access to appropriate medical specialists) if the client's physician determines that the client requires such a plan. In the case of an IPP under which drug therapy is provided for a client with a seizure disorder, the plan must provide for periodic reviews of the client's response to such therapy.

(4) COMPREHENSIVE FUNCTIONAL ASSESSMENT.—

(A) REQUIREMENT.—An habilitation facility must provide for comprehensive functional assessments, and review of such assessments, of each client by an interdisciplinary team. Such an assessment and review must identify each client's developmental and behavioral abilities and management needs. In the case of a client with a seizure disorder, the assessment must include a determination, by a professional with expertise in the diagnosis and treatment of such disorders, of the classification of the type of disorder in accordance with the most recent version of the International Classification of Epileptic Seizures.

(B) FREQUENCY.—

(i) ASSESSMENTS.—Such an assessment must be conducted promptly upon (but no later than 30 days after the date of) admission for each client admitted on or after January 1, 1991, and by not later than January 1, 1992, for each client of the facility on that date.

(ii) REVIEWS.—A review of each such assessment shall be performed in no case less often than once every 12 months.

(C) USE.—The results of such an assessment or review shall be used in developing, reviewing, and revising the client's IPP under paragraph (3).

(D) REQUIREMENTS RELATING TO PREADMISSION SCREENING FOR INDIVIDUALS WITH MENTAL RETARDATION OR A RELATED CONDITION.—An habilitation facility must not admit, on or after January 1, 1991, any new client who is an individual with mental retardation or a related condition (as defined in section 1905(s)) unless the State mental retardation or developmental disability authority has determined prior to admission, based on an independent evaluation performed by a person or entity other than the facility, that the individual requires the level of services provided by an habilitation facility. Such determination shall not affect an individual's eligibility for services other than habilitation facility services.

(5) PROVISION OF SERVICES AND ACTIVITIES.—

(A) IN GENERAL.—To the extent needed to fulfill all IPPs described in paragraph (3), an habilitation facility must provide (or arrange for the provision of)—

(i) physician services 24 hours a day;

(ii) annual physical examinations (including vision and hearing examination, routine immunizations and tuberculosis control, and routine laboratory examinations);

(iii) licensed nursing services sufficient to meet health needs of clients;

(iv) comprehensive dental diagnostic services, including—

(I) a complete extraoral and intraoral examination, not later than one month after the date of admission to the facility (unless such an examination was completed within 12 months before admission), and

(II) periodic examination and diagnosis performed at least annually;

(v) comprehensive dental treatment services, including—

(I) provision of emergency dental treatment on a 24-hour-a-day basis by a licensed dentist, and

(II) dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health;

(vi) routine and emergency drugs and biologicals for clients and procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals and that assure the accurate recording of the administration by staff of drugs and biologicals to clients and of the self-administration of drugs and biologicals by clients;

(vii) professional program services needed to implement the active treatment plan defined in each client's IPP; and

(viii) meal services, including at least 3 meals daily, and food and nutrition services that assure that the meals meet the daily nutritional and special dietary needs of each client.

The services provided or arranged by the facility must meet professional standards of quality. The facility may, to the extent permitted by State law, utilize physician assistants and nurse practitioners to provide services described in clauses (i) and (ii).

(B) QUALIFIED PERSONS PROVIDING SERVICES.—Services described in subparagraph (A) must be provided by qualified persons in accordance with each client's IPP.

(C) FACILITY STAFFING.—

(i). IN GENRAL.—An habilitation facility must have, or arrange for the provision of, sufficient direct care staff to meet the needs of clients at the facility.

(ii) NO DEPENDENCE ON VOLUNTEERS.—An habilitation facility may not use a client or volunteer to meet the requirements of this subparagraph.

(iii) NO USE OF CERTAIN INDIVIDUALS.—An habilitation facility may not use individuals in the facility who have been convicted of child or client abuse, neglect, or mistreatment or of a felony involving physical harm to an individual. The facility must take all reasonable steps to determine whether applicants for employment at the facility have histories indicating involvement in child or client abuse, neglect, or mistreatment or a criminal record involving physical harm to an individual and, if an applicant has such a history, not to use the applicant in the facility.

(6) PHYSICIAN SUPERVISION.—An habilitation facility must—

(A) require that the health care of every client be provided under the supervision of a physician, and

(B) provide for having a physician available to furnish necessary medical care in case of emergency.

(7) RECORDS.—An habilitation facility must maintain records on all clients, which records include clinical records, IPPs (described in paragraph (3)), and the clients' comprehensive functional assessments (described in paragraph (4)), as well as the findings of any preadmission screen.

(c) REQUIREMENTS RELATING TO CLIENT'S RIGHTS.—

(1) GENERAL RIGHTS.—

(A) SPECIFIED RIGHTS.—An rehabilitation facility must protect and promote the rights of each client, including each of the following rights:

(i) FREE FROM ABUSE.—The right to be free from physical, verbal, sexual, or psychological abuse, corporal or psychological punishment, aversive stimuli, and involuntary seclusion. Nothing in the previous sentence shall be construed to prohibit the use of "time-out" rooms for periods of less than one hour, if the use of

such a room is subject to review by the interdisciplinary team (described in subsection (b)(4)) to ensure the use of the least restrictive and most positive behavior management intervention and consistency with the objectives of the client's IPP.

(ii) FREE FROM RESTRAINTS.—The right to be free from any physical restraints or medications imposed for purposes of discipline or convenience of the staff or as a substitute for active treatment and not required to treat the client's medical symptoms. Any such imposition of such physical restraints or medications must be subject to review by the interdisciplinary team (described in subsection (b)(4)) to ensure protection of this right and consistency with the objectives of the client's IPP.

(iii) PRIVACY.—The right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and friends and of client groups.

(iv) CONFIDENTIALITY.—The right to confidentiality of personal and clinical records.

(v) ACCOMMODATION OF NEEDS.—The right—

(I) to reside and receive services with reasonable accommodations of individual needs and preferences (including the right of a husband and wife living in the same facility to share a room and including the right to retain and use personal possessions and clothing), except where the health or safety of the individual or other clients would be endangered, and

(II) to receive adequate notice and explanation of the reasons therefor before the room or roommate of the client in the facility is changed and, other than in extraordinary circumstances, to disapprove such a change.

(vi) DIGNITY.—The right to be treated with dignity in a manner consistent with the client's chronological age.

(vii) GRIEVANCES.—The right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal (or threat of discrimination or reprisal) for voicing the grievances and the right to prompt efforts by the facility to resolve grievances the client may have, including those with respect to the behavior of other clients.

(viii) PARTICIPATION IN CLIENT AND FAMILY GROUPS.—The right of the client to organize and participate in client groups in the facility and the right of the client's family to meet in the facility with the families of other clients in the facility. Nothing in this clause shall be construed as requiring a facility to provide for a room specifically designed to accommodate meetings under this clause.

(ix) PARTICIPATION IN OTHER ACTIVITIES.—The right of the client to participate in social, religious, and com-

munity activities that do not interfere with the rights of other clients in the facility.

(x) EXAMINATION OF SURVEY RESULTS.—The right to examine, upon reasonable request, the results of the most recent survey of the facility conducted by the Secretary or a State with respect to the facility and any plan of correction in effect with respect to the facility.

(xi) FREE CHOICE WITH RESPECT TO MEDICAL CARE AND TREATMENT.—The right to choose a personal attending physician and to choose a qualified mental retardation professional or case manager, to be fully informed in advance about care and treatment, to be fully informed in advance of any change in care or treatment that may affect the client's well-being, and to participate in planning care and treatment or changes in such care and treatment.

(xii) VOLUNTARY SERVICE.—The right not to be compelled to perform services for the facility and, if the client chooses to perform such services, to be compensated for such services at prevailing wages commensurate with the client's productivity.

(xiii) OTHER RIGHTS.—Any other right establishes by the Secretary.

(B) NOTICE OF RIGHTS.—A habilitation facility must—

(i) inform each client, parent (if the client is a minor), or legal guardian (if any), orally and in writing at the time of admission to the facility, of the client's legal rights during the stay at the facility; and

(ii) make available to each client, parent (if the client is a minor), or legal guardian (if any), upon reasonable request, a written statement of such rights (which statement is updated upon changes in such rights).

The written description of legal rights under this subparagraph shall include a description of the protection of personal funds under paragraph (6) and the mailing address, contact person, and telephone number of the State protection and advocacy system (established under part C of the Developmental Disabilities Assistance and Bill of Rights Act) or other appropriate agency with whom the client, parent, or guardian may file a complaint respecting client abuse and neglect and misappropriation of client property in the facility.

(C) RIGHTS OF INCOMPETENT CLIENTS.—In the case of a client adjudged incompetent under the laws of a State, the rights of the client under this title shall devolve upon, and, to the extent judged necessary by a court of competent jurisdiction, be exercised by, a person appointed under State law to act on the client's behalf. For purposes of the previous sentence, the term "person" includes an organization which is independent of a facility.

(D) USE OF PSYCHOPHARMACOLOGIC DRUGS.—Psychopharmacologic drugs may be administered only on the orders of a physician and only as a integral part of a plan (included in the IPP) designed to eliminate or modify the symptons or

behaviors for which the drugs are prescribed and only if, at least annually, an independent, external consultant trained in the administration and interaction of psychopharmacologic drugs reviews the appropriateness of the drug plan of each client receiving such drugs.

(2) TRANSFER AND DISCHARGE RIGHTS.—

(A) IN GENERAL.—A habilitation facility must permit each client to remain in the facility and must not transfer or discharge the client from the facility unless—

(i) the transfer or discharge is necessary to meet the client's welfare and the client's welfare cannot be met in the facility;

(ii) the transfer or discharge is appropriate because the client no longer requires continous active treatment;

(iii) the safety of individuals in the facility is endangered;

(iv) the health of individuals in the facility would otherwise be endangered; or

(v) the facility ceases to operate or the transfer or discharge is pursuant to a court order or under a reduction plan approved by the Secretary under subsection (i).

In each of the cases described in clauses (i) through (iv), the basis for the transfer or discharge must be documented in the client's clinical record. In the cases described in clauses (i) and (ii), the documentation must be made by a qualified mental retardation professional in consultation with the appropriate interdisciplinary team that developed the client's IPP, and in the case described in clause (iv) the documentation must be made by a physician. A facility may not transfer or discharge a client under clause (i) or (ii) unless the service needs of the client recommended under subparagraph (C)(ii) will be met in the client's new living environment. A facility may not transfer or discharge a client under clause (iii) or (iv) unless adequate arrangements have been made for an alternative placement.

(B) PRETRANSFER AND PREDISCHARGE NOTICE.—

(i) IN GENERAL.—Before effecting a transfer or discharge of a client (including such a transfer or discharge under a reduction plan under subsection (i)), a habilitation facility must—

(I) notify the client, parent (if the client is a minor), or legal guardian (if any) of the transfer or discharge and the reasons therefor,

(II) record the reasons in the client's clinical record (including any documentation required under subparagraph (A)), and

(III) include in the notice the items described in clause (iii).

(ii) TIMING OF NOTICE.—The notice under clause (i)(I) must be made at least 60 days in advance of the client's transfer or discharge except—

(I) in a case described in clause (iii) or (iv) of subparagraph (A);

(II) in a case described in clause (i) of subparagraph (A), where a more immediate transfer or discharge is necessitated by the client's urgent medical needs; or

(III) in a case where a client has not resided in the facility for 60 days.

In the case of such exceptions, notice must be given as many days before the date of the transfer or discharge as is practicable.

(iii) ITEMS INCLUDED IN NOTICE.—Each notice under clause (i) must include—

(I) for transfers or discharges effected on or after January 1, 1991, notice of the client's right to appeal the transfer or discharge under the State process established under subsection (e)(5)(B), and

(II) in the case of clients with developmental disabilities, the mailing address, contact person, and telephone number of the agency responsible for the protection and advocacy system for developmentally disabled individuals established under part C of the Developmental Disabilities Assistance and Bill of Rights Act.

(C) SUMMARY, POST-DISCHARGE PLAN, AND ORIENTATION.—If a client is to be either transferred or discharged (including such a transfer or discharge under a reduction plan under subsection (i)), the facility must—

(i) provide a final summary of the client's developmental, behavioral, social, health, and nutritional status and skills at the time for the discharge that is available for release to authorized persons and agencies, with the consent of the client, parent (if the client is a minor), or legal guardian (if any),

(ii) provide recommendations relating to the service needs of the client in the client's new living environment; and

(iii) provide the client with sufficient preparation and orientation (taking into account the client's length of stay at the facility) to ensure safe and orderly transfer or discharge from the facility.

(3) ACCESS AND VISITATION RIGHTS.—A habilitation facility must—

(A) permit immediate access to any client by any representative of the Secretary, by any representative of the State, by the protection and advocacy system described in paragraph (2)(B)(iii)(II), or by the client's physician or qualified mental retardation professional;

(B) permit immediate access to a client, subject to the client's right to deny or withdraw consent at any time, by immediate family or other relatives of the client;

(C) permit immediate access to a client, subject to reasonable restrictions and the client's right to deny or withdraw consent at any time, by others who are visiting with the consent of the client;

(D) permit reasonable access to a client by any other entity or individual that provides health, social, legal, or other services to the client or that is a friend of the client, subject to the right of the client, parent (if the client is a minor), or legal guardian (if any) to deny or withdraw consent at any time;

(E) permit representatives of the State protection and advocacy system (described in paragraph (2)(B)(iii)(II), with the permission of the client, parent (if the client is a minor), or legal guardian (if any) and consistent with State law, to examine a client's records; and

(F) permit representatives of such State protectoin and advocacy system to have access to any client and to examine the client's records, in the case of any client—

(i) who, by reason of the client's mental or physical condition, is unable to authorize such examination,

(ii) who does not have a legal guardian, conservator, or other legal representative, or for whom the legal guardian is the State, and

(iii) with respect to whom a complaint has been received by such system or with respect to whom there is probable cause to believe that such client has been subject to abuse and neglect.

(4) EQUAL ACCESS TO QUALITY CARE.—An habilitation facility must establish and maintain identical policies and practices regarding the admission, transfer, and discharge of, and the provision of services required under the State plan for, all individuals regardless of source of payment.

(5) ADMISSIONS POLICY.—With respect to admissions practices, an habilitation facility must—

(A)(i) not require individuals applying to reside or residing in the facility to waive their rights to benefits under this title, (ii) not require oral or written assurance that such individuals are not eligible for, or will not apply for, benefits under this title, and (iii) provide to such individuals (and their representatives) oral and written information about how to apply for and use such benefits and how to receive refunds for previous payments covered by such benefits;

(B) not require a third party guarantee of payment to the facility as a condition of admission (or expedited admission) to, or continued stay in, the facility; and

(C) in the case of an individual who is entitled to medical assistance for habilitation facility services, not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan under this title, any gift, money, donation, or other consideration as a precondition of admitting (or expediting the admission of) the individual to the facility or as a requirement for the individual's continued stay in the facility.

(6) MANAGEMENT OF CLIENT FUNDS.—

(A) IN GENERAL.—The habilitation facility—

(i) whether or not a client deposits personal funds with the facility, must allow individual clients to

manage their financial affairs and teach them to do so to the extent of their capabilities, and

(ii) upon the written authorization of the client, parent (if the client is a minor), or legal guardian (if any), must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this paragraph.

(B) FACILITY MANAGEMENT OF PERSONAL FUNDS. Upon a facility's acceptance of written authorization under subparagraph (A)(ii), the facility must manage and account for the personal funds of the client deposited with the facility as follows:

(i) DEPOSIT.—The facility must deposit any amount of personal funds in excess of $50 with respect to a client in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts and credit all interest earned on such separate account to such account. With respect to any other personal funds, the facility must maintain such funds in a noninterest bearing account or petty cash fund.

(ii) ACCOUNTING AND RECORDS.—The facility must assure a full and complete separate accounting of each such client's personal funds, maintain a written record of all financial transactions involving the personal funds of a client deposited with the facility, and afford the client, parent (if the client is a minor), or legal guardian (if any) reasonable access to such record.

(iii) NOTICE OF CERTAIN BALANCES.—The facility must notify each client receiving medical assistance under this title or the parent (if the client is a minor) or legal guardian (if any), when the amount in the client's account reaches $200 less than the dollar amount determined under section 1611(a)(3)(B) and the fact that if the amount in the account (in addition to the value of the client's other nonexempt resources) reaches the amount determined under such section the client may lose eligibility for such medical assistance or for benefits under title XVI.

(iv) CONVEYANCE UPON DEATH.—Upon the death of a client with such an account, the facility must convey promptly the client's personal funds (and a final accounting of such funds) to the individual administering the client's estate.

(C) ASSURANCE OF FINANCIAL SECURITY.—The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of clients deposited with the facility.

(D) LIMITATION ON CHARGES TO PERSONAL FUNDS.—The facility may not impose a charge against the personal funds of a client for any item or service for which payment is made under this title.

(E) NO FACILITY BORROWING OF PERSONAL FUNDS.—The facility may not borrow, or use as security for any indebtedness, personal funds deposited with the facility.

(d) REQUIREMENTS RELATING TO ADMINISTRATION AND OTHER MATTERS.—

(1) ADMINISTRATION.—An habilitation facility must be administered in a manner that enables it to use its resources effectively and efficiently to promote maintenance or enhancement of the quality of life, independence, productivity, and integration into the community of each client.

(2) LICENSING AND LIFE SAFETY CODE.—

(A) LICENSING.—An habilitation facility must be licensed under applicable State and local law.

(B) LIFE SAFETY CODE.—An habilitation facility must meet such provisions of such edition (as specified by the Secretary in regulation) of the Life Safety Code of the National Fire Protection Association as are applicable to health care occupancies or residential board and care occupancies; except that—

(i) the Secretary may waive, for such periods as he deems appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a facility, but only if such waiver would not adversely affect the health and safety of clients or personnel, and

(ii) the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects clients of and personnel in habilitation facilities.

(3) SANITATION AND INFECTION CONTROL AND PHYSICAL ENVIRONMENT.—An habilitation facility must—

(A) establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which clients reside and to help prevent the development and transmission of disease and infection, and

(B) be designed, constructed, equipped, and maintained in a manner to protect the health and safety of clients, personnel, and the general public.

(4) MISCELLANEOUS.—

(A) COMPLIANCE WITH FEDERAL, STATE, AND LOCAL LAWS AND PROFESSIONAL STANDARDS.—An habilitation facility must operate and provide services in compliance with all applicable Federal, State, and local laws and regulations (including the requirements of section 1124) and with accepted professional standards and principles which apply to professionals providing services in such a facility.

(B) OTHER.—An habilitation facility must meet such other requirements relating to the health and safety of clients or relating to the physical facilities thereof as the Secretary may find necessary.

(C) DISSEMINATION OF SURVEY RESULTS.—An habilitation facility must—

(i) make the results of the most recent survey of the facility conducted under subsection (g) available to anyone upon request, and

(ii) mail promptly an accurate summary of the results of each such survey to the parent (if the client is a minor), legal guardian (if any), or other legal representative of each client.

(e) STATE REQUIREMENT FOR PREADMISSION SCREENING AND IENT REVIEW.—

(1) IN GENERAL.—

(A) STATE CONDITION OF PLAN APPROVAL.—

(i) IN GENERAL.—As a condition of approval of its plan under this title, effective January 1, 1991, the State must have in effect a preadmission screening program, for making determinations (using any criteria developed under subparagraph (B)) described in subsection (b)(4)(D) for individuals with mental retardation or a related condition (as defined in section 1905(s)) who are admitted to habilitation facilities on or after January 1, 1991. The failure of the Secretary to develop minimum criteria under subparagraph (B) shall not relieve any State of its responsibility to have a preadmission screening program under this paragraph or to perform client reviews under paragraph (2).

(ii) TREATMENT OF READMISSIONS.—Clause (i) shall not apply to a readmission of a client upon discharge from a hospital.

(iii) DELAY IN APPLICATION OF PREADMISSION SCREENING FOR PRIVATE PAY CLIENTS.—In the case of clients who, at the time of admission to an habitilation facility, is not entitled to benefits under this title, the preadmission screening requirements of this subparagraph shall not apply until such time as the client is so entitled and, in such case, the preadmission screening requirements shall apply as of the end of the day following the date on which the individual is determined to be so entitled. The previous sentence shall not be construed as prohibiting a State from imposing such a preadmission screening requirement with respect to clients not so intitled at the time of admission.

(B) FEDERAL MINIMUM CRITERIA AND MONITORING FOR PREADMISSION SCREENING AND CLIENT REVIEW.—

(i) MINIMUM CRITERIA.—The Secretary shall develop, by not later than July 1, 1990, minimum criteria for States to use in making determinations with respect to habilitation facility services under subsection (b)(4)(D) and paragraph (2) of this subsection and in permitting individuals adversely affected to appeal such determinations, and shall notify the States of such criteria.

(ii) MONITORING COMPLIANCE.—The Secretary shall review a sufficient number of cases to allow reasonable inferences about the adequacy of each State's compliance with the requirements of paragraph (3)(A) (relat-

ing to discharge and placement for active treatment of certain clients).

(2) STATE REQUIREMENT FOR ANNUAL CLIENT REVIEW.—

(A) IN GENERAL.—As of January 1, 1991, except as provided in subparagraph (A)(iii), in the case of each client of an habilitation facility, the State mental retardation or development disability authority must review and determine (using any criteria developed under subsection (f)(8) and based on an independent evaluation performed on site by a person or entity other than the facility)—

(i) whether or not the client requires the level of services provided by an habilitation facility; and

(ii) whether or not the client requires community habilitation and supportive services.

Such independent evaluation shall take into account the comprehensive functional assessment under subsection (b)(4).

(b) FREQUENCY OF REVIEWS.—

(i) ANNUAL.—Except as provided in clauses (ii) and (iii), the reviews and determinations under subparagraph (A) must be conducted with respect to each client not less often than annually.

(ii) PREADMISSION REVIEW CASES.—In the case of a client subject to a preadmission review under subsection (b)(3)(F), the review and determination under subparagraph (A) need not be done until the client has resided in the habilitation facility for 1 year.

(iii) INITIAL REVIEW.—The reviews and determinations under subparagraph (A) must first be conducted (for each client not subject to preadmission review under subsection (b)(3)(F)) by not later than January 1, 1992.

(c) DELAY IN APPLICATION OF ANNUAL CLIENT REVIEW FOR PRIVATE PAY CLIENTS.—In the case of a client who, at the time of admission to an habilitation facility, is not entitled to benefits under this title, the annual client review requirements of this subparagraph shall not apply until such time as the client is so entitled. The previous sentence shall not be construed as prohibiting a State from imposing such an annual client review requirement with respect to individuals not so entitled at the time of admission.

(3) RESPONSE TO PREADMISSION SCREENING AND CLIENT REVIEW.—As of January 1, 1991, the State must meet the following requirements:

(A) CLIENTS NOT REQUIRING HABILITATION FACILITY SERVICES, BUT REQUIRING COMMUNITY HABILITATION AND SUPPORTIVE SERVICES.—In the case of a client who is determined, under paragraph (2), not to require the level of services provided by an habilitation facility, but to require community habilitation and supportive services, the State must, in consultation with the client's family or legal representative and care-givers—

(i) arrange for the safe and orderly discharge of the client from the facility, consistent with the requirements of subsection (c)(2),

(ii) prepare and orient the client for such discharge, and

(iii) provide for (or arrange for the provision of) such community habilitation and supportive services for the mental retardation or a related condition.

(B) CLIENTS NOT REQUIRING HABILITATION FACILITY SERVICES AND NOT REQUIRING COMMUNITY HABILITATION AND SUPPORTIVE SERVICES.—In the case of a client who is determined, under paragraph (2), not to require the level of services provided by an habilitation and supportive services, the State must—

(i) arrange for the safe and orderly discharge of the client from the facility, consistent with the requirements of subsection (c)(2), and

(ii) prepare and orient the client for such discharge.

(4) DENIAL OF PAYMENT.—

(A) WHERE FAILURE TO CONDUCT PREADMISSION SCREENING.—No payment may be made under section 1903(a) with respect to habilitation facility services furnished to an individual for whom a determination is required under subsection (b)(3)(F) or paragraph (2) but for whom the determination is not made.

(B) FOR RESIDENTS NOT REQUIRING HABILITATION FACILITY LEVEL OF SERVICES.—No payment may be made under section 1903(a) with respect to habilitation facility services furnished to an client who is determined, under paragraph (2), not to require the level of services provided by an habilitation facility.

(5) APPEALS PROCEDURES BOTH FOR PREADMISSION DETERMINATIONS AND CLIENT REVIEW AND FOR TRANSFERS AND DISCHARGES.—

(A) PREADMISSION AND CLIENT REVIEW DETERMINATIONS.—Each State, as a condition of approval of its plan under this title, effective January 1, 1991, must have in effect an appeals process for individuals adversely affected by determinations under paragraph (1) or (2).

(B) TRANSFERS AND DISCHARGES.—Each State, as a condition of approval of its plan under this title, effective January 1, 1991, must provide for a fair mechanism for hearing appeals on transfers or discharges of clients of habilitation facilities. Such mechanism must meet the guidelines established by the Secretary under subsection (f)(3); but the failure of the Secretary to establish such guidelines shall not relieve any State of its responsibility to provide for such a fair mechanism.

(f) RESPONSIBILITIES OF SECRETARY RELATING TO HABILITATION FACILITY REQUIREMENTS.—

(1) GENERAL RESPONSIBILITY.—It is the duty and responsibility of the Secretary to assure that requirements which govern the provision of care in habilitation facilities under State plans approved under this title, and the enforcement of such require-

ments, are adequate to protect the health, safety, welfare, and rights of clients and to promote the effective and efficient use of public moneys.

(2) OPERATIONAL DEFINITION OF CONTINUOUS ACTIVE TREATMENT.—The Secretary shall establish, by not later than January 1, 1991, an operational definition of continuous active treatment that promotes a consistent assessment of whether an habilitation facility is in compliance with the requirements of subsection (b)(2)(A) and clarifies the manner in which a program of interventions and services is considered to be continuous.

(3) FEDERAL GUIDELINES FOR STATE APPEALS PROCESS FOR TRANSFERS AND DISCHARGES.—For purposes of subsections (c)(2)(B)(iii) and (e)(5)(B), by not later than July 1, 1990, the Secretary shall establish guidelines for minimum standards which State appeals processes under subsection (e)(5)(B) must meet to provide a fair mechanism for hearing appeals on transfers and discharges of clients from habilitation facilities. The guidelines shall provide, upon the request of a client, parent (if the client is a minor), or legal guardian (if any), for the participation of a representative of the State protection and advocacy system (described in subsection (c)(2)(B)(iii)(II)) in the appeals process with respect to that client.

(4) CRITERIA FOR ADMINISTRATION.—The Secretary shall establish criteria for assessing an habilitation facility's compliance with the requirement of subsection (d)(1) with respect to—

(A) its governing body and management,

(B) disaster preparedness,

(C) laboratory and radiological services (if provided),

(D) clinical records, and

(E) client and advocate participation.

(g) SURVEY AND CERTIFICATION PROCESS.—

(1) STATE AND FEDERAL RESPONSIBILITY.—

(A) IN GENERAL.—Under each State plan under this title, the State shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of habilitation facilities (other than facilities of the State) with the requirements of subsections (b), (c), and (d). The Secretary shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of State habilitation facilities with the requirements of such subsections.

(B) EDUCATIONAL PROGRAM.—Each State shall conduct periodic educational programs for the staff and clients in habilitation facilities, and for the parents (if the client is a minor) and legal guardians (if any) of such clients, in order to present current regulations, procedures, and policies under this section.

(C) INVESTIGATION OF ALLEGATIONS OF CLIENT NEGLECT AND ABUSE AND MISAPPROPRIATION OF CLIENT PROPERTY.—The State shall provide, through the agency responsible for surveys and certification of habilitation facilities under this subsection, for a process for the receipt, review, and investigation of allegations of client neglect and abuse (including injuries of unknown source) by staff and of misap-

propriation of client property by staff in an habilitation facility. The State shall, after notice to the individual involved and a reasonable opportunity for hearing for the individual to rebut allegations, make a finding as to the accuracy of the allegations. If the State finds that an individual has neglected or abused a client receiving habilitation facility services or misappropriated such client's property, the State shall notify the individual against whom the finding is made. A State shall not make a finding that an individual has neglected a client if the individual demonstrates that such neglect was caused by factors beyond the control of the individual. The State shall provide for public disclosure of findings under this subparagraph upon request and for inclusion, in any such disclosure of such findings, of any brief statement (or of a clear and accurate summary thereof) of the individual disputing such findings. The findings relating to such allegations shall be made available, on request, to the State protection and advocacy system (described in subsection (c)(2)(B)(iii)(II)) and to other appropriate agency or agencies with whom a client, parent, or guardian may file a complaint respecting client abuse and neglect and misappropriation of client property in the facility.

(D) CONSTRUCTION.—The failure of the Secretary to issue regulations to carry out this subsection shall not relieve a State of its responsibility under this subsection.

(2) ANNUAL SURVEYS.—

(A) IN GENERAL.—Each habilitation facility shall be subject to an annual survey, to be conducted without any prior notice to the facility. Any individual who notifies (or causes to be notified) an habilitation facility of the time or date on which such a survey is scheduled to be conducted is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). The Secretary shall review each State's procedures for scheduling and conduct of annual surveys to assure that the State has taken all reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.

(B) CONTENTS.—Each annual survey shall include—

(i) a review, based on a respresentative sample of clients and IPPs, of the quality, appropriateness, and effectiveness of active treatment provided, and

(ii) a review of compliance with all requirements under this section.

(C) FREQUENCY.—Each habilitation facility shall be subject to an annual survey not later than 15 months after the date of the previous annual survey conducted under this subparagraph. The Statewide average interval between annual surveys of habilitation facilities shall not exceed 12 months.

(D) SURVEY PROTOCOL.—Annual surveys shall be conducted—

(i) based upon a protocol which the Secretary has developed, tested, and validated by not later than October 1, 1990, and

(ii) by individuals, of a survey team, who meet such minimum qualifications as the Secretary establishes by not later than such date.

The failure of the Secretary to develop, test, or validate such protocols or to establish such minimum qualifications shall not relieve any State of its responsibility (or the Secretary of the Secretary's responsibility) to conduct surveys under this subsection.

(E) CONSISTENCY OF SURVEYS.—Each State shall implement programs to measure and reduce inconsistency in the application of survey results among surveyors.

(F) SURVEY TEAMS.—

(i) IN GENERAL.—Surveys under this subsection shall be conducted by a multidisciplinary team of professionals.

(ii) PROHIBITION OF CONFLICTS OF INTEREST.—A State may not use as a member of a survey team under this subsection an individual who is serving (or has served within the previous 2 years) as a member of the staff of, or as a consultant to, the facility surveyed respecting compliance with the requirements of subsections (b), (c), and (d), or who has a personal or familial financial interest in the facility being surveyed.

(iii) TRAINING.—The Secretary shall provide for the comprehensive training of State and Federal surveyors in the conduct of annual surveys under this subsection, including the auditing of client assessments and IPPs. No individual shall serve as a member of a survey team unless the individual has successfully completed a training and testing program in survey and certification techniques that has been approved by the Secretary.

(3) VALIDATION SURVEYS.—

(A) IN GENERAL.—The Secretary shall conduct onsite surveys of a representative sample of habilitation facilities in each State, within 2 months of the date of surveys conducted under paragraph (2) by the State, in a sufficient number to allow inferences about the adequacies of each State's surveys conducted under paragraph (2). In conducting such surveys, the Secretary shall use the same survey protocols as the State is required to use under paragraph (2). If the State has determined that an individual habilitation facility meets the requirements of subsections (b), (c), and (d), but the Secretary determines that the facility does not meet such requirements, the Secretary's determination as to the facility's noncompliance with such requirements is binding and supersedes that of the State survey.

(B) REDUCTION IN ADMINISTRATIVE COSTS FOR SUBSTANDARD PERFORMANCE.—If the Secretary finds, on the basis of

such surveys, that a State has failed to perform surveys as required under paragraph (2) or that a State's survey and certification performance otherwise is not adequate, the Secretary may provide for the training of survey teams in the State and shall provide for a reduction of the payment otherwise made to the State under section 1903(a)(2)(D) with respect to a quarter equal to 33 percent multiplied by a fraction, the denominator of which is equal to the total number of clients in habilitation facilities surveyed by the Secretary that quarter and the numerator of which is equal to the total number of clients in habilitation facilities which were found pursuant to such surveys to be not in compliance with any of the requirements of subsections (b), (c), and (d). A State that is dissatisfied with the Secretary's findings under this subparagraph may obtain reconsideration and review of the findings under section 1116 in the same manner as a State may seek reconsideration and review under that section of the Secretary's determination under section 1116(a)(1).

(C) SPECIAL SURVEYS OF COMPLIANCE.—Where the Secretary has reason to question the compliance of an habilitation facility with any of the requirements of subsections (b), (c), and (d), the Secretary may conduct a survey of the facility and, on the basis of that survey, make independent and binding determinations concerning the extent to which the habilitation facility meets such requirements.

(4) INVESTIGATION OF COMPLAINTS AND MONITORING HABILITATION FACILITY COMPLIANCE.—Each State and the Secretary shall maintain procedures and adequate staff to—

(A) investigate complaints of violations of requirements by habilitation facilities, and

(B) monitor, onsite, on a regular, as needed basis, an habilitation facility's compliance with the requirements of subsections (b), (c), and (d), if—

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be in compliance with such requirements, has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State or the Secretary, respectively, has reason to question the compliance of the facility with such requirements.

(5) DISCLOSURE OF RESULTS OF INSPECTIONS AND ACTIVITIES.—

(A) PUBLIC INFORMATION.—Each State, and the Secretary, shall make available to the public—

(i) information respecting all surveys and certifications made respecting habilitation facilities, including statements of deficiencies and plans of correction,

(ii) copies of cost reports of such facilities filed under this title,

(iii) copies of statements of ownership under section 1124, and

(iv) information disclosed under section 1126.

(B) NOTICE TO PROTECTION AND ADVOCACY SYSTEM.—Each State shall notify the agency responsible for the protection and advocacy system for developmentally disabled individuals established under part C of the Developmental Disabilities Assistance and Bill of Rights Act of the State's findings of noncompliance with any of the requirements of subsections (b), (c), and (d), with respect to an habilitation facility in the State.

(C) NOTICE TO FAMILY.—If a State finds that an habilitation facility has provided services of substandard quality, the State shall notify the parent (if the client is a minor), or legal guardian (if any) of each client with respect to which such finding is made.

(D) ACCESS TO FRAUD CONTROL UNITS.—Each State shall provide its State medicaid fraud and abuse control unit (established under section 1903(q)) with access to all information of the State agency responsible for surveys and certifications under this subsection.

(h) ENFORCEMENT PROCESS.—

(1) IN GENERAL.—If a State finds, on the basis of an annual survey under subsection (g)(2) or otherwise, that an habilitation facility no longer meets a requirement of subsection (b), (c), or (d), and further finds that the facility's deficiencies—

(A) immediately jeopardize the health or safety of its clients, the State shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in paragraph (2)(A)(iii), or terminate the facility's participation under the State plan and may provide, in addition, for one or more of the other remedies described in paragraph (2); or

(B) do not immediately jeopardize the health or safety of its clients, the State may—

(i) terminate the facility's participation under the State plan,

(ii) provide for one or more of the remedies described in paragraph (2), or

(iii) do both.

Nothing in this paragraph shall be construed as restricting the remedies available to a State to remedy an habilitation facility's deficiencies. If a State finds that an habilitation facility meets the requirements of subsections (b), (c), and (d), but, as of a previous period, did not meet such requirements, the State may provide for a civil money penalty under paragraph (2)(A)(ii) for the days in which it finds that the facility was not in compliance with such requirements.

(2) SPECIFIED REMEDIES.—

(A) LISTING.—Each State shall establish by law (whether statute or regulation) at least the following remedies:

(i) Denial of payment under the State plan with respect to any individual admitted to the habilitation facility involved after such notice to the public and to the facility as may be provided for by the State.

(ii) A civil money penalty assessed and collected, with interest, for each day in which the facility is or was out of compliance with a requirement of subsection (b), (c), or (d). Funds collected by a State as a result of imposition of such a penalty (or as a result of the imposition by the State of a civil money penalty for activities described in subsection (g)(2)(A)) shall be applied to the protection of the health or property of clients of habilitation facilities that the State or the Secretary finds deficient, including payment for the costs of relocation of clients, maintenance of operation of a facility pending correction of deficiencies or closure, and reimbursement of clients for personal funds lost.

(iii) In cases where a correction or reduction plan has not been approved under subsection (i), the appointment of temporary management to oversee the operation of the facility and to assure the health and safety of the facility's clients, where there is a need for temporary management while—

(I) there is an orderly closure of the facility, or

(II) improvements are made in order to bring the facility into compliance with all the requirements of subsections (b), (c), and (d).

The temporary management under this clause shall not be terminated under subclause (II) until the State has determined that the facility has the management capability to ensure continued compliance with all the requirements of subsections (b), (c), and (d).

(iv) The authority, in the case of an emergency, to close the facility, to transfer clients in that facility to other facilities, or both.

The State also shall specify criteria, as to when and how each of such remedies is to be applied, the amounts of any fines, and the severity of each of these remedies, to be used in the imposition of such remedies. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the remedies and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies. In addition, the State may provide for other specified remedies, such as plans of correction and reduction plans under subsection (i).

(B) DEADLINE AND GUIDANCE.—As a condition for approval of a State plan for calendar quarters (beginning on or after January 1, 1991) in which the State plan provides for coverage of habilitation facility services, each State shall have in effect the remedies described in clauses (i) through (iv) of subparagraph (A). The Secretary shall provide, through regulations or otherwise by not later than July 1, 1990, guidance to States in establishing such remedies; but the failure of the Secretary to provide such guidance shall not relieve a State of the responsibility for establishing such remedies.

(C) ASSURING PROMPT COMPLIANCE.—If an habilitation facility has not complied with any of the requirements of subsections (b), (c), and (d), within 3 months after the date the facility is found to be out of compliance with such requirements, and a reduction plan has not been approved with respect to the facility under subsection (i), the State shall impose the remedy described in subparagraph (A)(ii) and the remedy described in subparagraph (A)(i) for all individuals who are admitted to the facility after such date.

(D) REPEATED NONCOMPLIANCE.—In the case of an habilitation facility which, on 3 consecutive annual surveys conducted under subsection (g)(2), has been found not to provide continuous active treatment of adequate quality and effectiveness, the State shall (regardless of what other remedies are provided)—

(i) impose the remedies described in clauses (i) and (ii) of subparagraph (A), and

(ii) monitor the facility under subsection (g)(4)(B),

until the facility has demonstrated, to the satisfaction of the State, that it is in compliance with the requirements of subsections (b), (c), and (d), and that it will remain in compliance with such requirements. Under clause (i), the remedy described in subparagraph (A)(ii) shall be applied with respect to each day of noncompliance covered under any of such 3 annual surveys.

(E) FUNDING.—The reasonable expenditures of a State to provide for temporary management and other expenses associated with implementing the remedies described in clauses (iii) and (iv) of subparagraph (A) shall be considered, for purposes of section 1903(a)(7), to be necessary for the proper and efficient administration of the State plan.

(F) INCENTIVES FOR HIGH QUALITY CARE.—In addition to the remedies specified in this paragraph, a State may establish a program to reward, through public recognition, incentive payments, or both, habilitation facilities that provide the highest quality care to clients who are entitled to medical assistance under this title. For purposes of section 1903(a)(7), proper expenses incurred by a State in carrying out such a program shall be considered to be expenses necessary for the proper and efficient administration of the State plan under this title.

(3) SECRETARIAL AUTHORITY.—

(A) FOR STATE HABILITATION FACILITIES.—With respect to a State habilitation facility, the Secretary shall have the authority and duties of a State under this subsection, including the authority to impose remedies described in clauses (i), (ii), and (iii) of paragraph (2)(A), except that the remedy described in subparagraph (C)(ii) shall be substituted for the remedy described in paragraph (2)(A)(ii).

(B) OTHER HABILITATION FACILITIES.—With respect to any other habilitation facility in a State, if the Secretary finds that an habilitation facility no longer meets a requirement of subsection (b), (c), or (d), and further finds that the facility's deficiencies—

(i) immediately jeopardize the health or safety of its clients, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in subparagraph (C)(iii), or terminate the facility's participation under the State plan and may provide, in addition, for one or more of the other remedies described in subparagraph (C); or

(ii) do not immediately jeopardize the health or safety of its clients, the Secretary may impose any of the remedies described in subparagraph (C).

Nothing in this subparagraph shall be construed as restricting the remedies available to the Secretary to remedy an habilitation facility's deficiencies. If the Secretary finds that an habilitation facility meets such requirements but, as of a previous period, did not meet such requirements, the Secretary may provide for a civil money penalty under subparagraph (C)(ii) for the days on which he finds that the facility was not in compliance with such requirements.

(C) SPECIFIED REMEDIES.—The Secretary may take the following actions with respect to a finding that a facility has not met an applicable requirement:

(i) DENIAL OF PAYMENT.—The Secretary may deny any further payments to the State for medical assistance furnished by the facility to all individuals in the facility or to individuals admitted to the facility after the effective date of the finding.

(ii) AUTHORITY WITH RESPECT TO CIVIL MONEY PENALTIES.—The Secretary may impose a civil money penalty in an amount not to exceed $10,000 for each day of noncompliance. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(iii) APPOINTMENT OF TEMPORARY MANAGEMENT.—In consultation with the State, the Secretary may appoint temporary management to oversee the operation of the facility and to assure the health and safety of the facility's clients, where there is a need for temporary management while—

(I) there is an orderly closure of the facility, or

(II) improvements are made in order to bring the facility into compliance with all the requirements of subsections (b), (c), and (d).

The temporary management under this clause shall not be terminated under subclause (II) until the Secretary has determined that the facility has the management capability to ensure continued compliance with all the requirements of subsections (b), (c), and (d).

The Secretary shall specify criteria, as to when and how each of such remedies is to be applied, the amounts of any fines, and the severity of each of these remedies, to be used in the imposition of such remedies. Such criteria shall be designed so as to minimize the time between the identifica-

tion of violations and final imposition of the remedies and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies.

(D) CONTINUATION OF PAYMENTS PENDING REMEDIATION.—The Secretary may continue payments, over a period of not longer than 6 months after the effective date of the finding, under this title with respect to an habilitation facility not in compliance with a requirement of subsection (b), (c), or (d), if—

(i) the State survey agency finds that it is more appropriate to take alternative action to assure prompt compliance of the facility with the requirements than to terminate the certification of the facility,

(ii) the State has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action, and

(iii) the State agrees to repay to the Federal Government payments received under this subparagraph if the corrective action is not taken in accordance with the approved plan and timetable.

The Secretary shall establish guidelines for the approval of corrective actions requested by States under this subparagraph.

(E) CONTINUATION OF PAYMENTS UNDER REDUCTION PLANS.—The Secretary may continue payments in the case of habilitation facilities under the terms and conditions of a reduction plan approved under subsection (i), but only with respect to services provided on or after the date of such approval.

(4) EFFECTIVE PERIOD OF DENIAL OF PAYMENT.—A finding to deny payment under this subsection shall terminate when the State or Secretary (or both, as the case may be) finds that the facility is in compliance with all the requirements of subsections (b), (c), and (d).

(5) IMMEDIATE TERMINATION OF PARTICIPATION FOR FACILITY WHERE STATE OR SECRETARY FINDS NONCOMPLIANCE AND IMMEDIATE JEOPARDY.—If either the State or the Secretary finds that an habilitation facility has not met a requirement of subsection (b), (c), or (d), and finds that the failure immediately jeopardizes the health or safety of its clients, the State or the Secretary—

(A) shall notify the other of such finding, and

(B) shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in paragraph (2)(A)(iii) or (3)(C)(iii), or terminate the facility's participation Under the State plan.

If the facility's participation in the State plan is terminated by either the State or the Secretary, the State shall provide for the safe and orderly transfer of the clients eligible under the State plan consistent with the requirements of subsection (c)(2).

(6) SHARING OF INFORMATION.—Notwithstanding any other provision of law, all information concerning habilitation facilities required by this section to be filed with the Secretary or a State agency shall be made available to Federal or State em-

ployees for purposes consistent with the effective administration of programs established under this title, including investigations by State medicaid fraud control units.

(i) REDUCTION PLANS.—

(1) IN GENERAL.—If there is a finding under subsection (h)(1)(B) (including a similar finding under subsection (h)(3)(A)) or (h)(3)(B)(ii) that an habilitation facility has any deficiency that does not immediately jeopardize the health or safety of its clients, the State may elect in accordance with this subsection to submit to the Secretary a written plan—

(A) for permanently reducing the number of certified beds, within 36 months after the effective date of the findings, so that, by the end of such period, the facility no longer has such deficiency, and

(B) for providing services to clients of the facility who will not continue to receive habilitation facility services at the affected facility after such reduction, including (for clients not in an habilitation facility) community services.

(2) APPROVAL OF PLANS.—The Secretary may not approve a plan submitted under paragraph (1) unless—

(A) the State has provided for a hearing on the plan at the facility involved at least 30 days before the date of submission of the plan, after reasonable notice thereof to the staff and clients of the facility, members of the clients' families, and the public,

(B) the State demonstrates that, with respect to clients described in paragraph (1)(B), the State has successfully provided services similar to the services to be provided to such clients under the plan,

(C) the plan meets the requirements of paragraph (3), and

(D) the State meets the requirements of subsection (j).

(3) REQUIREMENTS OF REDUCTION PLANS.—The requirements of this paragraph for a reduction plan with respect to a facility are as follows:

(A) The plan must—

(i) identify the clients described in paragraph (1)(B),

(ii) describe each such client's needs for services described in that paragraph and a timetable for providing such services,

(iii) provide for continuous active treatment for such clients under the clients' IPPs after their discharge from the facility,

(iv) identify necessary safeguards (including adequate standards for provider participation) to be taken to protect the health and welfare of such clients, and

(v) provide sufficient preparation and orientation to facilitate their safe and orderly transfer to another habilitation facility or integration into the community;

however, individually identifiable information identified under this subparagraph and respecting a client shall be treated as confidential and not made available to the public.

(B) The plan must permit each client of the facility who would continue to be eligible for medical assistance while a

client of such a facility the option of remaining a client of such a facility or a similar facility.

(C) The plan must specify the actions to be taken, including maintenance of adequate ratios of qualified staff to clients, to protect the health and safety of, and to provide for continuous active treatment under the clients' IPPs for, clients who remain at the facility while the reduction plan is in effect.

(4) SEMIANNUAL REVIEW OF COMPLIANCE.—The Secretary shall, at 6-month intervals, review compliance of States with reduction plans approved under this subsection. If the Secretary determines in such a review that the State has failed to comply with the requirements of paragraph (3) or the assurances described in subsection (j), the Secretary shall—

(A) terminate the facility's participation under the State plan, or

(B) disallow, for purposes of Federal financial participation, an amount equal to 5 percent of the cost of care for all eiibible individuals in the facility for each month for which the failure continues.

If the Secretary determines in such a review that the State has failed to comply with the requirement of paragraph (3)(C), the Secretary shall disallow, for purposes of Federal financial participation, the cost of care for all eligible individuals in the facility for each month for which the failure continues.

(j) EMPLOYEE PROTECTIONS FOR CAPACITY REDUCTIONS.—

(1) IN GENERAL.—As a requirement of its State plan under section 1902(a), the State must provide that, in the case of any closure or reduction in capacity (whether through a reduction plan under subsection (i) or otherwise) of an habilitation facility in the State made on or after the date of the enactment of this subsection, the following fair and equitable arrangements have been made to protect the interests of employees of the facility affected by such closure or reduction:

(A) The preservation of rights, privileges, and benefits (including continuation of pension rights and benefits), under applicable collective bargaining agreements.

(B) The continuation of collective bargaining rights through any certified representative.

(C) The protection of individual employees against a worsening of their positions with respect to their employment at the facility during the period of the closure or reduction.

(D) Except as provided in paragraph (3), assurance of employment of affected employees with at least the same compensation (including benefits) and a comparable level of job responsibilities. In the case of a State-operated habilitation facility, the State must offer to affected employees of the facility employment, with at least the same compensation (including benefits) and a comparable level of job responsibilities, with a provider of community services to individuals with mental retardation or a related condition or in a residential setting in which such services are provided.

(E) The establishment of paid training or retraining programs for employment of affected employees in the provision of community services to individuals with mental retardation or a related condition.

(F) Provision of—

(i) a grievance procedure (meeting the requirements of paragraph (2)) for affected employees to assure the preceding requirements have been met with respect to such employees, or

(ii) another grievance procedure with respect to affected employees who have a certified bargaining representative, if such other grievance procedure has been agreed to by the State and by the certified bargaining representative.

(2) REQUIREMENTS FOR GRIEVANCE PROCEDURE.—The grievance procedure under paragraph (1)(F)(i) shall include the following:

(A) Within 30 days after the date of presentation of a grievance to the management of a facility, a response from the management of the facility and, during the 60-day period beginning on the date of the presentation, informal resolution of the grievance.

(B) After such 60-day period, the affected employee shall be permitted, at the employee's election, the option of (i) submitting the grievance to binding arbitration before a qualified arbitrator who is jointly selected and independent of the interested parties, or (ii) a hearing on the grievance before the appropriate State agency.

(C) An arbitration proceeding or hearing on the grievance, under subparagraph (B), shall be held within 45 days after the date of the request for such arbitration or hearing under such subparagraph.

(D) A decision on the grievance shall be made within 30 days after the date of such proceeding or hearing.

(E) Costs of the arbitration proceeding shall be divided evenly between the affected employee and the State and costs of the hearing shall be borne by the State.

Costs of the State under subparagraph (E), and comparable costs of the State under another grievance procedure under paragraph (1)(F)(ii), shall not be considered, for purposes of section 1903(a), costs of administration of the State plan under this title.

(3) CONSTRUCTION.—Nothing in paragraph (1) shall be construed—

(A) as entitling an affected employee to lifetime employment,

(B) as protecting an employee against a discharge for good cause, or

(C) as superseding or abrogating any collective bargaining agreement or any statutory or contractual labor/management negotiating process to the extent that such agreement or process contains protections for individual employees that comply with the requirements of paragraph (1).

COMMUNITY CARE FOR FUNCTIONALLY DISABLED ELDERLY INDIVIDUALS

SEC. 1929. (a) COMMUNITY CARE DEFINED.—In this title, the term "community care" means one or more of the following services furnished to an individual who has been determined, after an assessment under subsection (c), to be a functionally disabled elderly individual, and in accordance with an individual community care plan (established and periodically reviewed and revised by a qualified community care case manager under subsection (d)):

(1) Homemaker/home health aide services.

(2) Chore services.

(3) Personal care services.

(4) Nursing care services (other than continuous 24-hour nursing care services) provided by, or under the supervision of, a registered nurse.

(5) Respite care.

(6) Training for family members in managing the individual.

(7) Adult day health services.

(8) In the case of an individual with chronic mental illness, day treatment or other partial hospitalization, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility).

(9) Such other home and community-based services (other than room and board) as the Secretary may approve.

With respect to services described in paragraphs (1) through (4), the services must be provided in a place of residence used as the individual's home.

(b) FUNCTIONALLY DISABLED ELDERLY INDIVIDUAL DEFINED.—

(1) IN GENERAL.—In this title, the term "functionally disabled elderly individual" means an individual who—

(A) is 65 years of age or older;

(B) is determined to be a functionally disabled individual under subsection (c); and

(C) (i) subject to section 1902(f) (as applied consistent with section 1902(r)(2)), is described in section 1902(a)(10)(A)(i), or

(ii) at the option of the State, is described in section 1902(a)(10)(C).

(2) TREATMENT OF CERTAIN INDIVIDUALS COVERED UNDER CERTAIN WAIVERS.—

(A) HOME AND COMMUNITY-BASED WAIVERS.—In the case of a State which—

(i) at the time of its election to provide coverage for community care under this section has a waiver approved under section 1915(c) or 1915(d) with respect to individuals 65 years of age or older, and

(ii) subsequently discontinues such waiver, individuals who were eligible for benefits under the waiver as of the date of its discontinuance and who would, but for income or resources, be eligible for medical assistance for community care under the plan shall, notwithstanding any other provision of this title, be deemed a functionally disabled elderly individual for so long as

the individual would have remained eligible for medical assistance under such waiver.

(B) OTHER WAIVERS.—In the case of a State which, as of December 31, 1989, has in effect a waiver under section 1115 that provides under the State plan under this title for personal care services for functionally disabled individuals, the term "functionally disabled elderly individual" may include, at the option of the State, an individual who—

(i) is 65 years of age or older or is disabled (as determined under the supplemental security income program under title XVI);

(ii) is determined to meet the test of functional disability applied under the waiver as of such date; and

(iii) meets the resource requirement and income standard that apply in the State to individuals described in section 1902(a)(10)(A)(ii)(V).

(3) USE OF PROJECTED INCOME.—In applying section 1903(f)(1) in determining the eligibility of an individual (described in section 1902(a)(10)(C)) for medical assistance for community care, a State may, at its option, provide for the determination of the individual's anticipated medical expenses (to be deducted from income) over a period of up to 6 months.

(c) DETERMINATIONS OF FUNCTIONAL DISABILITY.—

(1) IN GENERAL.—In this section, an individual is "functionally disabled" if the individual—

(A) due solely to physical impairment or due solely to mental illness, is unable to perform without substantial assistance from another individual at least 2 (or, at the option of the State, 3 or 4) of the following activities of daily living: bathing, dressing, toileting, transferring, and eating; or

(B) has a primary or secondary diagnosis of Alzheimer's disease.

For purposes of this section, an individual is considered to have a "mental illness" if the individual has primary or secondary diagnosis of mental disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition).

(2) ASSESSMENTS OF FUNCTIONAL DISABILITY.—

(A) REQUESTS FOR ASSESSMENTS.—If a State has elected to provide community care under this section, upon the request of an individual who is 65 years of age or older and who meets the requirements of subsection (b)(1)(C) (or another person on such individual's behalf), the State shall provide for a comprehensive functional assessment under this subparagraph which—

(i) is used to determine whether or not the individual is functionally disabled,

(ii) is based on a uniform minimum data set specified by the Secretary under subparagraph (C)(i), and

(iii) uses an instrument which has been specified by the State under subparagraph (B).

No fee may be charged for such an assessment.

(B) SPECIFICATION OF ASSESSMENT INSTRUMENT.—The State shall specify the instrument to be used in the State in complying with the requirement of subparagraph (A)(iii). Such instrument shall be—

(i) one of the instruments identified under subparagraph (C)(ii), or

(ii) an instrument which the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines specified by the Secretary in subparagraph (C)(i).

(C) SPECIFICATION OF ASSESSMENT DATA SET AND INSTRUMENTS.—The Secretary shall—

(i) not later than July 1, 1990—

(I) specify a minimum data set of core elements and common definitions for use in conducting the assessments required under subparagraph (A), and

(II) establish guidelines for use of the data set; and

(ii) by not later than July 1, 1990, identify one or more instruments which are consistent with the specification made under subparagraph (A) and which a State may specify under subparagraph (B) for use in complying with the requirements of subparagraph (A).

(D) PERIODIC REVIEW.—Each individual who qualifies as a functionally disabled elderly individual shall have the individual's assessment periodically reviewed and revised not less often than once every 12 months.

(E) CONDUCT OF ASSESSMENT BY INTERDISCIPLINARY TEAMS.—

(i) IN GENERAL.—An assessment under subparagraph (A) and a review under subparagraph (D) must be conducted by an interdisciplinary team designated by the State.

(ii) DELEGATION.—The Secretary shall permit a State to provide for assessments and reviews through teams under contracts—

(I) with State or local agencies, or

(II) with nonprofit or public organizations which do not provide community care or nursing facility services and do not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides, community care or nursing facility services.

(F) CONTENTS OF ASSESSMENT.—The interdisciplinary team must—

(i) identify in each such assessment or review each client's functional disabilities and need for community care (based on social, cognitive, and other relevant factors), and

(ii) based on such assessment or review, determine whether the individual is (or continues to be) functionally disabled.

The results of such an assessment or review shall be used in establishing, reviewing, and revising the individual's ICCP under subsection (d)(1).

(G) APPEAL PROCEDURES.—Each State which elects to provide community care under this section must have in effect an appeals process for individuals adversely affected by determinations under subparagraph (F).

(d) INDIVIDUAL COMMUNITY CARE PLAN (ICCP).—

(1) INDIVIDUAL COMMUNITY CARE PLAN DEFINED.—In this section, the terms "individual community care plan" and "ICCP" mean, with respect to a functionally disabled elderly individual, a written plan which—

(A)(i) is established by a qualified community care case manager in face-to-face consultation with and with notice to the individual and based upon a visit to the individual on the individual's residence and the most recent comprehensive functional assessment of such individual conducted under subsection (c)(2);

(ii) is periodically reviewed and (as appropraite) revised by such a manager in face-to-face consultation with (and with notice to) the individual and based upon a visit to the individual in the individual's residence and the most recent comprehensive functional assessment of such individual conducted under section (c)(2);

(B) reflects, consistent with subparagraph (C), the needs and preferences of the individual and, to the extent feasible, allows for and promotes the direction and oversight of community care by the individual;

(C) specifies, within any amount, duration, and scope limitations imposed on community care provided under the State plan, the community care to be provided to such individual under the plan;

(D) does not include community care for which payment is made by the individual or on the individual's behalf; and

(E) may specify services (other than those to be provided to the individual under the plan) required by such individual.

Nothing in this section shall be construed as authorizing an ICCP or the State to restrict the specific persons or individuals (who are competent to provide community care under the State plan) who will provide the community care described in subparagraph (C).

(2) QUALIFIED COMMUNITY CARE CASE MANAGER DEFINED.—In this section, the term "qualified community care case manager" means a nonprofit or public agency or organization which—

(A) has experience in establishing, and in periodically reviewing and revising, assessments or individual community care plans and in the provision of case management services to the elderly;

(B) is responsible (i) for assuring that community care covered under the State plan and specified in the ICCP is being provided and (ii) for visiting each individual receiv-

ing such care at the individual's residence not less often than once every 90 days;

(C) in the case of a non-public organization, does not provide community care or nursing facility services and does not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides, community care or nursing facility services;

(D) has procedures for assuring the quality of case management services it provides; and

(E) meets such other standards, established by the Secretary, as assure that—

(i) such a manager is competent to perform case management functions,

(ii) individuals whose community care they manage are not at risk of financial exploitation due to such a manager, and

(iii) meets such other standards as the State may establish.

(3) APPEAL PROCEDURES.—Each State which elects to provide community care under this section must have in effect an appeals process for individuals who disagree with the ICCP established under this subsection.

(e) CEILING ON PAYMENT AMOUNTS AND MAINTENANCE OF EFFORT.—

(1) CEILING ON PAYMENT AMOUNTS.—Payments may not be made under section 1903(a) to a State for community care provided under this section in a quarter to the extent that the medical assistance for such care in the quarter exceeds 30 percent of the product of—

(A) the average number of individuals in the quarter receiving such care under this section,

(B) the average per diem rate of payment which the Secretary has determined (before the beginning of the quarter) will be payable under title XVIII (without regard to coinsurance) for extended care services to be provided in the State during such quarter, and

(C) the number of days in such quarter.

(2) MAINTENANCE OF EFFORT.—

(A) ANNUAL REPORTS.—As a condition for the receipt of payment under section 1903(a) with respect to medical assistance provided by a State for community care (other than under a waiver under section 1915(c)) to functionally disabled elderly individuals, the State shall report to the Secretary, with respect to each Federal fiscal year (beginning with fiscal year 1989) and in a format developed or approved by the Secretary, the amount of non-Federal funds obligated by the State (including funds obligated by localities in the State) with respect to the provision of community care (other than under such a waiver) to functionally disabled elderly individuals in that fiscal year.

(B) REDUCTION IN PAYMENT IF FAILURE TO MAINTAIN EFFORT.—In applying section 1903(a)(1) with respect to the total amount expended by a State for calendar quarters in

a fiscal year (beginning with fiscal year 1990) for community care to the functionally disabled elderly individuals (other than under a waiver under section 1915(c)), such expenditures shall be reduced by the amount reported under subparagraph (A) with respect to fiscal year 1989.

(3) DIRECT PAYMENT TO PROVIDERS OF COMMUNITY CARE.—Nothing in this title shall be construed as authorizing a State to permit payment for community care to be made through a qualified community care case manager.

(f) MINIMUM REQUIREMENTS FOR COMMUNITY CARE.—

(1) IN GENERAL.—Community care provided under this section must meet such requirements for individuals' rights and quality as are published or developed by the Secretary under subsection (j). Such requirements shall include—

(A) the requirement that individuals providing community care are competent to provide such care,

(B) guidelines for such minimum compensation for individuals providing such care as will assure the availability and continuity of competent individuals to provide such care for functionally disabled individuals who have functional disabilities of varying levels of severity, and

(C) the rights specified in paragraph (2). Nothing in this section shall be construed as preventing competent individuals (other than members of the family of an individual) from providing, and being paid directly for, community care.

(2) SPECIFIED RIGHTS.—The rights specified in this paragraph are as follows:

(A) FREE CHOICE.—The right to be fully informed in advance about care and treatment, to be fully informed in advance of any changes in care or treatment that may affect the individual's well-being, and (except with respect to an individual adjudged incompetent) to participate in planning care and treatment or changes in care and treatment.

(B) FREE FROM RESTRAINTS.—The right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the individual's medical symptoms. Restraints may only be imposed—

(i) to ensure the physical safety of the individual or other individuals, and

(ii) only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances specified by the Secretary until such an order could reasonably be obtained).

(C) PRIVACY.—The right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and friends and of groups.

(D) CONFIDENTIALITY.—The right to confidentiality of personal and clinical records.

(E) GRIEVANCES.—The right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal (or threat of discrimination or reprisal) for voicing the grievances and the right to prompt efforts by the provider to resolve grievances the individual may have, including those with respect to the behavior of other individuals.

(F) OTHER RIGHTS.—Any other right established by the Secretary.

(g) MINIMUM REQUIREMENTS FOR COMMUNITY CARE SETTINGS.—

(1) COMMUNITY CARE SETTING DEFINED.—In this section, the term "community care setting" means—

(A) a nonresidential setting, or

(B) a residential setting (including a foster home, board-and-care facility, or other group living arrangement, but not including a setting to the extent it is a nursing facility) in which more than 2 unrelated adults reside and in which personal services (other than merely board) are provided in conjunction with residing in the setting, in which community care under this section is provided.

(2) MINIMUM REQUIREMENTS.—A community care setting in which community care is provided under this section must meet the following requirements:

(A) SECRETARIAL REQUIREMENTS.—A setting must meet such requirements as are published or developed by the Secretary under subsection (j).

(B) SPECIFIED RIGHTS, RIGHTS OF INCOMPETENT RESIDENTS, USE OF PSYCHOPHARMACOLOGIC DRUGS, ACCESS AND VISITATION RIGHTS, PROTECTION OF RESIDENT FUNDS.—A setting must meet the requirements of subparagraphs (A), (C), and (D) of paragraph (1), paragraph (3), and paragraph (6) of section 1919(c), to the extent applicable to such a setting.

(C) NOTICE OF RIGHTS.—A setting must inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting.

(D) LICENSING.—A setting must be licensed under applicable State and local law.

(E) LIFE SAFETY CODE.—A setting must meet such provisions of such edition (as specified by the Secretary in regulation) of the Life Safety Code of the National Fire Protection Association as are applicable and appropriate to the community care setting; except that—

(i) the Secretary may waive, for such periods as he deems appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a setting, but only if such waiver would not adversely affect the health and safety of clients or personnel, and

(ii) the provisions of such Code shall not apply in any State if the Secretary finds that in such State

there is in effect a fire and safety code, imposed by State law, which adequately protects clients of and personnel in community care settings.

(F) SANITARY AND INSPECTION CONTROL AND MAINTENANCE OF PHYSICAL ENIVORNMENT.—A setting must—

(i) establish and maintain infection control standards designed to provided a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection, and

(ii) be maintained in a manner to protect the health and safety of residents, personnel, and the general public.

(3) DISCLOSURE OF OWNERSHIP AND CONTROL INTERESTS AND EXCLUSION OF REPEATED VIOLATORS.—A community care setting—

(A) must disclose persons with an ownership or control interest (including such persons as defined in section 1124(a)(3)) in the setting, and

(B) may not have, as a person with an ownership of control interest in the setting, any individual or person who has been excluded from participation in the program under this title or who has had such an ownership or control interest in one or more community care settings which have been found repeatedly to be substandard or to have failed to meet the requirements of paragraph (2).

(9) SURVEY AND CERTIFICATION PROCESS.—

(1) CERTIFICATIONS.—

(A) REPONSIBILITIES OF THE STATE.—

(i) IN GENERAL.—Under each State plan under this title, the State shall be responsible for certifying the compliance of providers of community care and community care settings with the applicable requirements of subsections (f) and (g).

(ii) CONSTRUCTION.—The failure of the Secretary to issue regulations to carry out this subsection shall not relieve a State of its responsibility under this subsection.

(B) RESPONSIBILITIES OF THE SECRETARY.—The Secretary shall be responsible for certifying the compliance of State providers of community care, and of State community care settings in which such care is provided, with the requirements of subsections (f) and (g).

(C) FREQUENCY OF CERTIFICATIONS.—Certification of providers and settings under this subsection shall occur no less frequently than once every 12 months.

(2) REVIEWS OF PROVIDERS.—

(A) IN GENERAL.—The certification under this subsection with respect to a provider of community care must be based on a periodic review of the provider's performance in providing the care required under ICPP's in accordance with the requirements of subsection (f). Such periodic review shall be conducted, not less often than annually, by an agency (other than the single State agency described in sec-

tion 1902(a)(5)) and shall be based on information that includes the views of qualified community care case managers whose clients have received community care from such providers and from a sample of individuals receiving community care from such providers.

(B) SPECIAL REVIEWS OF COMPLIANCE.—If the Secretary has reason to question the compliance of a provider of community care with any of the requirements of subsection (f), the Secretary may conduct a review of the provider and, on the basis of that review, make independent and binding determinations concerning the extent to which the provider meets such requirements.

(3) SURVEYS OF COMMUNITY CARE SETTINGS.—

(A) IN GENERAL.—The certification under this subsection with respect to a community care setting must be based on a survey. Such survey for such a setting must be conducted without prior notice to the setting. Any individual who notifies (or causes to be notified) a community care setting of the time or date on which such a survey is scheduled to be conducted is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). The Secretary shall review each State's procedures for scheduling and conducting such surveys to assure that the State has taken all reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.

(B) SURVEY PROTOCOL.—Surveys under this paragraph shall be conducted based upon a protocol which the Secretary has provided for under subsection (j).

(C) PROHIBITION OF CONFLICT OF INTEREST IN SURVEY TEAM MEMBERSHIP.—A State and the Secretary may not use as a member of a survey team under this paragraph an individual who is serving (or has served within the previous 2 years) as a member of the staff of, or as a consultant to, the community care setting being surveyed (or the person responsible for such setting) respecting compliance with the requirements of subsection (g) or who has a personal or familial financial interest in the setting being surveyed.

(D) VALIDATION SURVEYS OF COMMUNITY CARE SETTINGS.—The Secretary shall conduct onsite surveys of a representative sample of community care settings in each State, within 2 months of the date of surveys conducted under subparagraph (A) by the State, in a sufficient number to allow inferences about the adequacies of each State's surveys conducted under subparagraph (A). In conducting such surveys, the Secretary shall use the same survey protocols as the State is required to use under subparagraph (B). If the State has determined that an individual setting meets the requirements of subsection (g), but the Secretary determines that the setting does not meet such requirements, the Secretary's determination as to the setting's

noncompliance with such requirements is binding and supersedes that of the State survey.

(E) SPECIAL SURVEYS OF COMPLIANCE.—If the Secretary has reason to question the compliance of a community care setting with any of the requirements of subsection (g), the Secretary may conduct a survey of the setting and, on the bais of that survey, make independent and binding determinations concerning the extent to which the setting meets such requirements.

(4) INVESTIGATION OF COMPLIANTS AND MONITORING OF PROVIDERS AND SETTINGS.—Each State and the Secretary shall maintain procedures and adequate staff to investigate complaints of violations of applicable requirements imposed on providers of community care or on community care settings under subsections (f) and (g).

(5) INVESTIGATION OF ALLEGATIONS OF INDIVIDUAL NEGLECT AND ABUSE AND MISAPPROPRIATION OF INDIVIDUAL PROPERTY AND PUBLIC DISCLOSURE OF FINDINGS.—The State shall provide, through the agency responsible for surveys and certification of providers of community care and community care settings under this subsection, for a process for the receipt, review, and investigation of allegations of individual neglect and abuse (including injuries of unknown source) by individuals providing such care or in such setting and of misappropriation of individual property by such individuals. The State shall, after notice to the individual involved and a reasonable opportunity for hearing for the individual to rebut allegations, make a finding as to the accuracy of the allegations. If the State finds that an individual has neglected or abused an individual receiving community care or misappropriated such individual's property, the State shall notify the individual against whom the finding is made. A State shall not make a finding that a person has neglected an individual receiving community care if the person demonstrates that such neglect was caused by factors beyond the control of the person. The State shall provide for public disclosure of findings under this paragraph upon request and for inclusion, in any such disclosure of such findings, of any brief statement (or of a clear and accurate summary thereof) of the individual disputing such findings.

(6) DISCLOSURE OF RESULTS OF INSPECTIONS AND ACTIVITIES.—

(A) PUBLIC INFORMATION.—Each State, and the Secretary, shall make available to the public—

(i) information respecting all surveys, reviews, and certifications made under this subsection respecting providers of community care and community care settings, including statements of deficiencies,

(ii) copies of cost reports (if any) of such providers and settings filed under this title,

(iii) copies of statements of ownership under section 1124, and

(iv) information disclosed under section 1126.

(B) NOTICES OF SUBSTANDARD CARE.—If a State finds that—

(i) a provider of community care has provided care of substandard quality with respect to an individual, the State shall make a reasonable effort to notify promptly (I) an immediate family member of each such individual and (II) individuals receiving community care from that provider under this title, or

(ii) a community care setting is substandard, the State shall make a reasonable effort to notify promptly (I) individuals receiving community care in that setting, and (II) immediate family members of such individuals.

(C) ACCESS TO FRAUD CONTROL UNITS.—Each State shall provide its State medicaid fraud and abuse control unit (established under section 1903(q)) with access to all information of the State agency responsible for surveys, reviews, and certifications under this subsection.

(i) ENFORCEMENT PROCESS FOR PROVIDERS OF COMMUNITY CARE.—

(1) STATE AUTHORITY.—

(A) IN GENERAL.—If a State finds, on the basis of a review under subsection (h)(2) or otherwise, that a provider of community care no longer meets the requirements of this section and further finds that the provider's deficiencies—

(i) immediately jeopardize the health or safety of individuals receiving its services, the State shall take immediate action to remove the jeopardy and correct the deficiencies or terminate the provider's participation under the State plan and may, in addition, provide for a civil money penalty, or

(ii) do not immediately jeopardize the health or safety of such individuals, the State may—

(I) terminate the provider's participation under the State plan,

(II) provide for a civil money penalty, or

(III) do both.

Nothing in this subparagraph shall be construed as restricting the remedies available to a State to remedy a provider's deficiencies. If the State finds that a provider meets such requirements but, as of a previous period, did not meet such requirements, the State may provide for a civil money penalty under subparagraph (B) for the period during which it finds that the provider was not in compliance with such requirements.

(B) CIVIL MONEY PENALTY.—

(i) IN GENERAL.—Each State shall establish by law (whether statute or regulation) at least the following remedy: A civil money penalty assessed and collected, with interest, for each day in which the provider is or was out of compliance with a requirement of this section. Funds collected by a State as a result of imposition of such a penalty (or as a result of the imposition by the State of a civil money penalty under subsection (h)(3)(A)) may be applied to reimbursement of individuals for personal funds lost due to a failure of commu-

nity care providers to met the requirements of this section. The State also shall specify criteria, as to when and how this remedy is to be applied and the amounts of any penalties. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the penalties and shall provide for the imposition of incrementally more severe penalties for repeated or uncorrected deficiencies.

(ii) DEADLINE AND GUIDANCE.—Each State which elects to provide community care under this section must establish the civil money penalty remedy described in clause (i) applicable to all providers of community care covered under this section. The Secretary shall provide, through regulations or otherwise by not later than July 1, 1990, guidance to States in establishing such remedy; but the failure of the Secretary to provide such guidance shall not relieve a State of the responsibility for establishing such remedy.

(2) SECRETARIAL AUTHORITY.—

(A) FOR STATE PROVIDERS.—With respect to a State provider of community care, the Secretary shall have the authority and duties of a State under this subsection, except that the civil money penalty remedy described in subparagraph (C) shall be substituted for the civil money remedy described in paragraph (1)(B)(i).

(B) OTHER PROVIDERS.—With respect to any other provider of community care in a State, if the Secretary finds that a provider no longer meets a requirement of this section and further finds that the provider's deficiencies—

(i) immediately jeopardize the health or safety of individuals receiving its services, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies or terminate the provider's participation under the State plan and may, in addition, provide for a civil money penalty under subparagraph (C), or

(ii) do not immediately jeopardize the health or safety of such individuals, the Secretary may—

(I) terminate the provider's participation under the State plan,

(II) provide for a civil money penalty under subparagraph (C), or

(III) do both.

If the Secretary finds that a provider meets such requirements but, as of a previous period, did not meet such requirements, the Secretary may provide for a civil money penalty under subparagraph (C) for the period during which the Secretary finds that the provider was not in compliance with such requirements.

(C) CIVIL MONEY PENALTY.—If the Secretary finds on the basis of a review under subsection (h)(2) or otherwise that a community care provider no longer meets the requirements of this section, the Secretary shall impose a civil money penalty in an amount not to exceed $10,000 for each day of

noncompliance. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). The Secretary shall specify criteria, as to when and how this remedy is to be applied and the amounts of any penalties. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the penalties and shall provide for the imposition of incrementally more severe penalties for repeated or uncorrected deficiencies.

(j) SECRETARIAL RESPONSIBILITIES.—

(1) PUBLICATION OF INTERIM REQUIREMENTS.—

(A) IN GENERAL.—The Secretary shall publish, by July 1, 1990, an interim regulation that sets forth interim requirements, consistent with subparagraph (B), for the provision of community care and for community care settings, including—

(i) the requirements of subsection (c)(2) (relating to comprehensive functional assessments, including the use of assessment instruments), of subsection (d)(2)(E) (relating to qualifications for qualified community care case managers), of subsection (f) (relating to minimum requirements for community care), and of subsection (g) (relating to minimum requirements for community care settings), and

(ii) survey protocols (for under subsection (h)(3)(A)) which relate to such requirements.

(B) MINIMUM PROTECTIONS.—Interim requirements under subparagraph (A) and final requirements under paragraph (2) shall assure, through methods other than reliance on State licensure processes, that individuals receiving community care are protected from neglect, physical and sexual abuse, financial exploitation, inappropriate involuntary restraint, and the provision of health care services by individuals in community care settings who are not competent to provide such care.

(2) DEVELOPMENT OF FINAL REQUIREMENTS.—The Secretary shall develop, by not later than October 1, 1991—

(A) final requirements, consistent with paragraph (1)(B), respecting the provision of appropriate, quality community care and respecting community care settings under this section, and including at least the requirements referred to in paragraph (1)(A)(i), and

(B) survey protocols and methods for evaluating and assuring the quality of community care settings.

the Secretary may, from time to time, revise such requirements, protocols, and methods.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as authorizing the Secretary to develop standards respecting the quality of community care and standards respecting community care settings beyond the scope of the interim and final requirements specified under paragraphs (1) and (2).

(4) NO DELEGATION TO STATES.—The Secretary's authority under this subsection shall not be delegated to States.

(5) NO PREVENTION OF MORE STRINGENT REQUIREMENTS BY STATES.—Nothing in this section shall be construed as preventing States from imposing requirements that are more stringent than the requirements published or developed by the Secretary under this subsection.

(k) APPLICABILITY IN STATES OPERATING UNDER DEMONSTRATION PROJECTS.—In the case of any State which is providing medical assistance under a waiver granted under section 1115(a) with respect to community care, the Secretary shall require the State to meet the requirements of this section in the same manner as the State would be required to meet such requirements if the State had in effect a plan approved under this title and had elected to cover community care under this section.

REFERENCES TO LAWS DIRECTLY AFFECTING MEDICAID PROGRAM

SEC. [1926] *1930.* (a) AUTHORITY OR REQUIREMENTS TO COVER ADDITIONAL INDIVIDUALS.—For provisions of law which make additional individuals eligible for medical assistance under this title, see the following:

(1) * * *

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OMNIBUS BUDGET RECONCILIATION ACT OF 1986

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Subtitle D—Provisions Relating to Medicare

* * * * * * *

PART 2—PROVISIONS RELATING TO PARTS A AND B

* * * * * * *

SEC. 9312. HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS.

(a) * * *

* * * * * * *

(c) RESTRICTING WAIVER OF REQUIREMENT OF 50 PERCENT NON-MEDICARE ENROLLMENT.—

(1) * * *

* * * * * * *

(3) EFFECTIVE DATES.—

(A) * * *

* * * * * * *

(D) TREATMENT OF CERTAIN WAIVERS.—In the case of an eligible organization (or successor organization) that is described in clauses (i) and (ii) of subparagraph (C) and that received a grant or grants totaling at least $3,000,000 in fiscal year 1987 under section 329(d)(1)(A) or 330(d)(1) of the Public Health Service Act—

(i) before January 1, [1990] *1994,* section 1876(f) of the Social Security Act shall not apply to the organization;

[(ii) beginning on January 1, 1990, the Secretary of Health and Human Services shall waive the requirement of such section with respect to the organization if—

[(I) before such date, the organization has submitted to the Secretary a schedule for the organization to comply with the requirement of section 1876(f)(1) of such Act, and the Secretary has found such schedule to be reasonable and has approved such schedule; and

[(II) periodically after such date, the Secretary reviews the organizations's compliance with such schedule and determines that the organization has complied, or made significant progress towards compliance, with such schedule; and

[(iii) after January 1, 1990, if the Secretary has approved a schedule under clause (ii)(I) and has determined, in a periodic review under clause (ii)(II), that the organization has not complied, or made significant progress towards compliance, with such schedule, the Secretary may provide for a sanction described in section 1876(f)(3) of the Social Security Act effective with respect to individuals enrolling with the organization after the date the Secretary notifies the organization of such noncompliance.]

(ii) beginning on January 1, 1990, the Secretary of Health and Human Service shall conduct an annual review of the organization to determine the organization's compliance with the quality assurance requirements of section 1876(c)(6) of such Act; and

(iii) after January 1, 1990, if the organization receives an unfavorable review under clause (ii), the Secretary, after notice to the organization of the unfavorable review and an opportunity to correct any deficiencies identified during the review, may provide for the sanction described in section 1876(f)(3) of such Act effective with respect to individuals enrolling with the organization after the date the Secretary notifies the organization that the organization is not in compliance with the requirements of section 1876(c)(6) of such Act.

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SEC. 9329. PAYMENT FOR SERVICES OF CERTIFIED REGISTERED NURSE ANESTHETISTS.

(a) * * *

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(k) AUTHORIZATION OF CONTINUATION OF PASS-THROUGH.—

(1) Subject to paragraph (2), the amendments made by this section shall not apply during [1989, 1990, and 1991] *a year (beginning with 1989)* to a hospital located in a rural area (as

defined for purposes of section 1886(d) of the Social Security Act) if the hospital establishes, [before April 1, 1989,] *at any time before the year* to the satisfaction of the Secretary of Health and Human Services that—

(A) as of January 1, 1988, the hospital employed or contracted with a certified registered nurse anesthetist (but not more than one full-fime equivalent certified registered nurse anesthetist).

(B) in 1987 the hospital had a volume of surgical procedures (including inpatient and outpatient procedures) requiring anesthesia services that did not exceed [250] *500* (or such higher number as the Secretary determines to be appropriate), and

(C) each certified registered nurse anesthetist employed by, or under contract with, the hospital has agreed not to bill under part B of title XVIII of such Act for professional services furnished by the anesthetist at the hospital.

(2) Paragraph (1) shall not apply in [1990 or 1991] *in a year (after 1989)* to a hospital unless the hospital establishes, before the beginning of [each respective year] *the year,* that the hospital has had a volume of surgical procedures (including inpatient and outpatient procedures) requiring anesthesia services in the previous year that did not exceed [250] *500* (or such higher number as the Secretary determines to be appropriate).

[(3) The Secretary shall implement this subsection in such a manner as to maintain budget neutrality consistent with section 1833(l)(3) of the Social Security Act.]

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Part 3—Provisions Relating to Medicare Part B

SEC. 9331. PAYMENT FOR PHYSICIANS' SERVICES.

(a) * * *

* * * * * * *

(d) Development and Use of HCFA Common Procedure Coding System.—

(1) Not later than July 1, 1989, the Secretary of Health and Human Services (in this subsection referred to as the "Secretary"), after public notice and opportunity for public comment and after consultation with appropriate medical and other experts, shall group the procedure codes contained in any HCFA Common Procedure Coding System for payment purposes to minimize inappropriate increases in the intensity or volume of services provided as a result of coding distinctions which do not reflect substantial differences in the services rendered.

(2) Not later than January 1, [1990,] *1993,* each carrier with which the Secretary has entered into a contract under section 1842 of the Social Security Act shall make payments under part B of title XVIII of such Act based on the grouping of procedure codes effected under paragraph (1).

* * * * * * *

SEC. 9335. PAYMENT RATES FOR RENAL SERVICES AND IMPROVEMENTS IN ADMINISTRATION OF END STAGE RENAL DISEASE NETWORKS AND PROGRAM.

(a) COMPOSITE RATES FOR DIALYSIS SERVICES.—

(1) IN GENERAL.—Effective with respect to dialysis services provided on or after October 1, 1986, and before October 1, [1988,] *1989,* the Secretary of Health and Human Services shall establish the base rate for routine dialysis treatment in a free-standing facility and in a hospital-based facility under section 1881(b)(7) of the Social Security Act at a level equal to the respective rate in effect as of May 13, 1986, reduced by $2.00. *No change may be made in the base rate in effect as of September 30, 1989, unless the Secretary makes such change in accordance with the notice and comment requirements set forth in section 1871(b)(1).*

* * * * * * *

SEC. 9432. STATE UTILIZATION REVIEW SYSTEMS.

(a) IN GENERAL.—*(1)* The Secretary of Health and Human Services (in this section referred to as the "Secretary") may not, [during the period beginning with the date of the enactment of this Act and ending with the date that is 180 days after the day on which the report required by subsection (b) is submitted to the Congress,] publish final or interim final regulations requiring a State plan approved under title XIX of the Social Security Act to include a program requiring second surgical opinions or a program of inpatient hospital preadmission review.

(2) The Secretary may not, during the period beginning on the date of the enactment of the Omnibus Budget Reconciliation Act of 1989 and ending on the date that is 180 days after the date on which the report required by subsection (d) is submitted to the Congress, publish final or interim final regulations requiring a State plan approved under title XIX of the Social Security Act to include a program for ambulatory surgery, preadmission testing, or same-day surgery.

(b) REPORT.—

(1) * * *

* * * * * * *

(4) In this subsection *and subsection (d),* the term "medical plan" means a State plan approved under title XIX of the Social Security Act.

* * * * * * *

(d) REPORT.—The Secretary shall report to Congress, by no later than January 1, 1992, for each State in a representative sample of States—

(1) an analysis of the procedures for which programs for ambulatory surgery, preadmission testing, and same-day surgery are appropriate for patients who are covered under the State medicaid plan, and

(2) the effects of such programs on access of such patients to necessary care, quality of care, and costs of care.

In selecting such a sample of States, the Secretary shall include some States with medicaid plans that include such programs.

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OMNIBUS BUDGET RECONCILIATION ACT OF 1987

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TITLE IV—MEDICARE, MEDICAID, AND OTHER HEALTH-RELATED PROGRAMS

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PART 3—RELATING TO PART B

Subpart A—Provisions Relating to Payments for Physicians' Services

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SEC. 4049. FEE SCHEDULES FOR RADIOLOGIST SERVICES.

(a) * * *

(b) DEADLINES AND EFFECTIVE DATE.—

(1) The Secretary of Health and Human Services shall establish the relative value scale and fee schedules for radiologist services (under section 1834(b) of the Social Security Act) by not later than August 1, 1988, and shall report to Congress on the development of such fee schedules not later than August 1, 1988.

(2) The amendments made by this section shall apply to services performed on or after January 1, 1989[, and until such time as the Secretary of Health and Human Services implements physician fees schedules based on the relative value scale developed under section 1845(e) of the Social Security Act].

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Subpart B—Provisions Relating to Payments for Other Services

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SEC. 4064. CLINICAL DIAGNOSTIC LABORATORY TESTS.

(a) * * *

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[(e) STATE CERTIFICATION OF HIGH-VOLUME PHYSICIAN OFFICE LABS.—

(1) Section 1861(s) of such Act (42 U.S.C. 1395x(s)) is amended, in the sentence following paragraph (11), by inserting "a laboratory not independent of a physician's office that has a volume of clinical diagnostic laboratory tests exceeding 5,000 per year" after "physician's office,".

[(2) The amendment made by paragraph (1) shall apply to diagnostic tests performend on or after January 1, 1990.]

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Subtitle C—Nursing Home Reform

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PART 2—MEDICAID PROGRAM

SEC. 4211. REQUIREMENTS FOR NURSING FACILITIES.

(a) * * *

(b) INCORPORATING REQUIREMENT INTO STATE PLAN.—

(1) * * *

(2) STATE PLAN AMENDMENT REQUIRED.—A plan of a State under title XIX of the Social Security Act shall not be considered to have met the requirement of section 1902(a)(13)(A) of the Social Security Act (as amended by paragraph (1)(A) of this subsection), as of the first day of a Federal fiscal year (beginning on or after October 1, 1990), unless the State has submitted to the Secretary of Health and Human Services, as of April 1 before the fiscal year, an amendment to such State plan to provide for an appropriate adjustment in payment amounts for nursing facility services furnished during the Federal fiscal year. *Each such amendment shall include a detailed description of the specific methodology to be used in determining the appropriate adjustment in payment amounts for nursing facility services.* The Secretary shall, not later than September 30 before the fiscal year concerned, review each such plan amendment for compliance with such requirement and by such date shall approve or disapprove each such amendment. If the Secretary disapproves such an amendment, the State shall immediately submit a revised amendment which meets such requirement. The absence of approval of such a plan amendment does not relieve the State or any nursing facility of any obligation or requirement under title XIX of the Social Security Act (as amended by this Act).

SEC. 4215. ANNUAL REPORT.

The Secretary of Health and Human Services shall report to the Congress annually on the extent to which nursing facilities are complying with the requirements of subsections (b), (c), And (d) of section 1919 of the Social Security Act (as added by the amendments made by this part) and the number and type of enforcement actions taken by States and the Secretary under section 1919(h) of such Act (as added by section 4213 of this Act). *Each such report shall also include a summary of the information reported by States under section 1919(e)(7)(C)(iv) of such Act.*

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MEDICARE CATASTROPHIC COVERAGE ACT OF 1988

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TITLE IV—UNITED STATES BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE, OBRA TECHNICAL CORRECTIONS, AND MISCELLANEOUS PROVISIONS

Subtitle A—United States Bipartisan Commission on Comprehensive Health Care

SEC. 401. ESTABLISHMENT.

There is established a commission to be known as the United States Bipartisan Commission on Comprehensive Health Care (in this title referred to as the "Commission") *and also to be known as the "Claude Pepper Commission" or the "Pepper Commission".*

* * * * * * *

SEC. 403. MEMBERSHIP.

(a) * * *

(b) CHAIRMAN AND VICE [CHAIRMAN] *CHAIRMEN.*—The Commission shall elect a chairman and [vice chairman] *vice chairmen* from among its members.

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SEC. 405. POWERS.

(a) * * *

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(f) USE OF MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as Federal agencies, *and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.*

* * * * * * *

(j) PRINTING.—For purposes of costs relating to printing and binding, including the costs of personnel detailed from the Government Printing Office, the Commission shall be deemed to be a committee of the Congress.

SEC. 406. REPORT.

(a) REPORT ON COMPREHENSIVE LONG-TERM CARE SERVICES FOR THE ELDERLY AND DISABLED.—The Commission shall submit to Congress a report[, not later than 6 months after the effective date of the first Act providing appropriations for the Commission,] containing its findings and recommendations regarding comprehensive long-term care services for the elderly and disabled. The report shall include detailed recommendations for appropriate legislative initiatives respecting such services.

(b) REPORT ON COMPREHENSIVE HEALTH CARE SERVICES.—The Commission shall submit to Congress a report[, not later than 1 years after the effective date of the first Act providing appropriations for the Commission,] containing its findings and recommendations regarding comprehensive health care services for the elderly and disabled and comprehensive health care services for all individuals in the United States. The report shall include detailed recommendations for appropriate legislative initiatives respecting such services.

(c) DEADLINES.—The two reports required under this section shall be submitted concurrently by not later than November 9, 1989.

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PUBLIC HEALTH SERVICE ACT

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TITLE III—GENERAL POWERS AND DUTIES OF PUBLIC HEALTH SERVICE

PART A—RESEARCH AND INVESTIGATION

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GENERAL AUTHORITY RESPECTING RESEARCH, EVALUATIONS, AND DEMONSTRATIONS IN HEALTH STATISTICS, HEALTH SERVICES, AND HEALTH CARE TECHNOLOGY ASSESSMENT

SEC. 304. (a)[(1) The Secretary, acting through the National Center for Health Services Research and Health Care Technology Assessment and the National Center for Health Statistics, shall conduct and support research, demonstrations, evaluations, and statistical and epidemiological activities for the purpose of improving the effectiveness, efficiency, and quality of health services in the United States.

[(2) In carrying out paragraph (1), the Secretary shall give appropriate emphasis to research, demonstrations, evaluations, and statistical and epidemiological activities respecting—

[(A) the accessibility, acceptability, planning, organization, distribution, utilization, and financing of systems for the delivery of health care,

[(B) alternative methods for measuring and evaluating the quality of systems for the delivery of health care,

[(C) the collection, analysis, and dissemination of health related statistics,

[(D) alternative methods to improve and promote health statistical and epidemiological activities,

[(E) the safety, efficacy, effectiveness, cost effectiveness, and social, economic, and ethical impacts of health care technologies,

[(F) alternative methods for disseminating knowledge concerning health and health related activities,

[(G) the special health problems of low income and minority groups and the elderly to insure that these problems are assessed on a periodic regular basis,

[(H) the prevention of illness, disability, and premature deaths in the United States,

[(I) health care costs, increases in such costs, and the reasons for such increases, and

[(J) the impact of the environment on individual health and on health care.

[(3)] The Secretary may, through [the National Center for Health Services Research and Health Care Technology Assess-

ment] *the Agency for Health Care Research Policy* or the National Center for Health Statistics or using National Research Service Awards or other appropriate authorities, undertake and support training programs to provide for an expanded and continuing supply of individuals qualified to perform the research, evaluation, and demonstration projects set forth in [sections 305, 306, and 309] *in section 306 and in title IX.*

(b) To implement subsection (a), *and section 306* the Secretary may, in addition to any other authority which under other provisions of this Act or any other law may be used by him to implement such subsection, do the following:

* * * * * * *

(c)(1) The Secretary shall coordinate all health services research, evaluations, and demonstrations, all health statistical and epidemiological activities, and all research, evaluations, and demonstrations respecting the assessment of health care technology undertaken and supported through units of the Department of Health and Human Services. To the maximum extent feasible such coordination shall be carried out through [the National Center for Health Services Research and Health Care Technology Assessment] *the Agency for Health Care Research and Policy* and the National Center for Health Statistics.

(2) The Secretary shall coordinate the health services research, evaluations, and demonstrations, the health statistical and (where appropriate) epidemiological activities, and the research, evaluations, and demonstrations respecting the assessment of health care technology authorized by this Act through [the National Center for Health Services Research and Health Care Technology Assessment] *the Agency for Health Care Research and Policy* and the National Center for Health Statistics.

NATIONAL CENTER FOR HEALTH SERVICES RESEARCH

[SEC. 305. (a) There is established in the Department of Health and Human Services the National Center for Health Services Research and Health Care Technology Assessment (hereinafter in this section referred to as the "Center") which shall be under the direction of a Director who shall be appointed by the Secretary and supervised by the Assistant Secretary for Health (or such other officer of the Department as may be designated by the Secretary as the principal adviser to him for health programs).

[(b) In carrying out section 304(a), the Secretary, acting through the Center, shall undertake and support research, evaluation, and demonstration projects (which may include and shall be appropriately coordinated with experiments and demonstration activities authorized by the Social Security Act and the Social Security Amendments of 1967) respecting—

[(1) the accessibility, acceptability, planning, organization, disribution, technology, utilization, quality, and financing of health services and systems;

[(2) the supply and distribution, education and training, quality, utilization, organization, and costs of health manpower;

[(3) the design, utilization, organization, and cost of facilities and equipment;

[(4) the role of market forces in the health care system and the appropriate role they may play in restraining cost increases and improving the availability and quality of care; and

[(5) the safety, efficacy, effectiveness, cost effectiveness, economic, and social impacts of health care technologies.

No grant or contract shall be made under this subsection for the purpose of funding clinical research that is directly related to determining the cause of any disease or disorder or clinical research that is directly and principally designed to evaluate the efficacy of any therapeutic, diagnostic, or preventive health measure.

[(c) In carrying out section 304(a), the Secretary, acting through the Center, shall undertake and support research, evaluation, and demonstration projects (that may include and shall be appropriately coordinated with experiments and demonstration activities authorized by the Social Security Act (42 U.S.C. 301 et seq.) and the Social Security Amendments of 1967 (Public Law 90-248; 81 Stat. 821)) respecting the delivery of health care services in rural areas (including frontier areas), which may include projects with respect to—

[(1) the future of the rural hospital;

[(2) long-term health care for the rural elderly;

[(3) hospital care for the rural poor and uninsured; and

[(4) alternative health care delivery systems and managed health care in rural areas.

[(d)(1) The Secretary shall afford appropriate consideration to requests of—

[(A) State, regional, and local health planning and health agencies,

[(B) public and private entities and individuals engaged in the delivery of health care, and

[(C) other persons concerned with health services,

to have the Center or other units of the Department of Health and Human Services undertake research, evaluations, and demonstrations respecting specific aspects of the matters referred to in subsection (b).

[(2) In carrying out this section, the Secretary shall assist State and local health agencies through a user liaison program and a technical assistance program.

[(e)(1) The Secretary shall, by grants or contracts, or both, assist public or private nonprofit entities in meeting the costs of planning and establishing new centers, and operating existing and new centers, for multidisciplinary health services research, evaluations, training, policy analysis, and demonstrations respecting the matters referred to in subsection (b). To the extent practicable, the Secretary shall approve, in accordance with the requirements of this subsection and section 308, a number of applications for grants and contracts under this subsection which will result in at least three of such centers (including two national special emphasis centers, one of which (to be designated as the Health Care Management Center) shall focus on the improvement of management and organization in the health field, the training and retraining of administrators of health care enterprises, and the development of leaders,

planners, and policy analysts in the health field; and one of which (to be designated as the Health Services Policy Analysis Center) shall focus on the development and evaluation of national policies with respect to health services, including the development of health maintenance organizations and other forms of group practice, with a view toward improving the efficiencies of the health services delivery system) being operational in each fiscal year.

[(2)(A) No grant or contract may be made under this subsection for planning and establishing a center unless the Secretary determines that when it is operational it will meet the requirements listed in subparagraph (B) and no payment shall be made under a grant or contract for operation of a center unless the center meets such requirements.

[(B) The requirements referred to in subparagraph (A) are as follows:

[(i) There shall be a full-time director of the center who possesses a demonstrated capacity for sustained productivity and leadership in health services research, demonstrations, and evaluations, and there shall be such additional full-time professional staff as may be appropriate.

[(ii) The staff of the center shall represent all relevant disciplines.

[(iii) The center shall (I) be located within an established academic or research institution with departments and resources appropriate to the programs of the center, and (II) have working relationships with health service delivery systems where experiments in health services may be initiated and evaluated.

[(iv) The center shall select problems in health services for research, evaluations, policy analysis, and demonstrations on the basis of (I) their regional or national importance, (II) the unique potential for definitive research on the problem, and (III) opportunities for local application of the research findings.

[(v) Such additional requirements as the Secretary may by regulation prescribe.

[(f)(1) The Center shall advise the Secretary respecting health care technology issues and make recommendations with respect to whether specific health care technologies should be reimbursable under federally financed health programs.

[(2) In making recommendations respecting health care technologies, the Center shall consider the safety, efficacy, and effectiveness, and, as appropriate, the cost-effectiveness and appropriate uses of the technology.

[(3) In carrying out its responsibilities under this section respecting health care technologies, the Center shall cooperate and consult with the National Institutes of Health, the Food and Drug Administration, and any other interested Federal departments or agencies.

[(g)(1) The Secretary, acting through the Center, shall undertake and support (by grant or contract) research regarding technology diffusion, methods to assess health care technology, and specific health care technologies.

[(2) Any grant or contract under paragraph (1), the direct cost of which will exceed $50,000, may be made or entered into only after

consultation with the National Advisory Council on Health Care Technology Assessment.

[(h)(1) There is established the National Advisory Council on Health Care Technology Assessment (hereinfaater in this section referred to as the "Council"). The Council shall advise the Secretary and the Director of the Center with respect to the performance of the health care technology assessment functions prescribed by this section. The Council shall make recommendations to the Director with respect to the development of criteria and methods to be used by the Center in making health care technology coverage recommendations.

[(2) The Council shall consist of—

[(A) the Director of the National Institutes of Health, the Chief Medical Director of the Veterans' Administration, the Assistant Secretary for Health and Environment of the Department of Defense, the head of the Centers for Disease Control, the head of the Health Care Financing Administration, and such other Federal officials as the Secretary may specify, who shall be ex officio members, and

[(B) twelve voting members appointed by the Secretary.

[(3)(A) The Secretary shall appoint to the Council—

[(i) six individuals distinguished in the fields of medicine, engineering, and science (including social science);

[(ii) four individuals distinguished in the fields of law, ethics, economics, and management; and

[(iii) two individuals representing the interests of consumers of health care services.

[(B) The Secretary shall ensure that members of the Council, as a group, are representative of professions and entities concerned with, or affected by, health care technology.

[(4)(A) Each appointed member of the Council shall be appointed for a term of three years, except that—

[(i) any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term; and

[(ii) of the members first appointed after the date of the enactment of this subsection, four shall be appointed for a term of three years, four shall be appointed for a term of two years, and four shall be appointed for a term of one year, as designated by the Secretary at the time of appointment.

Appointed members may be appointed for additional terms and may serve after the expiration of their terms until their successors have taken office.

[(B) Members of the Council who are not officers or employees of the United States shall receive for each day they are engaged in the performance of the functions of the Council compensation at rates not to exceed the daily equivalent of the annual rate in effect for grade GS–18 of the General Schedule, including traveltime; and all members, while so serving away from their homes or regular places of business, may be allowed travel expenses, including per diem in lieu of subsistance, in the same manner as such expenses are authorized by section 5703 of title 5, United States Code, for persons in the Government service employed intermittently.

[(5) The Council shall annually elect one of its appointed members to serve as Chairman until the next election.

[(6) The Council shall meet at the call of the Chairman, but not less often than three times a year.

[(7) The Director of the Center shall (A) designate a member of the staff of the Center to act as Executive Secretary of the Council, and (B) make available to the Council such staff, information, and other assistance as it may require to carry out its functions.

[(i) In each fiscal year, seven and one-half percent of the amount made available under section 2511 for such fiscal year for evaluations shall be made available to the Assistant Secretary for Health to conduct or support (by both grants and contracts) through the Center, evaluations of health services and health care technology which evaluations are not being conducted or supported under this section or section 304. In administering this subsection, the Secretary shall assure that the amount to be made available in any fiscal year is seven and one-half percent of the maximum amount authorized to be made available under section 2511 in such fiscal year.

[(j) The authority of the Secretary under section 304(b) shall be available to him with respect to the undertaking and support of projects under this section.]

NATIONAL CENTER FOR HEALTH STATISTICS

SEC. 306. (a) There is established in the Department of Health and Human Services the National Center for Health Statistics (hereinafter in this section referred to as the "Center") which shall be under the direction of a Director who shall be appointed by the Secretary. *The Secretary, acting through the Center, shall conduct and support statistical and epidemiological activities for the purpose of improving the effectiveness, efficiency, and quality of health services in the United States.*

(b) In carrying out [section 304(a),] *subsection (a),* the Secretary, acting through the Center—

(1) shall collect statistics on—

* * * * * * *

(m) For health statistical and epidemiological activities undertaken or supported under this section, there are authorized to be appropriated $55,000,000 for fiscal year 1988 and such sums as may be necessary for each of the fiscal years 1989 and 1990.

INTERNATIONAL COOPERATION

SEC. 307. (a) For the purpose of advancing the status of the health sciences in the United States (and thereby the health of the American people), the Secretary may participate with other countries in cooperative endeavors in biomedical research, health care technology, and the health services research and statistical activities authorized by [sections 304, 305, 306, and 309] *section 306 and by title IX.*

* * * * * * *

GENERAL PROVISIONS RESPECTING [SECTIONS 304, 305, 306, 307, AND 309] *EFFECTIVENESS, EFFICIENT, AND QUALITY OF HEALTH SERVICES*

SEC. 308. (a)(1) Not later than March 15 of each year, the Secretary shall submit to the President and Congress the following reports:

(A) A report on—

(i) the administration of [sections 304 through 307 and section 309] *sections 304, 306, and 307 and title* during the preceding fiscal year; and

(ii) the current state and progress of health services research, health statistics, and health care technology.

(B) A report on health care costs and financing. Such report shall include a description and analysis of the statistics collected under section 306(b)(1)(G).

(C) A report on health resources. Such report shall include a description and analysis, by geographical area, of the statistics collected under section 306(b)(1)(E).

(D) A report on the utilization of health resources. Such report shall include a description and analysis, by age, sex, income, and geographic area, of the statistics collected under section 306(b)(1)(F).

(E) A report on the health of the Nation's people. Such report shall include a description and analysis, by age, sex, income, and geographic area, of the statistics collected under section 306(b)(1)(A).

(2) The reports required by subparagraphs (B) through (E) of paragraph (2) shall be prepared through [the National Center for Health Services Research and Health Care Technology Assessment] *the Agency for Health Care Research and Policy* and the National Center for Health Statistics.

(b)(1) No grant or contract may be made under [sections 304, 305, 306, 307, and 309] *section 304, 306, or 307* unless an application therefor has been submitted to the Secretary in such form and manner, and containing such information, as the Secretary may by regulation prescribe and unless a peer review group referred to in paragraph (2) has recommended the application for approval.

(2)(A) Each application submitted for a grant or contract [under section 304 or 305, in an amount exceeding $50,000 of direct costs and for a health services research, evaluation, or demonstration project, shall be submitted] *under section 306 in an amount exceeding $50,000 of direct costs shall be submitted* to a peer review group for an evaluation of the technical and scientific merits of the proposals made in each such application. [Each application for a grant, contract, or cooperative agreement in an amount exceeding $50,000 of direct costs for the dissemination of research findings or the development of research agendas (including conferences, workshops, and meetings) shall be submitted to a standing peer review group with persons with appropriate expertise and shall not be submitted to any peer review group established to review applications for research, evaluation, or demonstration projects. The Secretary, acting through the Director of the National Center for Health Services Research and Health Care Technology Assessment (or, as appropriate, through the Director of the National Center for

Health Statistics), shall establish such peer review groups as may be necessary to provide for such an evaluation of an application described in the first two sentences of this subparagraph.] *The Director of the National Center for Health Statistics shall establish such peer review groups as may be necessary to provide for such an evaluation of each such application.*

(B) A peer review group to which an application is submitted pursuant to subparagraph (A) shall report its finding and recommendations respecting the application to the Secretary, acting through [the Director involved,] *the Director of the National Center for Health Statistics,* in such form and manner as the Secretary shall by regulation prescribe. The Secretary may not approve an application described in such subparagraph unless a peer review group has recommended the application for approval.

(C) The Secretary, acting through [the Directors,] *the Director of the National Center for Health Statistics,* shall make appointments to the peer review groups required in subparagraph (A) from among persons who are not officers or employees of the United States and who possess appropriate technical and scientific qualifications.

(3) If an application is submitted under section [304, 305, or 306] *306* for a grant or contract for a project for which a grant or contract may be made or entered into under another provision of this Act, such application may not be approved under [section 304, 305, or 306] *any of such sections* and funds appropriated under this section may not be obligated for such grant or contract. The applicant who submitted such application shall be notified of the other provision (or provisions) of this Act under which such application may be submitted.

(c) The aggregate number of grants and contracts made or entered into under sections 304 and 305 for any fiscal year respecting a particular means of delivery of health services or another particular aspect of health services may not exceed twenty; and the aggregate amount of funds obligated under grants and contracts under such sections for any fiscal year respecting a particular means of delivery of health services or another particular aspect of health services may not exceed $5,000,000.

(d) No information, if an establishment or person supplying the information or described in it is identifiable, obtained in the course of activities undertaken or supported under [section 304, 305, 306, 307, or 309] *section 304, 306, or 307* may be used for any purpose other than the purpose for which it was supplied unless such establishment or person has consented (as determined under regulations of the Secretary) to its use for such other purpose and [(1)] in the case of information obtained in the course of health statistical or epidemiological activities under section 304 or 306, such information may not be published or released in other form if the particular establishment or person supplying the information or described in it is identifiable unless such establishment or person has consented (as determined under regulations of the Secretary) to its publication or release [in other form, and (2) in the case of information obtained in the course of health services research, evaluations, or demonstrations under section 304 or 305 or in the course of health care technology activities under section 309, such infor-

mation may not be published or released in other form if the person who supplied the information or who is described in it is identifiable unless such person has consented (as determined under regulations of the Secretary) to its publication or release in other form.] *in other form.*

(e)(1) Payments of any grant or under any contract under [section 304, 305, 306, 307, or 309] may be made in advance or by way of reimbursement, and in such installments and on such conditions, as the Secretary deems necessary to carry out the purposes of such section.

(2) The amounts otherwise payable to any person under a grant or contract made under [section 304, 305, 306, 307, or 309] *section 304, 306, or 307*] *shall be reduced by—*

(A) amounts equal to the fair market value of any equipment or supplies furnished to such person by the Secretary for the purpose of carrying out the project with respect to which such grant or contract is made, and

(B) amounts equal to the pay, allowances, traveling expenses, and related personnel expenses attributable to the performance of services by an officer or employee of the Government in connection with such project, if such officer or employee was assigned or detailed by the Secretary to perform such services,

but only if such person requested the Secretary to furnish such equipment or supplies, or such services, as the case may be.

(f) Contracts may be entered into under [section 304, 305, 306, or 309] *section 304 or 306* without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

(g)(1) The Secretary shall—

(A) publish, make available and disseminate, promptly in understandable form and on as broad a basis as practicable, the results of health services research, demonstrations, and evaluations undertaken and supported under sections 304 and 305;

(B) make available to the public data developed in such research, demonstrations, and evaluations; and

(C) provide indexing, abstracting, translating, publishing, and other services leading to a more effective and timely dissemination of information on health services research, demonstrations, and evaluations in health care delivery to public and private entities and individuals engaged in the improvement of health care delivery and the general public; and undertake programs to develop new or improved methods for making such information available.

[Except as provided in subsection (d), the Secretary may not restrict the publication and dissemination of data from, and results of projects undertaken by, centers supported under section 305(d).]

(2) The Secretary shall (A) take such action as may be necessary to assure that statistics developed under [sections 304, 305, 306, and 309] *sections 304 and 306* are of high quality, timely, comprehensive as well as specific, standardized, and adequately analyzed and indexed, and (B) publish, make available, and disseminate such statistics on as wide a basis as is practicable.

(h)(l) Except where The Secretary determines that unusual circumstances make a larger percentage necessary in order to effectuate the purposes of [section 304, 305, 306, or 309] *section 306,* a

grant or contract under [section 304, 305, 306, or 309] *any of such sections* with respect to any project for construction of a facility or for acquisition of equipment may not provide for payment of more than 50 per centum of so much of the cost of the facility or equipment as the Secretary determines is reasonably attributable to research, evaluation, or demonstration purposes.

* * * * * * *

[(i)(1)(A) For health service research, evaluation, and demonstration activities undertaken or supported under section 304 or 305, there are authorized to be appropriated $30,000,000 for fiscal year 1988 and such sums as may be necessary for each of the fiscal years 1989 and 1990. At least 20 percent of the amount appropriated under the preceding sentence for any fiscal year or $6,000,000, whichever is less, shall be available only for health services research, evaluation and demonstration activities directly undertaken through the National Center for Health Services Research and Health Care Technology Assessment, and at least 10 percent of such amount or $1,500,000 whichever is less shall be available only for the user liaison program and the technical assistance program referred to in section 305(d)(2) and for dissemination activities directly undertaken through such Center.

[(B) For health care technology assessment activities undertaken under subsections (b)(5), (g), and (h) of section 305, the Secretary shall obligate from funds appropriated under this paragraph not less than $4,500,000 for each of the fiscal years 1988 through 1990.

[(C) For grants under section 309, the Secretary shall make available from funds appropriated under this paragraph not more than $750,000 for each of the fiscal years 1988 through 1990. Of such amounts made available, the Secretary shall, with respect to non-Federal contributions made available by grantees pursuant to section 309(a)(2)(B), obligate during each such fiscal year such amounts as may be necessary to pay the Federal share appropriate under such section as a result of such contributions.

[(D) Of the amounts appropriated under this paragraph for any fiscal year, not more than $1,500,000 may be used for grants and contracts for all the costs of planning, establishing, and operating centers under section 305(e).

[(2) For health statistical and epidemiological activities undertaken or supported under section 304 or 306, there are authorized to be appropriated $55,000,000 for fiscal year 1988 and such sums as may be necessary for each of the fiscal years 1989 and 1990.]

[GRANTS FOR A COUNCIL ON HEALTH CARE TECHNOLOGY

[SEC. 309. (a)(1) In accordance with this section, the Secretary shall make grants for the planning, development, establishment, and operation of a council on health care technology.

[(2)(A)(i) The Secretary shall make an initial grant under paragraph (1) for the planning, development, and establishment of the council. The amount of an initial grant may not exceed $500,000 and may be made for not more than two-thirds of the cost of the planning, development, and establishment of the council.

[(ii) The Secretary shall request the National Academy of Sciences, acting through appropriate units, to submit an application

for an initial grant under paragraph (1). If the Academy submits an acceptable application, the Secretary shall make the initial grant to the Academy. If the Academy does not submit an acceptable application for an initial grant under paragraph (1), the Secretary shall request one or more appropriate nonprofit private entities to submit an application for an initial grant under paragraph (1) and shall make a grant to the entity which submits the best acceptable application.

[(B) The Secretary may not make a grant for the operation of the council unless the application submitted to the Secretary for the grant containes written assurances from the applicant that the applicant will expend from non-Federal sources for the operation of the council an amount equal to at least twice the amount of the grant applied for, except that for fiscal years 1988 and 1989, the Secretary may only require expenditures from non-Federal sources in an amount not less than the amount of the grant applied for.

[(b) The purposes of the council shall include–

[(1) promoting the development and application of appropriate health care technology assessments; and

[(2) the review of existing health care technologies in order to identify obsolete or inappropriately used health care technologies.

[(c)(1) In order to qualify for a grant under this section for the operation of the council, the applicant must demonstrate that it has the capability to, and that under the grant it will—

[(A) serve as a clearinghouse for information on health care technologies and health care technology assessment;

[(B) collect and analyze data concerning specific health care technologies;

[(C) identify needs in the assessment of specific health care technologies and research on assessment methodologies;

[(D) develop and evaluate criteria and methodlogies for health care technology assessment;

[(E) promote education, training, and technical assistance in the use of health care technology assessment methodologies and results; and

[(F) stimulate, coordinate, and commission assessments of health care technologies.

[(2) No funds from any grant made by the Secretary under this section for the planning, development, and establishment of the council may be used to conduct any assessment of a health care technology.

[(d) In order to qualify for an initial grant under this section to plan, develop and establish the council under this section, the applicant must assure that the council will be composed of at least 10 members—

[(1) each of whom has education, training, experience, or expertise relating to the quality and cost effectiveness of health care technologies, and

[(2) who, as a group, provide representation of organizations of health professionals, hospitals, and other health care providers, health care insurers, employers, consumers, and manufacturers of products for health care.

[(c) As a condition for receiving a grant under this section, the applicant must agree to submit to the Secretary an annual report on the council's activities under the grant. The Secretary shall provide for timely transmittal of a copy of each such report to the Committee of Labor and Human Resources of the Senate and the Committee on Energy and Commerce of the House of Representatives.

[(f) No grant may be made under this section unless an application is submitted to the Secretary in such form and containing such information as the Secretary shall prescribe.]

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COMMUNITY HEALTH CENTERS

SEC. 330. (a) * * *

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(e)(1) * * *

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(3) Except as provided in subsection (d)(1)(B), the Secretary may not approve an application for a grant under paragraph (1)(A) or (1)(B) of subsection (d) unless the Secretary determines that the entity for which the application is submitted is a community health center (within the meaning of subsection (a)) and that—

(A) * * *

* * * * * * *

(G) the center has established a governing board which (i) *except in the case of an entity operated by an Indian tribe or tribal or Indian organization under the Indian Self-Determination Act,* is composed of individuals, a majority of whom are being served by the center and who, as a group, represent the individuals being served by the center, and (ii) meets at least once a month, selects the services to be provided by the center, schedules the hours during which such services will be provided, approves the center's annual budget, approves the selection of a director for the center and, except in the case of a governing board of a public center (as defined in the second sentence of this paragraph), establishes general policies for the center; and if the application is for a second or subsequent grant for a public center, the governing body has approved the application or if the governing body has not approved the application, the failure of the governing body to approve the application was unreasonable;

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TITLE IV—NATIONAL RESEARCH INSTITUTES

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PART F—AWARDS AND TRAINING

NATIONAL RESEARCH SERVICE AWARDS

SEC. 487. (a) * * *

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(d) For the purpose of making payments under National Research Service Awards and under grants for such Awards, there are authorized to be appropriated $300,000,000 for fiscal year 1989 and such sums as may be necessary for fiscal year 1990. Of the amounts appropriated under this subsection—

(1) * * *

* * * * * * *

(3) one-half of one percent shall be made available to the Secretary, acting through the Administrator of the Health Resources and Services Administration, for payments under National Research Service Awards which (A) are made to individuals affiliated with entities which have received grants or contracts under section 780, 784, or 786, and (B) are for research in primary medical care; and one-half of one percent shall be made available for payments under National Research Service Awards made for health services research by the [National Center for Health Services Research and Health Care Technology Assessment] *Agency for Health Care Research and Policy* under section 304(a)(3); and

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TITLE IX—AGENCY FOR HEALTH CARE RESEARCH AND POLICY

PART A—ESTABLISHMENT AND GENERAL DUTIES

SEC. 901. ESTABLISHMENT.

(a) IN GENERAL.—There is established within the Service an agency to be known as the Agency for Health Care Research and Policy.

(b) PURPOSE.—The purpose of the Agency is to enhance the quality, appropriateness, and effectiveness of health care services, and access to such services, through the establishment of a broad base of scientific research and through the promotion of improvements in clinical practice and in the organization, financing, and delivery of health care services.

(c) APPOINTMENT OF ADMINISTRATOR.—There shall be at the head of the Agency an official to be known as the Administrator for Health Care Research and Policy. The Administrator shall be appointed by the Secretary. The Secretary, acting through the Administrator, shall carry out the authorities and duties established in this title.

SEC. 902. GENERAL AUTHORITIES AND DUTIES.

(a) IN GENERAL.—In carrying out section 901(b), the Administrator shall conduct and support research, demonstration projects, evaluations, training, and the dissemination of information, on health

care services and on systems for the delivery of such services, including activities with respect to—

(1) the effectiveness, efficiency, and quality of health care services;

(2) subject to subsection (d), the outcomes of health care services and procedures;

(3) clinical practice, including primary care and practice-oriented research;

(4) health care technologies, facilities, and equipment;

(5) health care costs, productivity, and market forces;

(6) health promotion and disease prevention;

(7) health statistics and epidemiology; and

(8) medical liability.

(b) REQUIREMENTS WITH RESPECT TO RURAL AREAS AND UNDERSERVED POPULATIONS.—In carrying out subsection (a), the Administrator shall undertake and support research, demonstration projects, and evaluations with respect to—

(1) the delivery of health care services in rural areas (including frontier areas); and

(2) the health of low-income groups, minority groups, and the elderly.

(c) MULTIDISCIPLINARY CENTERS.—The Administrator may provide financial assistance to public or nonprofit private entities for meeting the costs of planning and establishing new centers, and operating existing and new centers, for multidisciplinary health services research, demonstration projects, evaluations, training, policy analysis, and demonstrations respecting the matters referred to in subsection (b).

(d) RELATION TO CERTAIN AUTHORITIES REGARDING SOCIAL SECURITY.—Activities required in this section may include, and shall be appropriately coordinated with, experiments, demonstration projects, and other related activities authorized by the Social Security Act and the Social Security Amendments of 1967. Activities under subsection (a)(2) shall be carried out consistent with section 1142 of the Social Security Act.

SEC. 903. DISSEMINATION.

(a) IN GENERAL.—The Administrator shall—

(1) promptly publish, make available, and otherwise disseminate, in understandable form and on as broad a basis as practicable, the results of research, demonstration projects, and evaluations conducted or supported under this title;

(2) promptly make available to the public data developed in such research, demonstration projects, and evaluations;

(3) provide indexing, abstracting, translating, publishing, and other services leading to a more effective and timely dissemination of information on research, demonstration projects, and evaluations with respect to health care to public and private entities and individuals engaged in the improvement of health care delivery and the general public, and undertake programs to develop new or improved methods for making such information available; and

(4) as appropriate, provide technical assistance to State and local health agencies and conduct liaison activities to such agencies to foster dissemination.

(b) PROHIBITION AGAINST RESTRICTIONS.—Except as provided in subsection (c), the Administrator may not restrict the publication or dissemination of data from, or the resutls of, projects conducted or supported under this title.

(c) LIMITATION ON USE OF CERTAIN INFORMATION.—No information, if an establishment or person supplying the information or described in it is identifiable, obtained in the course of activities undertaken or supported under this title may be used for any purpose other than the purpose for which it was supplied unless such establishment or person has consented (as determined under regulations of the Secretary) to its use for such other purpose. Such information may not be published or released in other form if the person who supplied the information or who is described in it is identifiable unless such person has consented (as determined under regulations of the Secretary) to its publication or release in other form.

(d) CERTAIN INTERAGENCY AGREEMENT.—The Administrator and the Director of the National Library of Medicine shall enter into an agreement providing for the implementation of subsection (a)(3).

SEC. 904. HEALTH CARE TECHNOLOGY AND TECHNOLOGY ASSESSMENT.

(a) IN GENERAL.—In carrying out section 901(b), the Administrator shall promote the development and application of appropriate health care technology assessments—

(1) by identifying needs in, and establishing priorities for, the assessment of specific health care technologies;

(2) by developing and evaluating criteria and methodologies for health care technology assessment;

(3) by conducting and supporting research on the development and diffusion of health care technology;

(4) by conducting and supporting research on assessment methodologies; and

(5) by promoting education, training, and technical assistance in the use of health care technology assessment methodologies and results.

(b) SPECIFIC ASSESSMENTS.—

(1) IN GENERAL.—carrying out section 901(b), the Administrator shall conduct and support specific assessments of health care technologies.

(2) CONSIDERATION OF CERTAIN FACTORS.—In carrying out paragraph (1), the Administrator shall consider the safety, efficacy, and effectiveness, and, as appropriate, the cost-effectiveness and appropriate uses of such technologies.

(c) INFORMATION CENTER.—

(1) IN GENERAL.—There shall be established at the National Library of Medicine an information center on health care technologies and health care technology assessment.

(2) INTERAGENCY AGREEMENT.—The Administrator and the Director of the National Library of Medicine shall enter into an agreement providing for the implementation of paragraph (1).

(d) RECOMMENDATIONS WITH RESPECT TO HEALTH CARE TECHNOLOGY.—

(1) IN GENERAL.—The Administrator shall make recommendations to the Secretary and to the Administrator of the Health Care Financing Administration with respect to whether specific health care technologies should be reimbursable under federally financed health programs, including recommendations with respect to any conditions and requirements under which any such reimbursements should be made.

(2) CONSIDERATION OF CERTAIN FACTORS.—In making recommendations respecting health care technologies, the Administrator shall consider the safety, efficacy, and effectiveness, and, as appropriate, the cost-effectiveness and appropriate uses of such technologies.

(3) CONSULTATIONS.—In carrying out this subsection, the Administrator shall cooperate and consult with the Director of the National Institutes of Health, the Commissioner of Food and Drugs, and the heads of any other interested Federal department or agency.

PART B—FORUM FOR QUALITY AND EFFECTIVENESS IN HEALTH CARE

SEC. 911. ESTABLISHMENT OF OFFICE.

There is established within the Agency an office to be known as the Office of the Forum for Quality and Effectiveness in Health Care. The office shall be headed by a director, who shall be appointed by the Administrator.

SEC. 912. DUTIES.

(a) ESTABLISHMENT OF FORUM PROGRAM.—The Administrator, acting through the Director, shall establish a program to be known as the Forum for Quality and Effectiveness in Health Care. For the purpose of promoting the quality, appropriateness, and effectiveness of health care, the Director, using the process set forth in section 913, shall arrange for the development and periodic review and updating of—

(1) clinically relevant guidelines that may be used by physicians and health care practitioners to assist in determining how diseases, disorders, and other health conditions can most effectively and appropriately be diagnosed and treated; and

(2) standards of quality, performance measures, and medical review criteria through which health care providers and other appropriate entities may assess or review the provision of health care and assure the quality of such care.

(b) CERTAIN REQUIREMENTS.—Guidelines, standards, performance measures, and review criteria under subsection (a) shall—

(1) be based on the best available research and professional judgment regarding the effectiveness and appropriateness of health care services and procedures; and

(2) be presented in formats appropriate for use by physicians, health care practitioners, providers, and medical review organizations and in formats appropriate for use by consumers of health care.

(c) AUTHORITY FOR CONTRACTS.—In carrying out this part, the Director may enter into contracts with public or nonprofit private entities.

SEC. 913. PANELS OF EXPERTS AND CONSUMERS.

(a) DEVELOPMENT OF GUIDELINES AND STANDARDS THROUGH PANELS AND CONTRACTS.—The Director shall—

(1) convene panels of appropriately qualified experts (including practicing physicians) and health care consumers for the purpose of developing and periodically reviewing and updating the guidelines, standards, performance measures, and review criteria described in section 912(a); and

(2) enter into contracts with public and nonprofit private entities for such purpose.

(b) AUTHORITY FOR ADDITIONAL PANELS.—The Director may convene panels of appropriately qualified experts (including practicing physicians) and health care consumers for the purpose of—

(1) making recommendations to the Director on priorities and strategies for carrying out this part;

(2) developing the standards and criteria described in section 914(b); and

(3) providing advice to the Administrator and the Director with respect to any other activities carried out under this part or under section 902(a)(2).

(c) SELECTION OF PANEL MEMBERS.—In selecting individuals to serve on panels convened under this section, the Director shall consult with a broad range of interested individuals and organizations, including organizations representing physicians in the general practice of medicine and organizations representing physicians in specialties pertinent to the purposes of the panel involved. The Director shall seek to appoint physicians reflecting a variety of practice settings.

SEC. 914. ADDITIONAL REQUIREMENTS.

(a) PROGRAM AGENDA.—

(1) IN GENERAL.—The Director shall provide for an agenda for the development of the guidelines, standards, performance measures, and review criteria described in section 912(a), including—

(A) with respect to the guidelines, identifying specific diseases, disorders, and other health conditions for which the guidelines are to be developed and those that are to be given priority in the development of the guidelines; and

(B) with respect to the standards, performance measures, and review criteria, identifying specific aspects of health care for which the standards, performance measures, and review criteria are to be developed and those that are to be given priority in the development of the standards, performance measures, and review criteria.

(2) CONSIDERATION OF CERTAIN FACTORS IN ESTABLISHING PRIORITIES.—Factors considered by the Director in establishing priorities for purposes of paragraph (1) shall include consideration of the extent to which the guidelines, standards, performance measures, and review criteria involved can be expected—

(A) to improve methods of diagnosis and treatment for the benefit of a significant number of individuals;

(B) to reduce clinically significant variations among physicians in the particular services and procedures utilized in making diagnoses and providing treatments; and

(C) to reduce clinically significant variations in the outcomes of health care services and procedures.

(b) STANDARDS AND CRITERIA.—

(1) EXPERT PANELS.—The Director shall establish standards and criteria to be utilized by the expert panels convened under section 913 in the development and periodic review and updating of the guidelines, standards, performance measures, and review criteria described in section 912(a).

(2) RECIPIENTS OF CONTRACTS.—The Director shall establish standards and criteria to be utilized for the purpose of ensuring that contracts entered into for the development or periodic review or updating of the guidelines, standards, performance measures, and review criteria described in section 912(a) will be entered into only with appropriately qualified entities.

(3) CERTAIN REQUIREMENTS FOR STANDARDS AND CRITERIA.—The Director shall ensure that the standards and criteria established under paragraphs (1) and (2) specify that—

(A) appropriate consultations with interested individuals and organizations are to be conducted in the development of the guidelines, standards, performance measures, and review criteria described in section 912(a); and

(B) such development may be accomplished through the adoption, with or without modification of guidlines, standards, performance measures, and review criteria that—

(i) meet the requirements of this part; and

(ii) are developed by entities independently of the program established in this part.

(4) IMPROVEMENTS OF STANDARDS AND CRITERIA.—The Director shall conduct and support research with respect to improving the standards and criteria developed under this subsection.

(c) DISSEMINATION.—The Director shall promote and support the dissemination of the guidelines, standards, performance measures, and review criteria described in section 912(a). Such dissemination shall be carried out through organizations representing health care providers, organizations representing health care consumers, peer review organizations, and other appropriate entities.

(d) PILOT TESTING.—The Director may conduct or support pilot testing of the guidelines, standards, performance measures, and review criteria developed under section 912(a). Any such pilot testing may be conducted prior to, or concurrently with, their dissemination under subsection (c).

(e) EVALUATIONS.—The Director shall conduct and support evaluations of the extent to which the guidelines, standards, performance standards, and review criteria developed under section 912 have had an effect on the clincial practice of medicine.

(f) RECOMMENDATIONS TO ADMINISTRATOR.—The Director shall make recommendations to the Administrator on activities that should be carried out under section 902(a)(2) and under section 1142 of the Social Security Act, including recommendations of particular research projects that should be carried out with respect to—

(1) evaluating the outcomes of health care services and procedures;

(2) developing the standards and criteria required in subsection (b); and

(3) promoting the utilization of the guidelines, standards, performance standards, and review criteria developed under section 912(a)

PART C—GENERAL PROVISIONS

SEC. 921. ADVISORY COUNCIL FOR HEALTH CARE RESEARCH, EVALUATION, AND POLICY.

(a) ESTABLISHMENT.—There is established an advisory council to be know as the National Advisory Council for Health Care Research, Evaluation, and Policy.

(b) DUTIES.—

(1) IN GENERAL.—The Council shall advise the Secretary and the Administrator with respect to activities to carry out the purpose of the Agency under section 901(b).

(2) CERTAIN RECOMMENDATIONS.—Activities of the Council under paragraph (1) shall include making recommendations to the Administrator regarding priorities for a national agenda and strategy for—

(A) the conduct of research, demonstration projects, and evaluations with respect to health care, including clinical practice and primary care;

(B) the development and periodic review and updating of guidelines for clinical practice, standards of quality, performance measures, and medical review criteria with respect to health care;

(C) the development and application of appropriate health care technology assessments; and

(D) the conduct of research on outcomes of health care services and procedures under section 1142 of the Social Security Act.

(c) MEMBERSHIP.—

(1) IN GENERAL.—The Council shall, in accordance with this subsection, be composed of appointed members and ex officio members. All members of the Council shall be voting members.

(2) APPOINTED MEMBERS.—The Administrator shall appoint to the Council 15 appropriately qualified representatives of the public who are not officers or employees of the United States. The Administrator shall ensure that the appointed members of the Council, as a group, are representative of professions and entities concerned with, or affected by, activities under this title and under section 1142 of the Social Security Act. Of such members—

(A) 8 shall be individuals distinguished in the conduct of research, demonstration projects, and evaluations with respect to health care;

(B) 3 shall be individuals distinguished in the practice of medicine;

(C) 2 shall be individuals distinguished in the fields of business, law, ethics, economics, and public policy; and

(D) 2 shall be individuals representing the interests of consumers of health care.

(3) EX OFFICIO MEMBERS.—The Administrator shall designate as ex officio members of the Council the Director of the National Institutes of Health, the Director of the Centers for Disease Control, the Administrator of the Health Care Financing Administration, the Assistance Secretary of Defense (Health Affairs), the Chief Medical Officer of the Department of Veterans Affairs, and such other Federal officials as the Administrator may consider appropriate for membership on the Council.

(d) TERMS.—

(1) Except as provided in paragraph (2), members of the Council appointed under subsection (c)(2) shall serve for a term of 3 years.

(2) Of the members first appointed to the Council under subsection (c)(2), the Secretary shall appoint 5 members to serve for a term of 3 years, 5 members to serve for a term of 2 years, and 5 members to serve for a term of 1 year.

(e) VACANCIES.—

(1) Any member of the Council appointed under subsection (c)(2) to fill a vacancy occurring before the expiration of the term of the predecessor of the member shall be appointed for the remainder of the term of the predecessor.

(2) A member of the Council appointed under subsection (c)(2) may continue to serve after the expiration of the term of the member until a successor is appointed.

(f) CHAIR.—The Administrator shall, from among the members of the Council appointed under subsection (c)(2), designate an individual to serve as the chair of the Council.

(g) MEETINGS.—The Council shall meet not less than once during each discrete 4-month period and shall otherwise meet at the call of the Administrator or the chair.

(h) COMPENSATION AND REIMBURSEMENT OF EXPENSES.—

(1) APPOINTED MEMBERS.—Members of the Council appointed under subsection (c)(2) shall receive compensation for each day (including traveltime) engaged in carrying out the duties of the Council. Such compensation may not be in an amount in excess of the maximum rate of basic pay payable for GS-18 of the General Schedule.

(2) EX OFFICIO MEMBERS.—Officials designated under subsection (c)(3) as ex officio members of the Council may not receive compensation for service on the Council in addition to the compensation otherwise received for duties carried out as officers of the United States.

(i) STAFF.—The Administrator shall provide to the Council such staff, information, and other assistance as may be necessary to carry out the duties of the Council.

(j) DURATION.—Notwithstanding section 14(a) of the Federal Advisory Committee Act, the Council shall continue in existence until otherwise provided by law.

SEC. 922. PEER REVIEW WITH RESPECT TO GRANTS AND CONTRACTS.

(a) REQUIREMENT OF REVIEW.—

(1) IN GENERAL.—Appropriate technical and scientific peer review shall be conducted with respect to each application for a grant, cooperative agreement, or contract under this title.

(2) REPORTS TO ADMINISTRATOR.—Each peer review group to which an application is submitted pursuant to paragraph (1) shall report it finding and recommendations respecting the application to the Administrator in such form and in such manner as the Administrator shall require.

(b) APPROVAL AS PRECONDITION OF AWARDS.—The Administrator may not approve an application described in subsection (a)(1) unless the application is recommended for approval by a peer review group established under subsection (c).

(c) ESTABLISHMENT OF PEER REVIEW GROUPS.—

(1) IN GENERAL.—The Administrator shall establish such technical and scientific peer review groups as may be necessary to carry out this section. Such groups shall be established without regard to the provisions of title 5, United States Code, that govern appointments in the competitive service, and without regard to the provisions of chapter 51, and subchapter III of chapter 53, of such title that relate to classification and pay rates under the General Schedule.

(2) MEMBERSHIP.—The members of any peer review group established under this section shall be appointed from among individuals who are not officers or employees of the United States and who by virtue of their training or experience are eminently qualified to carry out the duties of such peer review group.

(3) DURATION.—Notwithstanding section 14(a) of the Federal Advisory Committee Act, peer review groups established under this section shall continue in existence until otherwise provided by law.

(d) CATEGORIES OF REVIEW.—

(1) IN GENERAL.—With respect to technical and scientific peer review under this section, such review of applications with respect to research, demonstration projects, or evaluations shall be conducted by different peer review groups than the peer review groups that conduct such review of applications with respect to dissemination activities or the development of research agendas (including conferences, workshops, and meetings).

(2) AUTHORITY FOR PROCEDURAL ADJUSTMENTS IN CERTAIN CASES.—In the case of applications described in subsection (a)(1) for financial assistance whose direct costs will not exceed $50,000, the Administrator may make appropriate adjustments in the procedures otherwise established by the Administrator for the conduct of peer review under this section. Such adjustments may be made for the purpose of encouraging the entry of individuals into the field of research, for the purpose of encouraging clinical practice-oriented research, and for such other purposes as the Administrator may determine to be appropriate.

(e) REGULATIONS.—The Secretary shall issue regulations for the conduct of peer review under this section.

SEC. 923. CERTAIN PROVISIONS WITH RESPECT TO DEVELOPMENT, COLLECTION, AND DISSEMINATION OF DATA.

(a) STANDARDS WITH RESPECT TO UTILITY OF DATA.—With respect to data developed or collected by any entity for the purpose described in section 901(b), the Administrator shall, in order to assure the utility of such data for all interested entities, establish guidelines for uniform methods of developing and collecting such data. Such guidelines shall include specifications for the development and collection of data on the outcomes of health care services and procedures.

(b) STATISTICS.—The Administrator shall—

(1) take such action as may be necessary to assure that statistics developed under this title are of high quality, timely, and comprehensive, as well as specific, standardized, and adequately analyzed and indexed; and

(2) publish, make available, and disseminate such statistics on as wide a basis as is practicable.

SEC. 924. ADDITIONAL PROVISIONS WITH RESPECT TO GRANTS AND CONTRACTS.

(a) REQUIREMENT OF APPLICATION.—The Administrator may not, with respect to any program under this title authorizing the provision of grants, cooperative agreements, or contracts, provide any such financial assistance unless an application for the assistance is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Administrator determines to be necessary to carry out the program involved.

(b) PROVISION OF SUPPLIES AND SERVICES IN LIEU OF FUNDS.—

(1) IN GENERAL.—Upon the request of an entity receiving a grant, cooperative agreement, or contract under this title, the Secretary may, subject to paragraph (2), provide supplies, equipment, and services for the purpose of aiding the entity in carrying out the project involved and, for such purpose, may detail to the entity any officer or employee of the Department of Health and Human Services.

(2) CORRESPONDING REDUCTION IN FUNDS.—With respect to a request described in paragraph (1), the Secretary shall reduce the amount of the financial assistance involved by an amount equal to the costs of detailing personnel and the fair market value of any supplies, equipment, or services provided by the Administrator. The Secretary shall, for the payment of expenses incurred in complying with such request, expend the amounts withheld.

(c) APPLICABILITY OF CERTAIN PROVISIONS WITH RESPECT TO CONTRACTS.—Contracts may be entered into under this part without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

SEC. 925. CERTAIN ADMINISTRATIVE AUTHORITIES.

(a) DEPUTY ADMINISTRATOR AND OTHER OFFICERS AND EMPLOYEES.—

(1) DEPUTY ADMINISTRATOR.—The Administrator may appoint a deputy administrator for the Agency.

(2) OTHER OFFICERS AND EMPLOYEES.—The Administrator may appoint and fix the compensation of such officers and employees as may be necessary to carry out this title. Except as otherwise provided by law, such officers and employees shall be appointed in accordance with the civil service laws and their compensation fixed in accordance with title 5, United States Code.

(b) FACILITIES.—The Secretary, in carrying out this title—

(1) may acquire, without regard to the Act of March 3, 1877 (40 U.S.C. 34), by lease or otherwise through the Administrator of General Services, buildings or portions of buildings in the District of Columbia or communities located adjacent to the District of Columbia for use for a period not to exceed 10 years; and

(2) may acquire, construct, improve, repair, operate, and maintain laboratory, research, and other necesssary facilities and equipment, and such other real or personal property (including patents) as the Secretary deems necessary.

(c) PROVISION OF FINANCIAL ASSISTANCE.—The Administrator, in carrying out this title, may make grants to, and enter into cooperative agreements with, public and nonprofit private entities and individuals, and, when appropriate, may enter into contracts with public and private entities and individuals.

(d) UTILIZATION OF CERTAIN PERSONNEL AND RESOURCES.—

(1) DEPARTMENT OF HEALTH AND HUMAN SERVICES.—The Administrator, in carrying out this title, may utilize personnel and equipment, facilities, and other physical resources of the Department of Health and Human Services, permit appropriate (as determined by the Secretary) entities and individuals to utilize the physical resources of such Department, and provide technical assistance and advice.

(2) OTHER AGENCIES.—The Administrator, in carrying out this title, may use, with their consent, the services, equipment, personnel, information, and facilities of other Federal, State, or local public agencies, or any foreign government, with or without reimbursement of such agencies.

(e) CONSULTANTS.—The Secretary, in carrying out this title, may secure, from time to time and for such periods as the Administrator deems advisable but in accordance with section 3109 of title 5, United States Code, the assistance and advice of consultants from the United States or abroad.

(f) EXPERTS.—

(1) IN GENERAL.—The Secretary may, in carrying out this title, obtain the services of not more than 50 experts or consultants who have appropriate scientific or professional qualifications. Such experts or consultants shall be obtained in accordance with section 3109 of title 5, United States Code, except that the limitation in such section on the duration of service shall not apply.

(2) TRAVEL EXPENSES.—

(A) Experts and consultants whose services are obtained under paragraph (1) shall be paid or reimbursed for their expenses associated with traveling to and from their assignment location in accordance with sections 5724, 5724a(a)(1), 5724a(a)(3), and 5726(c) of title 5, United States Code.

(B) Expenses specified in subparagraph (A) may not be allowed in connection with the assignment of an expert or consultant whose services are obtained under paragraph (1) unless and until the expert agrees in writing to complete the entire period of assignment, or one year, whichever is shorter, unless separated or reassigned for reasons that are beyond the control of the expert or consultant and that are acceptable to the Secretary. If the expert or consultant violates the agreement, the money spent by the United States for the expenses specified in subparagraph (A) is recoverable from the expert or consultant as a debt of the United States. The Secretary may waive in whole or in part a right of recovery under this subparagraph.

(g) VOLUNTARY AND UNCOMPENSATED SERVICES.—The Administrator, in carrying out this title, may accept voluntary and uncompensated services.

SEC. 926. FUNDING.

(a) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this title, there are authorized to be appropriated $35,000,000 for fiscal year 1990, $50,000,000 for fiscal year 1991, and $70,000,000 for fiscal year 1992.

(b) EVALUATIONS.—In addition to amounts available pursuant to subsection (a) for carrying out this title, there shall be made available for such purpose, from the amounts made available pursuant to section 2611 of this Act (relating to evaluations), an amount equal to 40 percent of the maximum amount authorized in such section 2611 to be made available.

SEC. 927. DEFINITIONS.

For purposes of this title:

(1) The term "Administrator" means the Administrator for Health Care Research and Policy.

(2) The term "Agency" means the Agency for Health Care Research and Policy.

(3) The term "Council" means the National Advisory Council on Health Care Research, Evaluation, and Policy.

(4) The term "Director" means the director appointed to head the Office of the Forum for Quality and Effectiveness in Health Care.

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TITLE XXI—VACCINES

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Subtitle 2—National Vaccine Injury Compensation Program

PART A—PROGRAM REQUIREMENTS

* * * * * * *

PETITIONS FOR COMPENSATION

SEC. 2111. (a) GENERAL RULE.—

total of 45 percent of such costs in each such fiscal year; and

[(B) any such charge assessed pursuant to this paragraph shall be reasonably related to the regulatory service provided by the Commission and shall fairly reflect the cost to the Commission of providing such service.

[(2) ESTABLISHMENT OF AMOUNT BY RULE.—The amount of the charges assessed pursuant to this paragraph shall be established by rule.]

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TITLE IX—MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH PROGRAMS

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Subtitle B—Medicaid and Maternal and Child Health

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SEC. 9517. MODIFYING APPLICATION OF MEDICAID HMO PROVISIONS FOR CERTAIN HEALTH CENTERS.

(a) * * *

* * * * * * *

(c) HEALTH INSURING ORGANIZATIONS.—(1) Section 1903(m)(2)(A) of the Social Security Act (42 U.S.C. 1396b(m)(2)(A)) is amended, in the matter before clause (i)—

(1) by inserting "(including a health insuring organization)" after "any entity"; and

(2) by inserting "(directly or through arrangements with providers of services)" after "responsible for the provision".

(2)(A) Except as provided in subparagraph (B) *and in paragraph (3),* the amendments made by paragraph (1) shall apply to expenditures incurred for health insuring organizations which first become operational on or after January 1, 1986.

(B) In the case of a health insuring organization—

(i) which first becomes operational on or after January 1, 1986, but

(ii) for which the Secretary of Health and Human Services has waived, under section 1915(b) of the Social Security Act and before such date, certain requirements of section 1902 of such Act.

clauses (ii) and (iv) of section 1903(m)(2)(A) of such Act shall not apply during the period for which such waiver is effective.

(3)(A) Subject to subparagraph (C), in the case of up to 3 health insuring organizations which are described in subparagraph (B), which first become operational on or after January 1, 1986, and which are designated by the Governor, and approved by the Legislature, of California, the amendments made by paragraph (1) shall not apply.

(B) A health insuring organization described in this subparagraph is one that—

(i) is operated directly by a public entity established by a county government in the State of California under a State enabling statute;

(ii) enrolls all medicaid beneficiaries residing in the county in which it operates;

(iii) is subject to regulation under the Knox-Keene Act (Cal. Health and Safety Code, section 1340 et seq.) and the Waxman-Duffy Act (Cal. Welfare and Institutions Code, section 14450 et seq.);

(iv) assures a reasonable choice of providers, which includes providers that have historically served medicaid beneficiaries and which does not impose any restriction which substantially impairs access to covered services of adequate quality where medically necessary; and

(v) provides for a payment adjustment for a disproportionate share hospital (as defined under State law consistent with section 1923 of the Social Security Act) in a manner consistent with the requirements of such section.

(C) Subparagraph (A) shall not apply with respect to any period for which the Secretary of Health and Human Services determines that the number of medicaid beneficiaries enrolled with health insuring organizations described in subparagraph (B) exceeds 10 percent of the number of such beneficiaries in the State of California.

(D) In this paragraph, the term "medicaid beneficiary" means an individual who is entitled to medical assistance under the state plan under title XIX of the Social Security Act, other than a qualified medicare beneficiary who is only entitled to such assistance because of section 1902(a)(10)(E) of such title.

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SEC. 9523. EXTENSION OF TEXAS WAIVER PROJECT.

(a) RENEWED APPROVAL.—Notwithstanding any limitations contained in section 1115 of the Social Security Act but subject to subsection (b) of this section, the Secretary of Health and Human Services, upon application, shall renew approval of demonstration project number 11-P-97473/6-06 ("Modifications under the Texas System of Care for the Elderly: Alternatives to the Institutionalized Aged"), previously approved under that section, until [January 1, 1990] *July 1, 1990.*

(b) TERMS AND CONDITIONS.—The Secretary's renewed approval of the project under subsection (a)—

(1) shall be on the same terms and conditions as applied to the project as of December 31, 1985; and

(2) shall remain in effect until such time as the Secretary finds that the applicant no longer complies with such terms and conditions.

SECTION 303 OF THE FAMILY SUPPORT ACT OF 1988

SEC. 303. EXTENDED ELIGIBILITY FOR MEDICAL ASSISTANCE.

(a) * * *

* * * * * * *

(f) EFFECTIVE DATE.—(1) * * *

(2)(A) The amendment made by subsection (b)(3) shall become effective on April 1, 1990, *but such amendment shall not apply with respect to families that cease to be eligible for aid under part A of title IV of the Social Security Act before such date.*

SECTION 301 OF THE FEDERAL FOOD, DRUG, AND COSMETIC ACT

CHAPTER III—PROHIBITED ACTS AND PENALTIES

PROHIBITED ACTS

SEC. 301. The following acts and the causing therefore are hereby prohibited.

(a) * * *

* * * * * * *

(j) The using by any person to his own advantage, or revealing, other than to the Secretary or officers or employees of the Department, or to the courts when relevant in any judicial proceeding under this Act, any information acquired under authority of section 404, 409, 412, 505, 506, 507, 510, 512, 513, 514, 515, 516, 518, 519, 520, 704, 706, or 708 concerning any method of process which as a trade secret is entitled to protection. *This paragraph does not authorize the withholding of information from either House of Congress or from, to the extend of matter within its jurisdiction, any committee or subcommittee of such committee or any joint committee of Congress or any subcommittee of such joint committee.*

REPORT TO ACCOMPANY THE RECOMMENDATIONS OF THE COMMITTEE ON WAYS AND MEANS

CONTENTS

TITLE XI—REVENUE RECONCILIATION PROVISIONS

I. EXECUTIVE SUMMARY

TITLE X—OUTLAY AND REVENUE PROVISIONS RELATED TO SPENDING PROGRAMS

Subtitle A—Social Security Provisions

Subtitle A includes provisions which increase the retirement test exempt amount for workers age 65–69, increase the special minimum benefit, and repeal certain retroactive benefits. In addition, it establishes the Social Security Administration as an independent agency, provides for improvements in SSA services and the representative payee system, provides for benefits to children adopted after a worker's entitlement, and exempts from Social Security coverage members of certain religious faiths. Furthermore, it provides work incentives for disabled adult children and allows for recovery of Social Security overpayments to former beneficiaries through IRS offsets.

Finally, it specifies that contributions to deferred compensation plans, including amounts deferred in 401(k) plans would be included in the determination of average total wages for social security purposes. This will increase the wage base by approximately 2 percent for 1990.

Subtitle B—Medicare Provisions

Subtitle B contains numerous provisions designed to control costs and improve the hospital and physician payment systems. It also includes revisions to the Medicare Catastrophic Coverage Act of 1988.

Part A provisions include reducing capital payments to hospitals, setting the update factor and the disproportionate share adjustments for inner city and rural hospitals and establishing a rural hospital demonstration program. There are several miscellaneous provisions as well.

Part B provisions include the establishment of a new payment system for physicians, to take effect in fiscal year 1992. This reform package includes a resource based relative value scale (RB RVS), expenditure targets for overall payments to physicians, and limits on physician extra billing. In addition, the reimbursement rates for various services are altered, and the update factor for physician services is reduced.

Parts A and B provisions include payment delays, research projects, patient protection amendments, and HMO and physician referral provisions.

The Part B premium would be set at 25 percent of program costs through 1990.

Part F includes the revisions to the Medicare Catastrophic Coverage Act of 1988. The supplemental premium rates would be re-

duced by one-half beginning in calendar year 1989. Part B and prescription drug catastrophic coverage and the current voluntary Part B program would become voluntary as a package. Part A catastrophic coverage benefits would become part of the basic Part A program. The basic Part B premium would be set at 25 percent of the costs of the basic Part B program for calendar years 1991 through 1993. The Part B premium would be increased on an *ad hoc* basis and would increase by $3.50 per month in 1990, $4.00 in 1991, $4.10 in 1992 and $4.10 in 1993. The deductible for prescription drugs would be increased from $600 to $800 in calendar year 1991 and from $652 to $950 in calendar year 1992. Payments of Medicare claims would be delayed by five days at the end of fiscal year 1990, six days at the end of fiscal year 1991, three days at the end of fiscal year 1992 and by one year at the end of fiscal year 1993. The delayed payments would be made on October 1 of each year.

Subtitle C—Human Resources

Subtitle C contains provisions relating to children's programs, programs directed at the poor elderly, and unemployment compensation. It includes amendments to the Title XX social services block grant, child welfare, foster care, Supplemental Security Income (SSI), Aid to Families with Dependent Children (AFDC) quality control and unemployment compensation programs.

The major amendments in this subtitle would increase the entitlement ceiling for the Title XX social services block grant by $200 million in fiscal year 1991, $400 million in fiscal year 1992, and $600 million in fiscal year 1993 and thereafter; would permanently increase the authorization level of the Title IV-B child welfare services program from $266 million to $400 million; would revise the name, purpose and extend the current foster care independent living program for three years and increase the entitlement level to $100 million annually; would increase SSI participation by establishing a permanent SSI outreach program for disabled and blind children and adults; would require the Secretary of HHS, in determining SSI eligibility for the blind and disabled, to assess individually each child's functional limits that interfere with the activities of daily living, recognizing the age of the child; would allow social security disability insurance recipients who lose benefits because of earnings to become eligible for SSI and the work incentive provisions authorized by section 1619 of the Social Security Act; and would permanently modify the AFDC quality control system.

Subtitle D—Trade

Subtitle D contains trade agencies authorizations for the U.S. International Trade Commission (USITC), the U.S. Customs Service, and the Office of the U.S. Trade Representative. It also includes a number of customs user fees amendments, elimination of the Superfund petroleum excise tax differential, and several miscellaneous customs provisions.

Tax Penalty Reform

Title XI revises the civil penalty provisions of the Code. Among other things it, modifies the information-reporting penalties so that the amount of the penalty would vary with the length of time in which the taxpayer corrects the failure. The various accuracy penalties (for negligence, substantial understatements, and misvaluation) would be consolidated and coordinated to eliminate stacking of penalties and to target the applicable penalty to the portion of the underpayment that is attributable to the proscribed conduct.

Child Care Initiative

Title XI increases the amount of the earned income tax credit (EITC) and adjusts the credit for family size. In addition, a new supplemental credit is created for families with any children under the age of six. The Social Services Block Grant is permanently increased by $200 million for fiscal year 1990, $350 million for fiscal year 1991 and $400 million for fiscal year 1992 and thereafter. A state receiving these earmarked funds would have to have in effect state child care standards addressing several special categories.

Table 1 below illustrates the budgetary impact of the Committee on Ways and Means reconciliation proposals by major category. A positive sign indicates the provision reduces the deficit, for example an increase in revenues or outlay savings. A negative sign indicates the opposite—a decrease in revenues or an increase in outlays. Overall, the Committee's recommendations reduce the deficit by $9.5 billion in fiscal year 1990 and $10.6 billion for fiscal year 1991.

TABLE 1.—TOTAL BUDGET IMPACT OF COMMITTEE ON WAYS AND MEANS RECONCILIATION RECOMMENDATIONS BY MAJOR CATEGORY

[By fiscal year, dollars in billions]

Reconciliation instruction	1990	1991	1992	1993	1994
Outlays	2.3	2.3	0	0	0
Revenues	5.3	5.3	0	0	0
Either outlays or revenues	0.4	0.4	0	0	0
Total	8.0	8.0	0	0	0
Reconciliation Provisions:					
A. Social Security initiatives:					
Include deferred compensation in indexing of wage base	0.4	1.1	1.1	1.1	1.1
Miscellaneous amendments	(*)	(*)	−0.1	−0.2	−0.3
B. Trade initiatives:					
Custom service user fees	−0.2	0.8	(*)	(*)	(*)
Caribbean Basin Initiative (CBI)	(*)	(*)	(*)	(*)	(*)
Miscellaneous tariff measures	−0.1	−0.2	−0.2	−0.1	(*)
C. Human Resource initiatives:					
Children's initiative	−0.1	−0.4	−0.7	−0.8	−0.8
Elderly poor initiative	−0.2	−0.3	−0.3	−0.3	−0.3
Miscellaneous amendments	(*)	0	0	0	0
Quality Control amendments	0	−0.3	−0.5	−0.2	−0.2
Total	−0.3	−1.0	−1.5	−1.3	−1.3
D. Medicare initiatives:					
Part A	0.8	0.2	0.1	0.1	0.1
Part B	1.1	1.4	1.5	1.7	1.9

TABLE 1.—TOTAL BUDGET IMPACT OF COMMITTEE ON WAYS AND MEANS RECONCILIATION RECOMMENDATIONS BY MAJOR CATEGORY—Continued

[By fiscal year, dollars in billions]

Reconciliation instruction	1990	1991	1992	1993	1994
Parts A and B	0.8	0.9	0.8	0.6	0.3
Beneficiaries	0.3	0.5	0.5	0.5	0.5
Total	3.0	2.9	2.9	2.9	2.9
E. Amendments to Medicare:					
Catastrophic Program:					
Reduce supplemental premium	−2.5	−2.5	−2.4	−2.7	−3.0
Increase Part B premium [1]	1.0	2.0	2.8	3.8	4.2
Increase drug deductible	0	0.3	1.0	0.6	0
Make program voluntary	−0.1	−0.4	−0.2	−0.2	−0.2
Delay payments	2.0	0.7	−1.2	−0.9	−0.6
Total	.4	0.2	(*)	0.6	0.5
F. Child Care initiative:					
Earned Income Tax Credit	0	−0.4	−4.1	−4.4	−4.7
Title XX	−0.1	−0.3	−0.4	−0.4	−0.4
Total	−0.1	−0.7	−4.4	−4.8	−5.1
G. FSLIC Scoring Credit (H.R. 1278)	0.6	(*)	0.4	0.3	0.2
H. Revenue initiatives:					
Capital gains reduction	2.9	3.8	2.7	−5.7	−5.2
Permanent extension and speedup of telephone excise tax	0.1	1.6	2.7	2.9	3.1
Employee Stock Ownership Plan proposals	1.4	1.8	2.3	2.7	3.2
Suspend Airport & Airway Trust Fund Trigger for one year [2]	0.9	0.2	(*)	(*)	(*)
Administration "loophole closers"	0.4	0.7	0.8	1.0	1.0
Corporate mergers and acquisitions	0.5	0.8	0.8	0.8	0.8
Tax on ozone-depleting chemicals	0.4	0.6	0.8	1.2	1.4
Repeal bank foreign tax credit special rule	0.2	0.2	0.2	0.1	(*)
Permit limited use of excess pension funds for current retiree health benefits	0.3	0.5	0.2	0	0
Repeal balance of completed contract method of accounting	0.2	0.4	0.3	0.1	(*)
Impose income tax withholding on wages of certain agricultural workers	0.3	0.1	(*)	(*)	(*)
Payroll tax speedup for large companies (effective 1994)	0	0	0	0	1.8
Other revenue proposals	0.5	0.4	0.3	0.3	0.2
Expiring provisions	−1.6	−2.8	−3.0	−3.2	−3.7
Repeal section 89	−0.1	−0.1	−0.1	−0.1	−0.1
Corporate alternative minimum tax	−0.4	−0.7	−0.7	−0.7	−0.7
Tax penalty reform	0	−0.1	−0.1	−0.1	(*)
Total	5.8	7.5	7.2	−0.6	1.9
Grand total—deficit reduction	9.5	10.6	5.3	−2.1	−0.2

[1] Includes both the ad hoc Part B premium increases of $3.50 per month in calendar year 1990, $4.00 in 1991 and $4.10 in 1992 and 1993, and extension of the 25 percent rule through 1993.

[2] Also includes modification in collection period of airline ticket tax.

*Gain or loss of less than $50 million.

Source: Congressional Budget Office and the Joint Committee on Taxation.

Notes.—Minus indicates a decrease in revenues or an increase in outlays.

Since for reconciliation scoring, only direct spending and revenue provisions count, authorizations are not shown. Deficit reduction is net revenues plus net outlay savings.

Totals may not add due to rounding.

II. SUMMARY

TITLE X—OUTLAY AND REVENUE PROVISIONS RELATED TO SPENDING PROGRAMS

Subtitle A—Provisions Related to Social Security and Railroad Retirement

1. Establishment of the Social Security Administration as an independent agency

The Social Security Administration (SSA) would be removed from the Department of Health and Human Services (HHS) and established as an independent agency with responsibility for the Old-Age, Survivors and Disability Insurance (OASDI) program and the Supplemental Security Income (SSI) program. The new agency would be under the authority of a three-member, bi-partisan Social Security Board appointed by the President. The Board would formulate policy for the agency and would appoint an Executive Director to serve as chief operating officer and to direct the day-to-day operations of the agency.

Administrative Law Judges (ALJs) in the independent agency would report directly to the Board. They would preside over hearings of appeals of agency decisions, as well as appeals of medicare cases, as is currently the practice in SSA's Office of Hearings and Appeals. By July 1, 1992, both the Secretary of HHS (in consultation with the Board) and the Comptroller General of the United States would issue reports to Congress on the appropriateness of maintaining this arrangement for medicare appeal hearings.

2. Improvements in Social Security Administration services and beneficiary protections

A number of improvements would be made in SSA procedures regarding collection of overpayments; contacts with SSA teleservice centers; correction of earnings records; standards applicable in determinations of fault, good faith and good cause; applications by homeless persons for benefits; notices sent to social security beneficiaries; legal representatives of claimants; and in the avenues of recourse open to claimants and potential applicants who lose benefits because SSA provides them with inaccurate or incomplete information.

3. Improvements in the representative payee system

The representative payee system would be improved by: (a) requiring the Secretary of HHS to conduct a more extensive investigation of the representative payee applicant; (b) providing stricter standards in determining the fitness of the representative payee applicant to manage benefit payments on behalf of the beneficiary; and (c) directing SSA to make recommendations regarding the ap-

plication of stricter accounting procedures to certain high-risk representative payees.

In addition, the provision would allow certain community-based non-profit social service agencies providing representative payee services of last resort to collect a fee from an individual's social security benefit for expenses incurred in providing such services. The Secretary would be required to set the maximum fee which could be collected.

4. Statement of trust fund liabilities in trustees' report

The Report of the Trustees of the Old-Age, Survivors and Disability Insurance trust funds would include a statement of the unfunded liabilities of the funds.

5. Payment of benefits to a child adopted after a parent's entitlement to retirement or disability benefits

A child adopted after a worker becomes entitled to retirement or disability benefits would be eligible for child's insurance benefits regardless of whether he or she was living with and dependent on the worker prior to the worker's entitlement.

6. Extension of Social Security coverage exemption for members of certain religious faiths

The existing religious exemption from social security coverage would be extended to: (a) employees of partnerships in which each partner holds a religious exemption from social security coverage, and (b) employees of churches and church-controlled non-profit organizations who are treated as self-employed for purposes of social security taxation.

7. Prohibition of termination of coverage of U.S. citizens and residents employed abroad by a foreign affiliate of an American employer

American employers would no longer be able to terminate the social security coverage of U.S. citizens and residents employed abroad in their foreign affiliates.

8. Creation of work incentives for disabled adult children

The proposal would establish a system of continuing, partial benefit payments to disabled adult children (DACs) who attempt to work. This system would replace, for DACs, the existing system under which beneficiaries whose earnings exceed a specified level (substantial gainful activity) lose all social security benefits. The existing trial work period and extended period of eligibility (EPE) would be repealed. (DACs who are disabled by reason of blindness would continue to be subject to current law.)

9. Continuation of disability benefits during appeal

The provision in current law permitting disability beneficiaries to elect to have their disability benefits continued during appeal would be made permanent.

10. Repeal of carryover reduction in retirement or disability insurance benefits due to receipt of widow(er)s benefits before age 62

The carryover reduction applied to retirement or disability benefits received by widow(er)s who collected widow(er)s benefits before age 62 would be eliminated.

11. Preeffectuation review of favorable decisions by the Social Security Administration

The percentage of favorable decisions made by State Disability Determination Services which must be reviewed by the Secretary of HHS would be reduced from 65 percent of all such decisions to 50 percent of allowances and 25 percent of continuances, and the reviews would be targeted to cases most likely to contain errors.

12. Recovery of overpayments from former Social Security beneficiaries

The Social Security Administration would be permitted to recover overpayments from former beneficiaries through arrangements with the IRS to offset the former beneficiary's tax refund. The provision would remain in effect as long as the existing, government-wide offset program remains in effect (currently, until January 10, 1994).

13. Use of Social Security number by certain legalized aliens

Certain aliens who were granted amnesty under the provisions of the Immigration Reform and Control Act of 1986 would be exempted from criminal penalties for fraudulent use of a social security card. The exemption would not apply to those individuals who sold social security cards, possessed cards with intent to sell, or who counterfeited or possessed counterfeited cards with intent to sell.

14. Increase in the retirement test for workers age 65–69

The retirement test exempt amount for beneficiaries age 65–69 who work would be raised by $360 in 1990 and by an additional $240 in 1991. These increases would be in addition to the automatic annual increase in the exempt amount, which reflects the annual increase in wages in the economy. The projected thresholds would be raised in 1990 from $9,360 (under current law) to $9,720, and in 1991 from $9,840 (under current law) to $10,440.

15. Increase in the special minimum benefit

The special minimum benefit, which is designed for long-term, low-wage workers, would be increased. The increase for an individual who has worked for 30 years at low wages, and who retires in 1990 at age 65, would be $35 per month. In addition, the amount of earnings needed to earn a year of coverage toward the special minimum benefit would be reduced starting in 1990 from 25 percent of the old-law contribution and benefit base ($9,375), to 15 percent of the base ($5,625).

16. Repeal of retroactive benefits for certain categories of individuals

Retroactive benefits would no longer be available for two categories of individuals eligible for reduced benefits: (1) those with dependents entitled to unreduced benefits, and (2) those with pre-retirement earnings over the amount allowed under the retirement test who may use the retroactive benefits to charge off their excess earnings.

17. Inclusion of employer cost of group-term life insurance in compensation under the Railroad Retirement Tax Act

The value of employer-paid premiums for group-term life insurance coverage in excess of $50,000 would be made subject to the railroad retirement payroll tax, bringing the treatment of such premiums into conformity with their treatment under the Social Security Act.

18. Inclusion of deferred compensation arrangements, including 401(k) plans, in compensation under the Railroad Retirement Tax Act

Contributions to 401(k) deferred compensation plans would be subject to the railroad retirement payroll tax, bringing the treatment of 401(k) plans into conformity with their treatment under the Social Security Act.

19. Codification of the Rowan decision with respect to railroad retirement

Nothing in the Internal Revenue Service (IRS) regulations defining wages for purposes of the income tax could be construed as requiring a similar definition for purposes of the railroad retirement payroll tax.

20. One-year extension of general fund transfers to railroad retirement Tier II trust fund

The transfer of proceeds from the taxation of railroad retirement Tier II benefits from the General Fund of the Treasury to the railroad retirement trust fund would be extended for one additional year, to October 1, 1990.

21. Inclusion of deferred compensation in average total wages

Contributions to deferred compensation plans, including amounts deferred in 401(k) plans, would be included in the determination of average total wages for social security purposes. The year-to-year increase in average total wages is used to determine the annual increase in the contribution and benefit base, the benefit formula, the retirement test exempt amounts, and other social security program amounts. Under a transition provision, the contribution and benefit base would be affected beginning in 1990, while benefits and all other program amounts would not be affected until 1993.

22. Treatment of refunds by employers under the Medicare Catastrophic Coverage Act of 1988 for FICA and other purposes

Refunds to individuals by employers under the maintenance-of-effort provision of the Medicare Catastrophic Coverage Act of 1988 would be excluded from wages for FICA, FUTA, and railroad retirement and railroad unemployment insurance tax purposes. The refunds would also be excluded for purposes of determining average total wages, the year-to-year increase in which is used in determining the annual increase in the contribution and benefit base and other social security, railroad retirement, federal-state unemployment insurance, and railroad unemployment insurance program amounts.

Subtitle B—Medicare Provisions

PART A

1. Hospital capital payments

Capital payments to Prospective Payment System (PPS) hospitals would be reduced 15 percent from cost in fiscal year 1990. The General Accounting Office (GAO) would be directed to study the effects of low occupancy on hospital costs.

2. Hospital update factor and diagnosis related group (DRG) weights

The hospital update factors for fiscal year 1990 would be set as follows: for hospitals in large urban areas—market basket minus 1.25 percentage points; for hospitals in other urban areas—market basket minus 1.75 percentage points; and for hospitals in rural areas—market basket plus two percentage points.

In recalibrating the DRG weights on an annual basis, the Secretary of the Department of Health and Human Services (HHS) would be required to do so on a budget neutral basis for fiscal year 1990 and subsequent years.

3. Innercity and rural hospitals

(a) *Disproportionate Share Adjustments.*—The disproportionate share adjustment would be increased for all disproportionate share hospitals. The adjustment would increase .6 for every one-percent increase in disproportionate share, instead of .5 as in current law.

For hospitals in which the current disproportionate share adjustment exceeded 5.1, the adjustment would be increased by a further amount. For the portion of a hospital's number of low-income patients necessary to reach the 5.1 threshold, the adjustment would be calculated using the .6 multiplier. For the portion of a hospital's low-income patients above the threshold, the adjustment would increase .7 for every one-percent increase in disproportionate share.

Hospitals which qualify for an adjustment based upon revenue from indigent care received from State and local governments would receive an increase in the disproportionate share adjustment of two percent to 27 percent, instead of 25 percent as in current law.

(b) *Increased Update for Rural Hospitals.*—The hospital update for fiscal year 1990 for rural hospitals would, as indicated above, be

set at the market basket rate plus two percentage points. This would be 3.75 percentage points higher than the basic update provided hospitals in other urban areas.

(c) *Rural Referral Centers.*—Rural referral centers grandfathered under current law would be grandfathered for three additional years. Rural referral centers would receive a disproportionate share adjustment based upon the same formula as that used for urban hospitals although the threshold for disproportionate share rural hospitals would be retained.

(d) *Sole Community Providers.*—Sole community provider hospitals would be defined as all hospitals more than 35 miles from another hospital. Payment to these hospitals would be, at the hospitals' option, either: (1) 100-percent hospital-specific prospective rates based on 1982 costs; (2) 100-percent hospital-specific prospective rates based on 1987 costs; or (3) PPS payments. Grandfathered sole community providers not meeting the new criterion would be paid under current sole community provider payment rules.

(e) *Geographic Classification of Hospitals.*—The Secretary would establish a process for hospitals to apply for changes in their geographic status. The Secretary would have 12 months to act on applications by hospitals under this system. The Secretary could reclassify rural counties as urban, reclassify urban counties into a large urban area, and classify urban counties into a different wage area. Any decision by the Secretary to approve a request for a change in wage areas could not result in a reduction in the wage index of hospitals in an adjoining area.

(f) *Study of the Differential in the PPS Standardized Amount.*—The Secretary would analyze and evaluate the current differential in the PPS standardized amounts. The Secretary would make recommendations concerning the adjustments in such amounts necessary to reflect the differences in costs among hospitals in different types of areas.

(g) *Essential Access Community Hospital (EACH) Demonstration Program.*—An EACH demonstration program would be established in up to ten States.

States would apply on a voluntary basis to establish programs to support the development of EACH networks. States' responsibilities under the demonstration program would include the designation of EACH hospitals and the support of the development of rural health networks. These networks would include EACH hospitals and Rural Primary Care Hospitals (RPCH). States would be required to consult with State hospital associations and rural hospitals in the States. Participation by hospitals in the development of such networks would be voluntary.

EACH hospitals could be no less than 35 miles from another EACH hospital, a rural referral center, or an urban hospital which meets the criteria for a referral center. The Secretary could waive this criterion if the State proposed different criteria in its application. In addition, EACH hospitals could have no less than 75 beds, unless no other hospital was within 35 miles, or the Secretary granted a waiver to assure access, and the hospital met such other criteria established by a State with the approval of the Secretary.

An EACH hospital would be required to: (1) provide emergency and back-up services for its network and throughout the service

area; (2) accept transfers from RPCH hospitals in the network; (3) provide staff privileges to physicians in the service area providing care at RPCH hospitals; and (4) meet other responsibilities provided by the State or the Secretary.

EACH hospitals would have the same three options for payment as sole community providers.

RPCH hospitals would be institutions that: (1) provide 24-hour emergency care necessary to stabilize emergency patients; (2) have arrangements with the nearest EACH hospital, rural referral center or urban hospital for the transfer of patients and the provision of other back-up services; and (3) may continue to maintain up to six holding beds for patients where patients could be cared for up to 72 hours prior to transfer to another hospital. RPCH hospitals would cease providing acute inpatient care, unless this requirement was waived by the Secretary, and would be reimbursed on a cost basis.

Authorizations of appropriations from the Part A Trust Fund include $10 million for planning grants to hospitals for purposes of the current Rural Transition Grant program, $15 million for implementation grants to hospitals for conversion to primary care hospitals, and $15 million for grants to States for their activities under the program.

(h) *Rural Health Medical Education Demonstration.*—The demonstration created by the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), providing for support of the costs of allowing resident physicians to develop field clinical experience in rural areas, would be expanded by adding an additional six sponsoring teaching hospitals to the four sites currently authorized.

(i) *Reporting Requirements.*—Hospitals receiving disproportionate share adjustments, sole community providers, rural referral centers, and EACH hospitals would be required to report their costs and statistics on a uniform basis as developed by the Secretary under the uniform hospital reporting demonstration authorized by OBRA '87.

4. Hospice

Hospice payment rates would be increased by 20 percent, effective October 1, 1989. In subsequent years, the payment rates would be indexed to the hospital market basket.

5. Miscellaneous part A provisions

(a) *Cancer Center Hospitals.*—Cancer center hospitals would be exempted from PPS, with a base year of 1987 for payments to these hospitals. For purposes of payment for capital-related costs, the exemption would be retroactive to fiscal year 1987.

(b) *Medicare Buy-In for Social Security Disability Insurance (SSDI) Beneficiaries.*—SSDI beneficiaries would be allowed to purchase Medicare coverage after they have worked a full 48 months, and are no longer eligible for Medicare coverage.

(c) *Applications for Adjustment to Limits for PPS-exempt Hospitals.*—The Secretary would be directed to specify within six months of enactment an application process for hospitals seeking adjustments in their limit set by the Tax Equity Fiscal Responsibility Act of 1982 (TEFRA).

(d) *Study of Hospital Care of the Medically Indigent and Posting of Medicaid Participation.*—GAO would be required to survey hospitals regarding each hospital's policy towards treatment of Medicaid-eligible individuals and the percentage of each hospital's net revenue from Medicaid. Medicare-participating hospitals would be required to post information regarding the hospital's participation in the Medicaid program.

(e) *Periodic Interim Payment (PIP) for Merged Hospitals.*—In the case of hospitals currently eligible for PIP that merge with another hospital, the merged hospital would continue to receive PIP payments if the new entity met the disproportionate share adjustment threshold for PIP payments after the merger.

(f) *Information on Accreditation.*—Each hospital which is deemed to meet the conditions of participation in Medicare, due to accreditation by the Joint Committee on the Accreditation of Health Organizations (JCAHO), would be required to agree to the release by JCAHO of accreditation surveys and other related information to the Secretary. As authorized by the hospitals, JCAHO would be explicitly required to release surveys and related information to the Secretary. The Secretary would be authorized to withdraw deemed status from a hospital based on any information he has received as to significant deficiencies, rather than only on information discovered in a validation survey, as under current law.

(g) *Extension of Waiver for Finger Lakes Area Hospital's Corporation (FLAHC).*—The test for continuation of the FLAHC waiver would be modified such that aggregate payments made by Medicare under the FLAHC system since October 1, 1983, would be compared to payments made since that date under the national system.

(h) *Hospital Bad-Debt Collection Policies.*—The existing prohibition on changes in bad-debt collection policy for hospitals would be further clarified. If a fiscal intermediary had accepted a hospital's bad-debt collection policy prior to August 1, 1987, the Secretary would be prohibited from directing the hospital to change its policy, or collecting retroactively from the hospital based upon the expectation of a change in the hospital's collection policy.

(i) *Dentists as Hospital Medical Directors.*—The current requirement of Medicare conditions of participation for hospitals, that provides that only a physician may be a medical staff director, would be revised to permit a dentist to be a medical staff director if permitted by State law.

(j) *Medical Necessity Certification in Skilled Nursing Facilities (SNF's).*—Nurse practitioners and clinical nurse specialists would be authorized to carry out certification and recertification activities in SNF's.

(k) *Hospital-Based and Free-Standing SNF's.*—The GAO would conduct a study to assess differences in costs and case-mix between free-standing and hospital-based SNF's. The GAO would make recommendations concerning the payment differential between free-standing and hospital-based SNF's.

(l) *Skilled Nursing Facility Cost Limits.*—The Secretary would be mandated to make adjustments to cost limits for skilled nursing facilities using cost reports for cost reporting periods beginning on or after October 1, 1985, effective for cost reporting periods beginning on or after October 1, 1989.

(m) *Intermediate Sanctions for Psychiatric Hospitals.*—The Secretary would be authorized to impose intermediate sanctions on psychiatric hospitals if the quality deficiencies at the hospital did not pose an immediate threat to the health and safety of patients.

PART B

6. Reduction in payments for certain physician services

(a) *Overpriced Procedures.*—Payments for overpriced procedures, and procedures that are closely related to overpriced procedures, would be reduced by an amount equal to half the difference between the 1989 local prevailing charge, and the amount that would be paid in the locality using the resource based relative value scale (RB RVS) recommended by the Physician Payment Review Commission (PhysPRC). Reductions would not exceed 15 percent.

Overpriced procedures are procedures with national average allowed charges at least 15 percent higher than would be paid under the PhysPRC recommended RB RVS. The base RB RVS fee would be calculated using an adjustment on the overhead portion of the fee by a Geographic Practice Cost Index (GPCI). In localities where the RB RVS fee for an overpriced procedure is less than the local prevailing charge, the prevailing charge would not be reduced. The list of overpriced procedures would not include pathology services.

The actual charges for procedures whose prevailing charges would be reduced under this provision would be subject to the specific limits on actual charges for overpriced procedures provided by current law. The special limits on actual charges would not apply for a procedure in localities where no reduction is made in the prevailing charge.

The reductions in overpriced procedures would be effective April 1, 1990.

(b) *Radiology Services.*—Payments for radiology services, except portable x-ray services, would be reduced by eight percent, effective April 1, 1990. This reduction would be implemented by: (1) reducing the 1989 national average conversion factor by eight percent; (2) adjusting the overhead portion of the reduced amount by the GPCI; and (3) reducing local conversion factors to the adjusted amount, but not by more than 15 percent. Local conversion factors below the adjusted amount would not be reduced. Prevailing charges for radiology services not paid under the fee schedule would be limited by the reduced prevailing charge for the service.

(c) *Anesthesiology Services.*—Anesthesiologists and certified registered nurse anesthetists (CRNAs) would be paid for the actual time of services provided rather than for 15 and 30 minute time units, as under current practice. This policy would be effective April 1, 1990.

7. Reduction in percentage increase in the MEI

The update of both customary and prevailing charges would be delayed from January 1, 1990, to April 1, 1990. The Medicare Economic Index (MEI) update would be two percent, except for primary care services that would receive the full baseline MEI update of 5.3 percent. Procedures identified as overpriced including radiology and anesthesiology services would not receive any update.

8. Physician payment reform

(a) *Resource Based Relative Value Scale (RB RVS).*—Payments for physician services using the RB RVS would begin to be phased-in beginning on October 1, 1991. The RB RVS would be established by the Secretary based on the Harvard RB RVS study, with consideration of the recommendations of PhysPRC. The component of fees representing overhead would be adjusted by a GPCI.

The component of fees representing malpractice costs would be adjusted for variations in malpractice costs, once the necessary information is available. The Subcommittee intends to hold hearings on alternative approaches for resolving malpractice claims.

The new fees would be phased-in so that prevailing charges for services would be increased or reduced each year by amounts not to exceed 15 percent, until the RB RVS fee levels are reached. The phase-in would be completed on December 31, 1995, after which all payments would be based on the RB RVS fee schedule. Payments for surgical services would be made based on uniformly defined global fees. The Secretary would set the conversion factor each year during the phase-in at a level to insure budget neutrality.

(b) *Expenditure Targets.*—Targets would be set for expenditures for physician services beginning with fiscal year 1990. A separate target would be set for surgical services, and such other categories of services as the Secretary deems appropriate. Each year, the Secretary and PhysPRC would recommend expenditure targets for the following fiscal year. In recommending the targets, the Secretary would be required to consider inflation, growth in the covered population, changes in volume and technology, and other factors. The actual amount of the targets would be considered by the Committee on Ways and Means and the Committee on Energy and Commerce (the Committees) and enacted by statute.

In the February following the end of each fiscal year target period, the Secretary would recommend to the Committees updates for physician fees for the subsequent calendar year. PhysPRC would also make recommendations in May for the update for the subsequent year.

The Secretary and PhysPRC would have wide discretion to recommend differential updates for procedures or groups of procedures based on detailed analysis of the increase in costs of various physician services. The Secretary would consider performance relative to any separate target in determining his recommendation.

The recommended update would be equal to the MEI, increased or decreased by the percentage by which expenditures in the target period were above or below the target amount. If a specific update is not enacted by the Congress prior to the beginning of a calendar year, the update would be set by the Secretary by regulation.

The Secretary would study and report to the Committees on how the expenditure target system could set separate targets for States or other geographic areas, or for specific physician specialty services.

The expenditure target for fiscal year 1990 would be 10.0 percent. This is .5 percent below the estimated baseline increase in payments for physician services for fiscal year 1990.

(c) *Limits on Extra Billing.*—New limits on actual charges would begin to be phased-in on January 1, 1991. In 1991, physicians with 1990 maximum allowable actual charge (MAAC) limits above 115 percent of the prevailing charge or local RB RVS fee would be subject to an actual charge limit of 125 percent in 1991, 120 percent in 1992, and 115 percent in 1993. The Secretary would monitor the effects of this provision on assignment and participation rates.

The actual charges of physicians with 1990 MAAC limits at 115 percent of prevailing charges would be subject to limits on actual charges of 115 percent of prevailing charges until September 30, 1991, and 115 percent of the local fee under the RB RVS as of October 1, 1991. The Secretary would monitor changes in extra billing, and PhysPRC would report to the Committees in this regard.

9. Other physician provisions

(a) *New Physician Customary Charges.*—The customary charges of new physicians would be no greater than 80 percent in the first year of practice, increasing by five percent each year until the limit becomes 100 percent of the prevailing charge in the fifth year of practice. This provision would expire when the new RB RVS fee schedule goes into effect on October 1, 1991.

(b) *Designated Specialties.*—The Secretary would designate a primary specialty for frequently performed Medicare procedures. In carrier localities with specialty-specific prevailing charges, no specialty would have a prevailing charge for a service that is higher than the prevailing charge of the designated primary specialty.

10. Outpatient hospital capital payments

Capital payments for hospital outpatient services would be reduced 15 percent from cost in hospital fiscal years beginning during fiscal year 1990.

11. Durable medical equipment (DME)

(a) *DME Rentals.*—Payments for the rental of DME would be based on a fee schedule equal to ten percent of the average allowed purchase price in a base period for the first three months of rental, and seven and one-half percent of the average allowed purchase price for the fourth through fifteenth months of rental. Payment for items currently paid under the "frequently serviced items" category would be subject to the fifteen-month limit for rental payments. This provision would be effective April 1, 1990.

The Secretary would be required to establish the reasonable useful lifetime of rental items. A new cycle of rental payments would be allowed for replacement equipment.

(b) *Payment for Oxygen Supplies and Equipment.*—Payment for oxygen supplies and equipment would be reduced by five percent from the 1989 levels.

(c) *Enteral Equipment.*—Payment for enteral equipment would be made under the DME fee schedules.

(d) *DME Update.*—The update for DME would be delayed until April 1, 1990, and would be reduced to two percent.

(e) *Limit on DME Fee Schedules.*—Local DME fee schedules would be limited to 95 percent of the median of local fee schedules.

(f) *Overpriced DME.*—The section in current law prohibiting the Secretary from using his "inherent reasonableness" authority with respect to DME would be deleted. The Secretary would publish a list of over-priced DME. The fees for these services would be reduced by 15 percent three months following publication of this list. The fees for seatlift chairs, motorized scooters, and transcutaneous electrical nerve stimulation devices would be reduced by 15 percent, effective April 1, 1990. A reduction of 15 percent in payments for motorized wheelchairs would be at the discretion of the Secretary, based on his review of payments for these services.

(g) *Limits on DME Suppliers.*—DME suppliers would be prohibited from distributing Medicare medical necessity forms to patients. Suppliers violating these provisions would be subject to civil money penalties. Suppliers would be required to disclose whether any person with ownership interest is a physician. Claims of suppliers with physician owners would be subject to more stringent review by carriers. Assignment would be required for all DME services and supplies.

(h) *DME Study.*—The GAO would review and make recommendations concerning appropriate standards determining the medical necessity of various items of durable medical equipment.

12. Clinical laboratory services

(a) *Update.*—The update for clinical laboratory services would be reduced to two percent.

(b) *Limit on Clinical Laboratory Fee Schedules.*—Local clinical laboratory fee schedules would be limited to 95 percent of the median of local fee schedules.

13. Mental health services

(a) *Psychologists.*—Clinical psychologists would be paid directly. These services would be subject to the current 50 percent coinsurance requirement for mental health services. Assignment would be required for these services. The Secretary would provide by regulation for psychologists to consult with a patient's attending physician within a reasonable period of time.

(b) *Mental Health Limit.*—The current $1,100 limit on mental health services would be eliminated.

14. Miscellaneous part B

(a) *Certified Registered Nurse Anesthetists (CRNA's).*—The conversion factor for direct reimbursement of the services of CRNA's would be $14 per unit for medically directed CRNA's, and $21 per unit for non-medically directed CRNA's.

Claims would reflect actual time, as for physician anesthesiologists. The CRNA conversion factor could not exceed the conversion factor of anesthesiologists in the same locality, except where there is no physician anesthesiologist providing anesthesiology services in the facility. Current Medicare policy prohibiting payments to surgeons for medical direction of CRNA's would be codified. These provisions would be effective April 1, 1990.

(b) *Payments to Community Health Centers (CHC's).*—This provision would establish a statutory basis for payments to CHC's. Centers that meet all the requirements of Sections 329, 330, or 340 of

the Public Health Service Act would be eligible to receive payments, whether or not they receive funds under these sections.

Payments would be made at 80 percent of an all-inclusive rate. Existing anti-kickback provisions would be waived to allow CHC's to reduce or waive coinsurance amounts under sliding fee schedules for the indigent and near-indigent. Payments to CHC's would be made without regard to the Part B deductible.

(c) *Small Blood Labs.*—Payments would be made to small blood labs for special trips to collect specimens from nursing home or homebound patients when ordered by physicians on an emergency basis. To qualify, a lab must receive at least 85 percent of its Medicare revenues from tests provided to nursing home or homebound patients.

(d) *Municipal Health Service Demonstration Waivers.*—The current Medicare waivers for the four municipal health service demonstration projects, established by the Robert Wood Johnson Foundation, would be extended for four years. HHS would conduct a study of the effectiveness of these projects in improving the quality and efficiency of health services.

(e) *Diabetic Shoe Inserts.*—Payments would be made for up to three inserts per year under the therapeutic shoes demonstration project.

(f) *Studies.*—A number of studies are mandated: (1) a study by HHS of payments for ambulance services; (2) a PhysPRC study of payments for assistants at surgery, including the services of nonphysician first assistants; (3) a GAO study of the cost of magnetic resonance imaging services; (4) a ProPAC study of costs and payments for services in hospital outpatient departments; and (5) a GAO study of coverage and payments for services of nurse practitioners.

PARTS A AND B

15. Payment delay

Payments to providers under Parts A and B would be delayed for 16 days prior to payment in fiscal year 1990, as compared to 14 days under current law. Ninety-five percent of "clean" claims would be required to be paid within 21 days for participating physicians and 26 days for all other providers.

16. Medicare secondary payer

(a) *Identification of Medicare Secondary Payer Situations.*—The Internal Revenue Service (IRS) and the Social Security Administration (SSA) would provide information to HHS to improve identification of Medicare secondary payer cases. HHS would use this information to link spouses with beneficiaries to identify individuals with health insurance coverage provided by employers. Medicare carriers would be required to maintain appropriate standards of confidentiality for all data provided by the IRS and the SSA.

Employers would be required to respond to inquiries regarding employer-provided health coverage within 30 days of receiving a letter. This provision would, following current law, apply only to employers with 20 or more employees.

Medicare would pay as secondary payer on all claims for beneficiaries currently covered by an employer health plan. Payments would be recovered for claims erroneously paid for beneficiaries, if the claim was submitted at a time when the beneficiary was covered by an employer health plan.

This provision would expire on September 30, 1991.

(b) *Prohibition of Liens Against Liability Insurance.*—Liens against liability insurance would be prohibited. Providers, participating physicians and participating suppliers would be prohibited from filing liens against liability settlements and awards. They would also be prohibited from collecting more than deductibles and coinsurance from beneficiaries who receive liability payments.

(c) *Penalties for Non-Complying Employers.*—Existing penalties for non-complying employers of the working-disabled would be extended to employers of the working-aged and End Stage Renal Disease (ESRD) beneficiaries. Non-complying employers would face an excise tax equal to 25 percent of the group health plans' expenses. The Secretary would have a right of action with provision for double damages to enforce all secondary payer provisions.

(d) *Worker's Compensation and Liability Payments.*—Payments under worker's compensation or liability and related insurance would be credited toward Medicare deductibles. The special enrollment period for the disabled would be comparable to the special enrollment period for the aged.

(e) *Medicare Carriers.*—The Secretary would be prohibited from requiring Medicare contractors that are Medicare carriers to cross-match data files to identify secondary payer cases, as a condition of remaining a contractor.

(f) *Coverage for Members of Religious Orders.*—Religious orders whose members take a "vow of poverty" and who opt to contribute to Social Security would not be treated as employers for purposes of Medicare secondary payer provisions.

17. End stage renal disease (ESRD)

(a) *Method I Payment Rate.*—The current Medicare composite-payment rate for renal facilities would be maintained for fiscal year 1990. The OTA would conduct a study to determine the cost of providing dialysis treatments to Medicare beneficiaries and would recommend how the composite rate should be established in fiscal year 1991, and updated thereafter.

(b) *Method II Payment Rate.*—The Method II payment rate, based upon itemized bills and reasonable charges, would be capped at the Method I payment level.

Medicare beneficiaries who receive treatments that are reimbursed under Method II would be required to obtain a formal written agreement with one supplier. These beneficiaries would also be required to sign a written agreement with a local Medicare-approved ESRD facility, stating that the facility would provide all necessary home dialysis support services and back-up in-facility dialysis services when necessary.

(c) *ESRD Patient Rights.*—Renal dialysis facilities and providers of services would be required to inform ESRD patients of their rights related to their treatment, including such rights as: (1) to have information about treatments and alternatives; (2) to have

access to their own medical records; (3) to file grievances without the fear of reprisal; and (4) to be informed of the specific circumstances under which they may be discharged or transferred.

An advisory board would establish outcome-based quality standards and survey protocols to be used by States to annually survey renal facilities and providers of services beginning in 1992. Sanctions could be imposed upon facilities and providers of services found to be out of compliance with quality standards.

(d) *Erythropoietin.*—The Secretary would summarize information provided by the manufacturer and would report to the Committees concerning the methodology and rationale for establishing the payment rate for erythropoietin used to treat ESRD patients. The report would include a plan for monitoring the appropriateness of rates in the future. The report would be due on April 1, 1990.

The GAO would review the Secretary's findings and report to the Committees by June 1, 1990. The OTA would report on alternative acquisition and reimbursement strategies to reduce expenditures for certain drugs, without sacrifice to quality of care.

18. Medical outcomes and effectiveness research

(a) *Research Program on Outcomes and Effectiveness of Care.*—A medical outcomes and effectiveness research program would include: (1) reviews of literature; (2) development of new methodologies; (3) grants and contracts with research centers and other entities to conduct outcomes, effectiveness and appropriateness research; and (4) projects that demonstrate the use of claims data in such research.

New information and medical innovation would be incorporated into the research program in a timely fashion. The Committee intends that the Secretary insure that research and guidelines developed by physicians are not used to limit services rendered by non-physician professionals, unless the non-physician professionals are involved in the research and development of guidelines.

(b) *Data Base Development.*—Uniform definitions of data, standards of security, and common reporting formats for administrative and clinical data bases would be developed. The Secretary would report to the Committees regarding the feasibility of linking data between HHS and other Federal agencies.

(c) *Educational Programs and Dissemination of Findings.*—An educational program would: (1) disseminate research findings; (2) fund research on effective methods of educating providers and consumers on the findings from the outcomes and effectiveness research program; (3) to provide for the development of practice guidelines; and (4) provide for a demonstration project that uses the guidelines related to three conditions in the review of Medicare services.

(d) *Annual Report.*—The Secretary would provide an annual report on the medical outcomes and effectiveness research programs and on their effects on medical care.

(e) *Advisory Council.*—An advisory council would assist and advise the Secretary on the program. The council membership would include a broad range of professionals, provider groups, consumers, and other interested parties.

(f) *Coordinating Group.*—The Administrator of HCFA, the Assistant Secretary for Planning and Evaluation, and the Assistant Secretary for Health would coordinate the research agenda and priorities. The group would recommend the medical procedures to be examined, two-thirds of which must have the concurrence of the HCFA Administrator.

(g) *Budget.*—Authorization for this program would be $72 million in fiscal year 1990, $110 million in fiscal year 1991, $175 million in fiscal year 1992, $225 million in fiscal year 1993, and $270 million in fiscal year 1994. Two-thirds of the amounts authorized would come from the Medicare trust funds, 60 percent from the Hospital Insurance Trust Fund and 40 percent from the Supplemental Medical Insurance Trust Fund. The remainder would come from general revenues. In fiscal year 1990, one-third of the funds would be allocated for the research program, one-third for data base development, one-sixth for guideline development and one-sixth for education and research dissemination.

19. Medicare hospital patient protection amendments

Clarifying amendments would be made to existing patient antidumping provisions, including: (1) a requirement that hospitals post signs informing patients of the hospital's obligations under the statute; (2) a requirement that hospitals create, maintain, and send with transferred patients certain records; (3) a risk/benefit approach to assessing transfers would be mandated; (4) a strict standard of liability for hospitals and physicians relating to civil monetary penalties would be established; (5) the obligations of physicians would be extended to on-call, attending physicians, with hospitals being required to maintain a list of such physicians; (6) physician liability would be clarified; and (7) "whistle-blower" protection would be provided for physicians who refuse to transfer an unstable patient.

20. Health maintenance organizations (HMO's)

(a) *Physician Incentive Arrangements.*—The Secretary would be required to specify the degree of risk at which individual physicians providing services within HMO's could be placed.

The Secretary would identify potentially high-risk physician compensation arrangements. HMO's could certify to the Secretary that they do not use such arrangements. HMO's which use such arrangements would be required to provide information to permit a determination regarding the risk of reduced services to beneficiaries. Direct and specific individual payment to a physician, as an inducement to withhold or limit a specific medically necessary service to an identifiable patient, would be prohibited.

(b) *Exclusion of Prisoners and Welfare Beneficiaries from Calculation of the 50/50 Rule.*—Local or State prisoners and persons on behalf of whom a local or state government purchases health benefits as part of a general welfare assistance program could not be counted as non-Medicare or Medicaid enrollees for purposes of meeting the requirement that organizations enroll at least 50 percent of the members from commercial sources.

(c) *Publication of Methodology and Assumptions for the Adjusted Average Per Capital Costs (AAPCC).*—The Secretary would be re-

quired to publish the methodology and assumptions used to devise the AAPCC used to reimburse HMO's.

(d) *Benefit Stabilization Fund.*—Authority for the benefit stabilization fund for HMO's would be made permanent.

21. Physician ownership/referral

(a) *General Provision Regarding Physician Ownership/Referral.*—A physician would be prohibited from referring a patient for a Medicare-covered service to a provider if the physician or immediate family member has: (1) an ownership or investment interest in the provider, or (2) other compensation arrangements with the provider. Providers would be prohibited from submitting any bills or claims for reimbursement for services provided pursuant to a prohibited referral.

(b) *Exemptions.*—Various exemptions would be provided from the general rule, including: (1) services provided directly by a physician or by his or her employees, including certain temporary employees actually employed by others but under the physician's direct supervision; (2) services provided within a group practice; (3) services of radiologists, radiation therapy specialists, and pathologists; (4) services within pre-paid plans; (5) ownership of investment securities in large publicly-held corporations; (6) certain non-public pharmacies providing treatment for cancer; (7) services provided by any rural provider; and (8) services provided by free-standing and hospital-based renal dialysis facilities.

Services provided by a hospital in which a physician has an ownership interest would be exempt if the physician has admitting privileges at the hospital and the ownership interest is in the hospital as a whole. Hospitals would be required to meet the same reporting requirements as entities exempted due to being in operation prior to March 1, 1989, discussed below. Joint ventures between hospitals and physicians would also be exempt if the hospital was a majority owner and the hospital met the same criteria as entities applying for a case-by-case exemption would be required to meet, discussed below.

Entities with physician-owners, which did not qualify for one of the general exceptions, could apply to the Secretary for an exception if the services provided by the entity were not available in the service area, the entity provided services at a lower cost than other entities in the service area, or services were more convenient to patients in the service area.

(c) *Provisions for Exempt Entities.*—To qualify for an exception, entities would have to meet certain other requirements, including: (1) investment in the venture would be open to investors other than physicians; (2) participation in the venture could not encourage referrals; (3) the investment must be of a bona fide nature; (4) investors would be required to make an equity contribution to the venture; (5) return on investment must be reasonable, and if the risk of loss to an investor is limited, the return must be proportionately limited; (6) ownership interests would be required to be disclosed to, and acknowledged by, patients in a form and manner satisfactory to the Secretary; and (7) hospital cost-reporting requirements would apply to joint ventures involving hospitals, with such reports based on uniform hospital reports.

(d) *Entities in Operation on March 1, 1989.*—Services provided by entities substantially in operation prior to March 1, 1989, would be exempt, but would be subject to new reporting and registration requirements.

(e) *Requirements for Provider Numbers on Claims.*—All Part B claims would be required to include the name and provider number of the referring physician.

(f) *Treatment of Home IV Providers.*—Referrals by physicians to home IV therapy providers would be regulated under provisions adopted in the Medicare Catastrophic Coverage Act of 1988 and would not be subject to the new requirements of this legislation.

(g) *Denial of Payments.*—Medicare payment would be denied for any item or service provided pursuant to a prohibited referral. A person who received any payment from a Medicare beneficiary, including any coinsurance or deductible payments or any payment for an unassigned claim for a service provided pursuant to a prohibited referral, would be required to make a prompt refund to the beneficiary.

Any physician who makes a referral that the physician knows or should know is prohibited would be subject to civil money penalties and exclusion from the Medicare program, if a claim or bill is submitted pursuant to such a referral. A provider submitting the bill or claim would be subject to the same penalties if the provider knew or should have known that the bill or claim was for a service provided pursuant to a prohibited referral.

A civil money penalty would be up to $15,000 for each item or service provided pursuant to a prohibited referral, plus an amount equal to twice the amount billed for the item or service. Circumvention schemes would be prohibited, and subject to civil money penalties of up to $100,000 and exclusion from the Medicare program.

22. Miscellaneous parts A and B

(a) *Extension of Authority to Terminate Intermediary and Carrier Contracts.*—The Secretary's authority to terminate up to two fiscal intermediary and two carrier contracts per year for cause, and to replace those contractors with contracts in which reimbursement is on other than a cost basis, would be extended for an additional four years. In addition, the Secretary would be authorized to enter into additional contracts on other than a cost basis, if the contractor and the Secretary reached mutual agreement to do so. The Secretary could not condition contract renewal on a contractor so agreeing.

(b) *Long-Term Care Study.*—HHS would contract with IOM to conduct a study to examine practices of existing public and private long-term care programs. The study would identify areas of knowledge that could be used to develop and provide long-term care benefits for Medicare beneficiaries.

(c) *Long-Term Care Insurance.*—The GAO would study standards for inflation protections and non-forfeiture benefits for private long-term care insurance policies, and report to the Committee on Ways and Means by April 1, 1990.

The Committee intends that standards for inflation protection and non-forfeiture benefits are important considerations for con-

sumer protection and that the National Association of Insurance Commissioners should act to address these issues.

(d) *Study of Administrative Costs.*—The GAO would review the costs to physicians and other providers of complying with the administrative requirements of the Medicare program. The study will include an examination of the trends of these costs since 1982.

(e) *PRO Review of Non-physician Services.*—PRO's would be required to establish procedures for involving non-medical doctors in the review of services within their own professions.

(f) *PRO Quality Denials.*—PRO's would reconsider formal notices of quality denials before notifying beneficiaries of such denials.

(g) *Hospital-based Nursing Schools.*—Direct medical education reimbursement would be authorized for certain hospital-based nursing schools.

(h) *Cancer Center Treatment Demonstration Project and Study.*—A cancer center demonstration program would be authorized in two cancer center hospitals. Under the demonstration, payment would be authorized for treatment under certain experimental protocols. The Office of Technology Assessment (OTA) would study and report on the appropriateness of Medicare payments for the treatment of patients under these protocols.

(i) *Innercity Hospital Triage Demonstration Project.*—The Secretary would be authorized to establish one project in an innercity public hospital which has already established a triage effort.

(j) *Home Health Paperwork Study.*—The GAO would study the costs and justifications for the current administrative requirements on Medicare certified home health agencies. The GAO would review the feasibility of eliminating the requirements for dual reporting to the Medicare and Medicaid programs.

(k) *Home Health Waiver of Liability.*—For purposes of the presumptive waiver calculation, denials would be deemed final if the initial denial is not appealed by the home health agency within the current 60-day period allowed for the appeal, or if the fiscal intermediary issues a decision on reconsideration. The Secretary would be required to monitor the volume of denied claims and to report to the Congress if the volume of appealed denials is substantially increased.

BENEFICIARIES

23. Part B premium

The requirement that the Part B premium be set at 25 percent of program costs would be extended through calendar year 1990.

OTHER

24. Extension of the Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage for SSDI disability

Individuals who obtain health insurance coverage under COBRA coverage provisions, and who are receiving SSDI disability payments, would be eligible to continue to purchase coverage for the period from 19 to 29 months. The premium for these 11 additional months would be set at 150 percent of the average cost of coverage

for the employer, rather than the 102 percent rate set for the initial 18 months.

REVISIONS TO THE MEDICARE CATASTROPHIC COVERAGE ACT OF 1988

1. Supplemental premium rates

The supplemental premium rates would be reduced by one-half beginning in calendar year 1989.

The rates would be reduced from 15 to 7.5 percent in 1989, 25 to 12.5 percent in 1990, 26 to 13 percent in 1991, 27 to 13.5 percent in 1992 and from 28 to 14 percent in 1993. The supplemental premium rate would be set at the 14-percent level in 1994 and in subsequent years.

2. Option to decline medicare catastrophic coverage

(a) *Voluntary Option.*—Part B and prescription drug catastrophic coverage and current physician and outpatient services covered by Part B would be optional as a package. Part A catastrophic coverage benefits would become a part of the basic Part A program.

(b) *Opt-out Process.*—Current beneficiaries would have a one-time option to disenroll from Medicare Part B coverage and Part B and prescription drug catastrophic coverage during the period between October 1, 1989 and December 31, 1989. New beneficiaries would also be given a one-time opportunity to decline participation in Medicare Part B and Part B and prescription drug catastrophic coverage.

Beneficiaries who decline participation in Part B and catastrophic coverage could subsequently re-enroll, but would be subject to substantial penalties.

Beneficiaries would automatically be enrolled in Part B and prescription drug catastrophic coverage and current Part B coverage unless they submit and sign an application to the Health Care Financing Administration (HCFA) to decline coverage.

HCFA would provide information to all Medicare beneficiaries on the option to decline coverage. The information package would include: a general description of the Medicare program and catastrophic coverage benefits; the subsidy value of optional benefits; an analysis of the costs of alternative private insurance coverage; and, an explanation of payment penalties for late enrollment. The information package would also include a request form for a disenrollment application.

Upon request, HCFA would provide disenrollment applications to Medicare beneficiaries. HCFA would send beneficiaries additional information to explain the subsidies and costs of alternative private sector coverage and a full explanation of payment penalties for late enrollment. Each beneficiary would be required to sign the application in order to opt out of Medicare Part B and Part B and prescription drug catastrophic benefits and premiums. In the case of married beneficiaries, adjustments would be made for couples filing separately.

HCFA would provide a hot line to respond to questions of Medicare beneficiaries.

(c) *Payment Penalties for Delayed Enrollment.*—The current penalty for delayed Part B enrollment would be retained. The supple-

mental premium would be 15 percent higher each year for those who enroll at any point after the designated disenrollment period.

(d) *Exemption for Beneficiaries With Employer-Provided Primary Health Coverage.*—Beneficiaries with employer-provided health insurance coverage could apply on a year-to-year basis to be exempt from Part B and catastrophic coverage benefits and premiums, without penalty. Upon termination of employment-based health insurance coverage, such beneficiaries would have a 60-day period to decline Part B and catastrophic coverae.

3. Part B premium

The basic Part B premium would be set at 25 percent of the costs of the basic Part B program for calendar years 1991 through 1993.

4. Catastrophic flat monthly premium

The Part B premium would be increased on an *ad hoc* basis for calendar years 1990 through 1993. The premium increase by $3.50 in 1990, $4.00 in 1991, $4.10 in 1992 and $4.10 in 1993.

This portion of the premium and the previously enacted catastrophic coverage flat premium would would become a part of the basic Part B premium in 1993 and would increase the cost-of-living-adjustment (COLA) rate for 1994 and subsequent years.

5. Prescription drug deductible

The deductible for prescription drugs would be increased from $600 to $800 in calendar year 1991 and from $652 to $950 in calendar year 1992.

6. Payments to providers

Payments of Medicare claims would be delayed by five days at the end of fiscal year 1990, six days at the end of fiscal year 1991, three days at the end of fiscal year 1992 and by one day at the end of fiscal year 1993.

The delayed payments would be made on October 1 of each year.

7. Federal Catastrophic Drug Insurance (CDI) Trust Fund

The Managing Trustee would transfer funds from the SMI trust fund to the CDI trust fund sufficient to cover prescription drug expenditures for calendar years 1990 through 1993. The Managing Trustee would transfer an amount sufficient to assure end year balances of 150 percent of expenditures in 1990, 100 percent of expenditures in 1991, 75 percent of expenditures in 1992 and 50 pecent of expenditures at the end of 1993.

Beginning in 1994, the Managing Trustee would transfer to the CDI trust fund amounts from the Medicare supplemental premium and catastrophic coverage monthly premium. The amount of funds attributable to the catastrophic coverage monthly premium transferred to the CDI trust fund would increase by the percentage by which prescription drug outlays in years subsequent to 1993 exceed outlays for prescription drugs in 1993. The portion of supplemental premium revenues transferred to the CDI trust fund would increase by the percentage by which aggregate supplemental premiums for taxable years subsequent to 1993 exceed premiums imposed for 1993.

8. Medicare catastrophic coverage account

The Secretary would be required to report each year through 1993 on the balance between the revenues and receipts included in this package, and the costs of restructured benefits. This report would be submitted with the Trustees Report on the Part B trust fund due on April 1 of each year. The General Accounting Office would comment on the Secretary's report within 60 days.

Part A catastrophic coverage benefits would be incorporated into Part A benefits, and Part B catastrophic coverage benefits would be incorporated as Part B benefits.

The Hospital Insurance Catastrophic Coverage Reserve Fund would be eliminated. The portion of revenues and receipts from the supplemental premium and the Part B premium not placed into the Federal Catastrophic Drug Insurance Trust Fund would continue to be placed into the Part B trust fund.

9. Miscellaneous provisions

Additional necessary conforming revisions would be made to the provision of the Medicare Catastrophic Coverage Act. Technical amendments to the Medicare Catastrophic Coverage Act would also be made.

Subtitle C—Human Resources Amendments

I. Children's Initiative

A. Social Services

Title XX.—Would increase the entitlement ceiling for the Title XX social services block grant by $200 million in fiscal year 1991, $400 million in fiscal year 1992, and $600 million in fiscal year 1993 and thereafter.

B. Foster Care and Child Welfare Amendments

1. *Increase in Child Welfare Authorization.*—Effective beginning fiscal year 1990, would permanently increase the authorization level of the Title IV-B child welfare services program from $266 million to $400 million.

2. *Three-year Extension of Authority to Transfer Foster Care Funds.*—Would extend the foster care ceilings and the authority to transfer foster care funds to child welfare services for three years, through September 30, 1992, and would permanently increase the Title IV-B child welfare services appropriations level at which a mandatory foster care ceiling is triggered from $266 million to $400 million.

3. *Requirement for State Report on Preventive Services.*—Effective beginning fiscal year 1990, would require that the State child welfare agency compile on an annual basis a detailed report specifying which preplacement preventive and reunification programs and services are operating and available to children and families in need in the State.

4. *Increase in Federal Reimbursement for Foster Parent Training.*—Effective beginning fiscal year 1990, would allow Federal reimbursement for foster and adoptive parent training under Title IV-E at the rate of 75 percent. In addition to travel and per diem,

reimbursable activities would include the short-term training of foster and adoptive parents and the staff of licensed or approved child care institutions, in ways that increase their ability to provide support and assistance to Title IV–E foster and adopted children.

5. *Require Health and Education Records in Case Plan.*—Effective beginning fiscal year 1990, would require that a foster child's case plan include, at the time of placement, a record of his educational and health status. Also would require that Medicaid-eligible foster children receive health examinations and follow-up services.

6. *Address the Special Problems of Adolescents.*—Would revise the purpose of the foster care independent living program. The revised program would be called the Foster Care Adolescent Services Block Grant and would be authorized for three years beginning in fiscal year 1990. The entitlement level of the program would be increased to $100 million annually. States would be required to spend at least 70 percent of the funds on independent living services to foster children age 16 or more; the remaining funds could be used on a wide range of services to foster children age 10 or older.

7. and 8. *Improving Data Collection, Oversight and Accountability.*—Would require that the Secretary of Health and Human Services (HHS) collect and report, on an annual basis by the last day of the calendar year, foster care and adoption information (based on the preceding Federal fiscal year) useful for monitoring the operation of the child welfare programs under Titles IV–E and IV–B, including information on Federal and State expenditures, program participation, the characteristics of children in foster care and adoption, the monthly rate of payment for foster care maintenance, and fiscal and compliance reviews and disallowances resulting from such reviews. Proposed regulations to implement this requirement would have to be issued within 4 months of enactment, with final regulations issued 10 months after enactment. The new State reporting system would take effect in fiscal year 1992; however, HHS would be instructed to prepare two interim reports for fiscal years 1990 and 1991.

In addition, the Secretary of HHS would be required to continue to collect certain aggregate and case-specific child abuse and neglect data.

The provision also would substantially revise the process for evaluating State compliance with section 427 of the Social Security Act and would prevent HHS from collecting any disallowances associated with triennial reviews under current law.

C. SSI Disabled Children Amendments

1. *Outreach Program for Disabled and Blind Children.*—Effective on the date of enactment, would establish a permanent SSI outreach program for disabled and blind children.

2. *Individual Functional Assessments of Children.*—Effective October 1, 1989, would require the Secretary of HHS, in determining SSI eligibility for the blind and disabled, to assess individually each child's functional limits that interfere with the activities of daily living, recognizing the age of the child.

3. *Presumptive Disability Based on Genetic or Congenital Impairments for Children under Four Years Old.*—Effective October 1,

1989, would require the Secretary of HHS to presume eligibility for SSI of children under four years old who were born with genetic or congenital impairments that are likely to test positively for a disability later when medical professionals can administer a valid test at an older age.

4. *Revised Listings of Impairments for Children.*—Would require the Secretary of HHS to publish a notice of proposed rulemaking on the "Revised Childhood Listings of Mental Impairments" within 60 days after the date of enactment, with final regulations issued nine months after enactment.

Also would require the Secretary to solicit advice from childhood disability experts on changes that should be made to the children's "Listing of Impairments" so that they account for medical and functional rules that are appropriate to the age of the child. Would require publication of proposed revisions for public comment within 18 months from the date of enactment. Regulations would have to be final 24 months after the date of enactment.

5. *Eligibility for Recipients with Weekly or Biweekly Income.*—Effective October 1, 1989, would require the Secretary to deem certain individuals eligible for SSI benefits for the purpose of retaining Medicaid eligibility as long as they would be eligible for SSI benefits otherwise. An individual must meet three conditions: (1) he must receive earned income on a regular weekly or biweekly basis; (2) he must be ineligible for SSI for the month because of an extra paycheck; and (3) he must be eligible for SSI if the amount of his earned income in such month were equal to his average monthly rate of pay.

6. *SSI Benefit for Disabled Children of Parents Who Work Overseas.*—Effective October 1, 1989, would extend SSI benefits to disabled children who reside with parents working overseas.

7. *SSI Personal-Needs Allowance for Certain Severely Disabled Children.*—The Committee agreed to extend the $30-per-month SSI personal-needs allowance to certain severely disabled children who qualify for home-based services under a State Medicaid program and would otherwise qualify for SSI if parental income were not deemed to the child.

8. *Intergenerational Demonstration Project for Disabled Children.*—Effective October 1, 1989, would authorize demonstration projects in 10 communities to test the use of volunteer senior aides to provide basic medical assistance and support to families with disabled or chronically ill children.

9. *Treatment of Income-Producing Property under SSI.*—The Committee approved a rule that would treat income-producing assets under the SSI program in a way that parallels their treatment under the Food Stamp program. Work-related equipment used in a trade, business, or by an employee would be excluded from countable resources.

D. Child Support Enforcement Amendments

1. *Extension of IRS Intercept for Non-AFDC Families.*—Effective on the date of enactment, would extend for five years present law that allows States to request that the Internal Revenue Service (IRS) collect child support arrearages of at least $500 out of income

tax refunds due to non-custodial parents. Since the current provision expires at the end of 1990, it would be extended through 1995.

Effective January 1, 1990, would eliminate the minor child restriction on non-AFDC, court-ordered child support arrearages under the income tax refund offset for adults with a current support order who are disabled, as defined under OASDI or SSI.

2. *Medicaid Transition in Child Support Cases.*—Effective October 1, 1989, would make permanent that Medicaid benefits continue for four months after a family loses AFDC eligibility as a result of collection of child support enforcement payments under the IV-D program. Would conform this requirement to the Family Support Act by extending these benefits for a total of 12 months after a family leaves AFDC, due to collection of child support. The current provision expires October 1, 1989.

II. INITIATIVE FOR THE POOR ELDERLY

A. SSI Benefit Increase

Effective October 1, 1990, would increase SSI benefits by $2 per month for individuals, and $3 per month for couples.

B. Improve Program Participation

Effective on the date of enactment, would establish a permanent SSI outreach program for adults. Would require the Secretary of HHS to report annually on the effectiveness of this program.

C. Representative Payee Reform

Effective July 1, 1990, would prohibit persons who have been convicted of violations of certain provisions of the Social Security Act and the U.S. Code, or who have been dismissed for misuse of payments, from being certified as representative payees, and would improve the process for selecting representative payees.

The Secretary would also be required to maintain a list in each Social Security Administration office of all agencies and organizations providing representative payee services. Community based nonprofit social services agencies would be allowed to receive a fee from beneficiaries, as determined by the Secretary, for providing representative payee services.

D. Treatment of Income in Shared Living Arrangements

Effective January 1, 1990, would count the lesser of the actual value of in-kind assistance received by individuals, or the current law one-third of the SSI benefit, against the SSI benefit. Would require the Secretary to study the effect this provision has on SSI beneficiaries and the administration of the program, and to report to Congress not later than two years after the date of enactment.

E. Treatment of Transportation Gifts

Would exclude from income gifts of domestic commercial transportation tickets given to an individual or eligible spouse, which are used by that individual or spouse and not converted to cash.

F. Separated Couples Treated Jointly

Would consider a husband and wife who are aged, blind, or disabled, who have been living apart for one full month to be treated as separate individuals.

G. Treatment of Burial Space

Effective October 1, 1989, Would exclude interest and accruals on burial spaces from resources for SSI purposes.

H. SSI Work Incentives

Effective July 1, 1990, would allow social security disability insurance recipients who lose benefits because of earnings to become eligible for SSI and the work incentive provisions authorized by section 1619 of the Social Security Act.

I. Treatment of Victims' Assistance under SSI

Would exclude from income victims' assistance grants received by SSI recipients if they can show that the payment was compensation for expenses incurred or losses suffered as a result of a crime.

J. Improve Social Security Administration Services and Beneficiary Protections.

The Committee agreed to apply to SSI recipients several provisions for improved services and protections that were adopted by the Committee and applied to social security beneficiaries.

III. MISCELLANEOUS AMENDMENTS

A. Unemployment Compensation and AFDC—

1. *Optional Benefits for Non-Professional School Employees.*—Would allow States the option to provide UC benefits to nonprofessional school employees between academic years or terms.

2. *Prohibition on Collateral Estoppel.*—Would prohibit the courts from using UC hearing decisions to stop law suits on other employment related issues.

3. *Prohibition on Implementation of Certain AFDC Regulations.*—The Committee agreed to extend to October 1, 1990, the moratorium barring the Secretary of Health and Human Services from implementing, in whole or in part, the proposed regulations published in the Federal Register on December 14, 1987. These regulations would restrict the use of AFDC emergency assistance funds for homeless families, and would limit States' authority to use AFDC funds for shelter in temporary quarters, whether as a basic or special need.

4. *Administrative Expenses in Self-Employment Demonstration Projects.*—The Committee authorized appropriations of $1 million to cover State administrative expenses for operating self-employment demonstration projects, which were authorized by the Omnibus Budget Reconciliation Act of 1987.

5. *Minnesota Family Investment Plan (MFIP) Demonstration Project.*—The Committee agreed to an amendment which would allow the State of Minnesota to conduct a demonstration project of the Minnesota Family Investment Plan (MFIP). The goals of the

MFIP are to simplify the State's welfare system and encourage families to work toward self-sufficiency.

IV. AFDC QUALITY CONTROL

A. Resolve the Backlog of Disallowances through FY90

Would subject States to potential disallowances if their official error rates are above the higher of the lowest national annual average achieved in prior years, or in the case of fiscal years 1981 and 1982, the target error rate in effect for those fiscal years for the respective States. State official error rates would be recalculated excluding so-called "technical errors."

All States subject to potential disallowances could either pay 75 percent of the potential disallowance or appeal directly to the Departmental Appeals Board. There would be no appeal to the Secretary for a waiver of the disallowance. States would have six months from the later of the date of enactment, or the official announcement of the disallowance, in which to file an appeal. The Board would be required to rule on the appeal within 12 months from the date on which the appeal is filed. The Board's decisions would be subject to judicial review. States ultimately found to owe disallowances would pay interest on the final amount from the date of the Departmental Appeals Board decision.

These provisions would take effect on July 1, 1989, and would apply to potential disallowances for fiscal years 1981 through 1990.

B. Permanently Modify the Quality Control System after Fiscal Year 1990

Proposes a new system under which the official State error rates would be the midpoint of the confidence interval around each State estimate. Confidence intervals would be set at the 95 percent level.

States with error rates below one-half of the lowest sum of the national average overpayment and underpayment error rates ever achieved in prior years, beginning with fiscal year 1981, would receive incentive payments equal to half the difference between the incentive threshold and the State's error rate, times the Federal share of the State's total payments. Technical errors would be excluded.

States with error rates above one percentage point, plus the lowest sum of the national average overpayment and underpayment error rates ever achieved in prior years, beginning with fiscal year 1981, would be identified for potential disallowances equal to the Federal share of erroneous payments in excess of the error rate threshold. Technical errors would be excluded.

As in the resolution of the backlog of disallowances, States could pay 75 percent of the proposed disallowance amount or appeal the sanction directly to the Departmental Appeals Board. Interest would be charged on disallowances ultimately imposed after appeals are exhausted, to dissuade States from simply delaying the collection by appealing.

States would be required to collect and report data on underpayments and negative case actions as part of the basic quality control sample. The Secretary would be required to study negative case actions and make recommendations to Congress on how to incorpo-

rate them into State error rates and the Federal incentive and disallowance formulas. States would have to begin collecting and reporting all data by no later than October 1, 1990. The Secretary would be required to report to Congress no later than October 1, 1992.

Subtitle D—Trade Provisions

1. Trade agency authorizations

The bill combines three separate trade agency authorizations of appropriations under the jurisdiction of the Committee.

The bill authorizes appropriations of $39,943,000 for the U.S. International Trade Commission (ITC) for fiscal year 1990, the amount requested by the ITC. Of this amount, not more than $2,500 may be used for reception and entertainment expenses, subject to approval of the Chairman.

Further, the bill authorizes a total amount of $1,075,290,000 for salaries and expenses for the U.S. Customs Service for fiscal year 1990. The bill authorizes appropriations for fiscal year 1990 for noncommercial operations of not to exceed $418,822,000, and authorizes appropriations not less than $656,468,000 for commercial operations. These amounts maintain current levels of service, provide for authorization of the fiscal year 1989 pay raise, and reauthorize unfunded Customs drug enforcement programs from the Anti-Drug Abuse Act of 1988 (Public Law 100–690). The bill also authorizes appropriations not to exceed $128,128,000 for Operations and Maintenance of the Customs Aviation Program, as requested by the Administration.

Further, the bill authorizes appropriations for the Office of the U.S. Trade Representative (USTR) of $21,143,000, of which not to exceed $89,000 may be used for entertainment and representation expenses and $1 million would remain available until expended.

2. Customs User Fee Amendments

In February 1988 the Contracting Parties to the General Agreement on Tariffs and Trade (GATT) adopted a panel finding that the present ad valorem user fee structure is inconsistent with U.S. obligations under the GATT. The bill incorporates the substance of H.R. 2628, the "Customs User Fees Amendments Act of 1989," providing a revised customs user fee authority that addresses the issues raised by the GATT ruling as an interim measure for one year, pending a six-month study by the General Accounting Office of the costs of Customs Service commercial operations. For fiscal year 1990, the user fee on any formal entry will be 0.17 percent ad valorem or $575, whichever is less. The costs of commercial operations on which the fee level is based will exclude air passenger processing costs, export control costs, and costs of international affairs activities. The exceptions to application of the fee under present law will continue, but the costs of processing such entries will be funded from general revenues rather than from user fees applied to other entries.

The bill exempts Israel from the existing and interim user fees if the U.S. Trade Representative determines that Israel has provided reciprocal concessions in return. The bill also provides the Customs

TITLE XI—REVENUE PROVISIONS

This summary is designed as a brief explanation of significant actions taken by the Committee on Ways and Means with respect to revenue issues in the reconciliation of the fiscal year 1990 budget. This summary is not intended to be the legislative history of the actions of the Committee.

A. Prior Committee Action

In this consideration of H.R. 1278, the Financial Institutions Reform, Recovery and Enforcement Act of 1989 (P.L. 101–73), the Committee agreed to repeal the three special tax provisions contained in the Internal Revenue Code (Code) to assist financially-troubled financial institutions, effective for all transactions occurring on or after May 10, 1989. Under prior law, these provisions were scheduled to expire on January 1, 1990.

B. Capital Gains

The Committee agreed to an amendment providing individuals a 30-pecent exclusion on the net capital gain from sales or exchanges of assets (other than collectibles) held more than one year which are disposed of during the period beginning September 14, 1989, and ending December 31, 1991. This gain would not be subject to the additional five-percent tax, commonly known as the "bubble." The amendment would result in a maximum regular tax rate on these capital gains of 19.6 percent. Depreciation, amortization and depletion would be recaptured in full. This exclusion would not be taken into account for purposes of computing the alternative minimum tax.

With respect to dispositions of assets acquired after December 31, 1991, the Committee agreed to provide that an individual would be allowed to index the basis of the asset for inflation occurring after 1991 for purposes of determining gain (but not loss). Indexed assets include corporate stock (other than certain preferred stock and stock in foreign corporations) and tangible assets which are capital assets or business assets and which are held more than one year. In addition, the Committee agreed that the net capital gain (other than from the sale of collectibles) on assets sold after December 31, 1991, would not be subject to the additional five-percent rate, thus resulting in a maximum 28-percent rate. Depreciation, amortization and depletion would be recaptured in full.

The Committee also agreed that the material participation standard in the passive loss rules would be modified for individuals owning timber.

C. Child Care Initiative

1. Increase in earned income tax credit

The Committee agreed to increase the amount of the earned income tax credit (EITC) and to adjust the credit for family size. As a result, the credit available to a family with three dependent children would be greater than the credit available to a family with equal income, but only one or two children.

In addition, the Committee agreed to a supplemental credit for families with any children under the age of six. Like the EITC, the supplemental credit would be refundable; that is, it would be available in cash to families with zero tax liability.

2. Modifications to Title XX of the Social Security Act

The Committee action would permanently increase funds for Title XX of the Social Security Act by $200 million for fiscal year 1990, by $350 million for fiscal year 1991, and $400 million in fiscal year 1992 and subsequent fiscal years. These funds would be earmarked for child care services and child care related administration and training, as well as the enforcement of State child care standards. A State receiving earmarked funds under Title XX would have to have in effect State child care standards addressing several specific categories. The standards would have to apply to all Title XX funded child care and to any child care services delivered by providers that receive public funds for child care services.

D. Temporary Extensions

1. Employer-provided educational assistance

The exclusion for employer-provided educational assistance would be restored retroactively to the date of its expiration under prior law (years beginning on or after January 1, 1989). The extension is for three years beginning from that date, through December 31, 1991. The agreement also clarifies the extent to which employer-provided educational assistance is excludable as a working condition fringe benefit.

2. Extension and modification of targeted jobs credit

Under the agreement the targeted jobs tax credit (TJTC), which under present law is scheduled to expire for years after December 31, 1989, would be extended for two years through December 31, 1991.

3. Extension of qualified mortgage bonds

The Committee agreed to extend for two years the authority to issue qualified mortgage bonds and the mortgage credit certificate program, through December 31, 1991.

4. Extension of qualified small-issue bonds

The Committee agreed to extend for two years the authority to issue qualified small-issue bonds for manufacturing facilities and certain property for first-time farmers, through December 31, 1991.

III. DETAILED EXPLANATION OF PROVISIONS

Subtitle A. Provisions Related to Social Security and Railroad Retirement

1. Establishment of the Social Security Administration as an Independent Agency (Sections 10001–10014)

Current Law

Section 702 of the Social Security Act gives the Secretary of Health and Human Services (HHS) responsibility for the Old-Age, Survivors and Disability Insurance (OASDI) program and the Supplemental Security Income (SSI) program. The administration of both these programs has been delegated to the Social Security Administration (SSA).

The SSA Office of Hearings and Appeals holds hearings on appeals of denied claims for OASDI, SSI, and medicare benefits. These hearings are conducted by Administrative Law Judges (ALJ's).

Proposal

The provision would establish the Social Security Administration as an independent agency with administrative responsibility for the OASDI and SSI programs. The new agency would be governed by a bipartisan, full-time, three-member Social Security Board. Members of the Board would be appointed by the President, with the advice and consent of the Senate, and would serve staggered six-year terms, with the exception of the first three members whose terms would expire on June 30, 1993; June 30, 1995; and June 30, 1997. Board members could only be removed from office for neglect of duty or malfeasance. The Chairperson of the Board would be designated by the President from among the members of the Board to serve as Chairperson for a four-year term.

The Board would establish broad legislative and regulatory policy for the independent agency and would oversee its operation. The policies and regulations established by the Board would be covered under the notice and public comment provisions of the Administrative Procedures Act of 1946. To handle day-to-day administration, the Board would appoint an Executive Director to act as chief operating officer. The Executive Director would serve a four-year term and could be removed only for cause. In establishing this organizational structure, the Committee intends that the Board would focus on developing policy for SSA and that the Executive Director would manage the agency.

The provision also establishes the positions of Deputy Director, General Counsel, Inspector General, and Beneficiary Ombudsman.

Administrative Law Judges (ALJ's) in the agency would report directly to the Board. The Board would appoint the Chief ALJ, who

would be charged with assuring that hearings are conducted in accordance with applicable law and regulations. In addition to presiding over hearings of appeals of agency decisions, ALJ's would hear appeals of medicare claims, as is currently the practice in SSA's Office of Hearings and Appeals. The Board would consult with the Secretary of HHS about any changes in appeal procedures which affect medicare claims. By July 1, 1992, both the Secretary of HHS (in consultation with the Social Security Board) and the Comptroller General of the United States would be required to issue reports to Congress on the appropriateness of maintaining this arrangement for medicare appeal hearings.

In addition to establishing the independence of SSA from HHS, the provision would provide SSA with demonstration authority to perform certain management functions generally controlled by the Office of Personnel Management (OPM) and the General Services Administration (GSA). Specifically, the board would have authority to test the new agency's capacity to recruit, compensate, and manage personnel and to acquire and maintain facilities. (GSA's current authority over SSA's procurement of automated data processing and telephone equipment and services would remain unchanged). Before initiating a demonstration project relating to personnel, agency management would be required to consult with affected personnel and their union representatives. Before July 1, 1994, the General Accounting Office would report to Congress on the outcome of the demonstration projects and assess the readiness of the agency to assume permanent and full authority for these management functions.

All orders, determinations, rules, regulations, permits, contracts, collective bargaining agreements, recognitions of labor organizations, certificates, licenses, and privileges in effect at SSA at the time of the transition would remain in force at the new agency until their expiration or modification in accordance with law. Thus, a union's national consultation rights with SSA would be unaffected by the transition; and individual work units would retain their collective bargaining agent to the extent that the same community of interest continued to exist within them after the transition, in accordance with current law. Furthermore, the practice of appointing ALJ's pursuant to the provisions of the Administrative Procedures Act would be unaffected by the transition to the new agency. Finally, following the precedent of recent legislation establishing the Department of Energy and the Department of Education and separating the National Archives from GSA, the transfer would not cause any full-time or part-time employee to be reduced in grade or compensation for one year after the transition.

The Department of Health and Human Services would transfer to the new agency six level V and six level IV Executive Schedule positions. To adjust for the new agency's expanded responsibilities, the Board would be required to develop a comprehensive workforce plan as part of its appropriations request which could serve as a basis for an increase in the number of Senior Executive Service positions allocated to it.

Effective Date

In general, the provision would take effect July 1, 1990.

2. Improvements in Social Security Administration Services and Beneficiary Protections (Sections 10021–10030)

Current Law

a. *Recovery of Overpayments.*—When an individual is paid more than the correct amount of title II benefits, the Secretary must attempt to recover the overpayment by:

(i) requiring the overpaid person or his estate to refund the amount,

(ii) decreasing any payment to which the individual is entitled,

(iii) decreasing any payment to his dependents or his estate, or

(iv) using any combination of these measures.

The requirement to repay an overpayment is waived in cases where the individual is without fault and recovery would (i) be against equity and good conscience or (ii) defeat the purpose of title II of the Social Security Act. By regulation, the Social Security Administration (SSA) has interpreted "defeat the purpose of this title" to mean that recovery is waived if the overpaid individual needs substantially all of his or her income and financial resources to meet normal living expenses.

b. *SSA Telephone Service.*—SSA currently operates 37 Teleservice Centers (TSCs) which respond to inquiries from the public. These TSCs can access SSA's beneficiary computer files and can schedule appointments at local offices throughout the country. In October 1988, the TSCs were integrated into a toll-free telephone network which covers 60 percent of the population. In October 1989, toll-free service will be extended via the TSCs and four new mega-TSCs to the entire country. At the same time, direct telephone access to SSA's local field offices will be terminated, so that the public will no longer be able to call these offices directly.

c. *Correction of Earnings Records.*—The Secretary is required to establish and maintain records of wages and self-employment income paid to workers and records of periods during which these payments are made. The Secretary can correct errors in these records at any time up to three years, three months, and fifteen days after the year in which the wages were paid or self-employment income was derived.

After this time limit has passed, only specified types of corrections can be made. These include:

(i) corrections of entries established through fraud,

(ii) corrections of clerical or mechanical errors,

(iii) corrections to make records conform to an employer or self-employment tax return,

(iv) corrections of misallocations of wages among workers or over time periods, and

(v) corrections to add wage entries to records for periods in which an employer paid wages to an employee but did not report any wages to the Secretary for the employee.

In cases where the Secretary finds that an employer has underreported wages for an employee, this fifth exception does not permit his wage record to be corrected after the statutory time limit.

d. *Standards Applicable in Determinations of Fault, Good Faith, and Good Cause*

(i) *Fault.*—When the Secretary finds that an individual has been paid more than the correct amount of title II benefits, he must attempt to recover the overpayment, as described in (a), above. However, the requirement to repay an overpayment is waived in cases where the individual is without fault and recovery would either be against equity and good conscience or defeat the purpose of title II of the Social Security Act. SSA regulations require that in determining whether an individual was "without fault", consideration be given to his age, intelligence, education, and physical and mental capabilities.

(ii) *Good Faith.*—A title II beneficiary receiving benefits based on disability whom the Secretary determines is no longer disabled has the option of having his or her benefits continued through a hearing before an Administrative Law Judge (ALJ). Benefits paid during this period are considered overpayments if the individual loses the appeal and are subject to recovery by the Secretary. However, if the individual acted in good faith in pursuing the appeal, repayment of the benefits can be waived, as described in (i), above. SSA regulations establish a presumption that appeals are made in good faith unless the individual fails to cooperate with the agency during the appeal (for example, fails to provide requested medical information).

(iii) *Good Cause.*—Title II beneficiaries who:

—work for more than 45 hours during a month in non-covered employment outside the United States,

—cease to have a dependent child in care, or

—have earnings in excess of the annual exempt amount under the retirement test

are subject to penalties for failure to report these facts to SSA. However, if the individual can demonstrate to the satisfaction of the Secretary that he had good cause for failing to make a timely report, these penalties are waived.

In addition, disability benefits are terminated when a beneficiary fails, without good cause, to cooperate with the Secretary in reviewing his entitlement to benefits or in following a treatment which is expected to restore his ability to work.

e. *Homeless Outreach.*—In some areas of the country, SSA has participated in projects designed to assist homeless individuals in qualifying for title II and title XVI benefits. The law is silent regarding SSA's responsibilities to potentially eligible homeless persons.

f. *General Notice Requirements.*—The Secretary must use understandable language in notifying individuals of a denial of disability benefits. The law is silent regarding the language of other notices.

g. *Notices to the Blind.*—Blind individuals who apply for or receive Supplemental Security Income (SSI) may opt to:

(i) be informed by telephone within five days of the mailing of a written notice of any decision, determination, or other action taken by the Secretary which affects them,

(ii) receive written notices of such decisions, determinations, or actions by certified letter, or

(iii) receive such notifications through some alternative procedure established by the Secretary.

These options are not available under title II to blind individuals.

h. *Representation of Claimants.*—SSA currently requires that applicants for title II and title XVI benefits who wish to be represented by an attorney or other individual sign an appointment-of-representative form designating a legal representative. When this form is completed and placed in the individual's claim file, the agency will deal directly with the representative on matters relating to the applicant's claim. In the process of an appeal, SSA frequently moves a claimant's file from a local office to a state disability determination service or to an SSA Office of Hearings and Appeals. Without the file, and the appointment-of-representative form that it contains, local offices sometimes refuse to do business with the claimant's representative.

In addition, current law does not require the Secretary to provide claimants for title II or title XVI benefits with information on the availability of legal counsel in appealing an agency decision.

i. *Appeal Versus Reapplication for Benefits under Title II or Title XVI.*—The decision by a claimant to submit a new application rather than appeal a denial may result in ineligibility or loss of benefits. There are two problems associated with this situation. First, SSA's denial notices do not adequately inform claimants of this danger. Second, hearings by the Subcommittee on Social Security point to instances where claimants have chosen to reapply rather than appeal as a result of misinformation from SSA.

Specifically, if a claimant for title II disability benefits successfully appeals a denial, he may receive benefits for up to 12 months retroactive to the date of his application. (Title XVI claimants receive benefits retroactive only to the date of application.) If, on the other hand, instead of appealing, the claimant reapplies and is found to be disabled, the claimant may not be able to receive full retroactive benefits. This occurs because SSA regulations prohibit the reopening of an original application in those cases of interest in the current legislation, i.e., those cases in which the individual was misled by SSA into filing a new application rather than an appeal and in which the original evidence (without the introduction of any new evidence) properly supports a finding of eligibility.

In a different way, for title II claimants, the decision to reapply rather than to appeal can lead to outright denial of eligibility. This is particularly true for claimants who were wrongly denied on their first application (as opposed to those who base their reapplication on new evidence of disability). Ineligibility under reapplication may result from the failure of the claimant to pass the recency-of-work test. This test requires that a claimant have a specified minimum number of quarters of social security coverage in the period immediately preceding his established onset of disability. On appeal, an individual who satisfied the recency-of-work test originally will satisfy it again. On reapplication, however, that individual may fail the test since the reference period (e.g., the forty quarters preceding the disability) will be moved forward to fit the time frame of the new application, dropping more distant quarters of coverage in which the claimant has worked and adding more recent quarters in which he has not. This shift occurs only on reap-

plication, not appeal. SSA's regulatory restriction on reopening a prior application, mentioned above, and its consequent inability to relocate the reference period properly, force the denial of eligibility in this circumstance.

Prior to May 1989, SSA's standard denial notice informed claimants that they could reapply for benefits at any time, without explaining the possibly adverse consequences of reapplying versus appealing a denial. A May 1989 modification of this notice includes a statement that the decision to reapply rather than to appeal can result in a loss of benefits. However, this modified notice does not explain that an individual who reapplies rather than appealing may also become entirely ineligible for title II benefits due to a subsequent inability to satisfy the recency-of-work test.

j. *Misinformation Given to Prospective Applicants by SSA Workers.*—When an individual contacts SSA by telephone and expresses an intention to apply for title II or title XVI benefits, the worker with whom he speaks is required to establish a protective application at the time of the call. The requirement for a protective filing date in this circumstance is provided in SSA's Program Operations Manual Systems (POMS). If the individual subsequently qualifies for benefits, this procedure enables him to receive payments retroactive to the date on which he first contacted SSA. (When an individual is eligible for additional retroactive benefits for some period—i.e., benefits beginning with the onset of a disability—this retroactive period is established by counting backward from the protective filing date).

When an individual does not express an interest in applying for benefits because an SSA worker incorrectly informs him that he is not eligible, SSA will not assign him a protective filing date. As a result, if the individual qualifies for benefits upon subsequent application, he will be unable to receive benefits retroactive to the date that SSA discouraged him from filing by providing him with incorrect information.

k. *Interviews on Time-Sensitive Transactions.*—Current law contains no requirement that SSA offices respond promptly to individuals who visit them on matters of personal financial urgency or under time deadlines imposed by the agency.

Proposal

The provision would establish an additional set of protections for title II and title XVI claimants and beneficiaries, as well as codifying certain procedural safeguards in order to ensure more national uniformity in their application.

a. *Recovery of Overpayments.*—Except in cases involving fraud, concealment, or willful misrepresentation, the Secretary would be required to recover title II overpayments on a schedule that would not cause a beneficiary undue financial hardship. Further, in cases where a title II beneficiary is also receiving SSI, title II overpayments would be recovered by withholding an amount equal to 10 percent of his title II benefit.

b. *SSA Telephone Service.*—The Secretary would be required to carry out demonstration projects testing a set of accountability procedures in at least three teleservice centers. These procedures are intended to assure that individuals who conduct business with the

agency via telephone concerning title II and title XVI benefits are not disadvantaged, either as a result of receiving incorrect information or from their inability to document their own actions and requests. Under these procedures, callers would be provided with written confirmation of the date and nature of their telephone communication with the agency. This confirmation would include the name of the SSA employee with whom the caller spoke, a description of any action that the employee said would be taken in response to the call, and any advice which the caller was given. SSA would be required to maintain a copy of this confirmation for a minimum of five years following the termination of the demonstration projects.

Routine telephone communication would be excluded from these requirements. Thus, callers making inquiries which do not relate to potential or current entitlement or eligibility for title II or title XVI benefits—i.e., questions about the location or hours of operation of local offices—would not be subject to the accountability procedures described above.

The demonstration projects must begin within six months of enactment and continue for one to three years.

The Secretary would be required to issue periodic reports to the Committee on Ways and Means and the Committee on Finance on the demonstration projects. These reports would:

(i) assess the costs and benefits of the accountability procedures,

(ii) identify any major difficulties encountered in implementing the demonstration projects, and

(iii) assess the feasibility of implementing the accountability procedures nationally.

The first of these reports would cover the first six months of operation of the demonstration projects and would be submitted nine months after their inception. A final report would be submitted 90 days after the termination of the projects. (If the demonstration projects continued for more than one year, additional annual reports would also be required.)

c. *Correction of Earnings Records.*—The current list of exceptions to the three year, three month, and fifteen day time limit for correcting erroneous earnings records would be expanded to allow the Secretary to add wages to records where an entry for an employer is present but incorrect. This additional authority would fill a gap in the Secretary's ability to correct errors in wage records after the expiration of the statutory time limit.

d. *Standards Applicable in Determinations of Fault, Good Faith, and Good Cause.*—In making determinations of whether a title II beneficiary:

(i) is without fault in causing an overpayment,

(ii) has acted in good faith in appealing a termination of his disability benefits,

(iii) has good cause for having failed to make a timely report of overseas work, of earnings above the retirement test exempt amount, or of ceasing to have a child in care, or

(iv) has good cause for having failed to participate in a reassessment of his disability or in a program of treatment,

the Secretary would be required to take into account any physical, mental, educational, or linguistic limitation that the individual has (including any lack of facility in the use of English). In the case of (iv) above, failure to cooperate in the reassessment of a disability or in a program of treatment, the Committee intends the Secretary to consider the individual's limitations only in relation to his understanding of the requirements being placed upon him, not as the basis for an exemption from the requirements themselves.

e. *Assistance to the Homeless.*—The Secretary would be required to establish a program to identify homeless individuals who may be eligible for title II or title XVI benefits and to provide them with reasonable assistance and support in making application. In addition, upon a request from a state or local government or non-profit organization, the Secretary would be required to cooperate in a joint effort to facilitate benefit applications from homeless individuals. Such efforts would include regular visits to the primary nighttime residences of homeless individuals, as well as to facilities which regularly provide meals to the homeless.

The Secretary would report annually to the Committee on Ways and Means and the Committee on Finance on the accomplishments of this outreach program.

f. *General Notice Requirements.*—In issuing notices concerning title II and title XVI benefits, the Secretary would be required to:

(i) use clear and simple language,

(ii) in notices generated by SSA local offices, include the name, address and telephone number of a responsible contact person, and

(iii) in notices generated by SSA central offices, include the name and address of the local office which serves the recipient of the notice and a telephone number through which that office can be reached.

In addition, the Secretary would be required to issue a report to the Committee on Ways and Means and the Committee on Finance on (i) its current procedures for providing title II and title XVI notices in foreign languages, and (ii) options for expanding the use of foreign language notices to individuals who have limited capacity to communicate with the agency in English.

g. *Notices to the Blind.*—Blind individuals who apply for or receive title II disability benefits would have the option to:

(i) be informed by telephone of any decision, determination, or other action affecting them taken by the Secretary within five days of the mailing of a written notice,

(ii) receive written notices of such decisions, determinations or actions by certified letter, or

(iii) receive such notices through some alternative procedure established by the Secretary.

These requirements parallel current notice requirements for blind SSI applicants and recipients.

h. *Representation of Claimants.*—The Secretary would be required to maintain an up-to-date electronic record, accessible to SSA field offices through the agency's computer system, of the identities of the legal representatives of all claimants for title II and title XVI benefits. This requirement is intended to facilitate cooperation between local field offices and claimants' attorneys at

times when the claimant's file, and the appointment-of-representative form contained in it, are not physically present in the office.

The Secretary would also be required to include in title II and title XVI benefit denial notices information on options for obtaining legal representation in an appeal before the agency. This information would include notification of the existence of legal services organizations which provide assistance free-of-charge to qualified claimants.

i. Reapplication Versus Appeal.—When an applicant for title II or title XVI benefits can demonstrate that he failed to appeal an adverse decision because he relied on incorrect, incomplete, or misleading information provided by SSA, his failure to appeal could not serve as the basis for denial by the Secretary of a second application for such benefits for any period.

The Secretary would be required to include in all notices of denial of title II benefits a clear, simple description of the effect on possible entitlement to benefits of reapplying rather than making an appeal.

j. *Misinformation Given to Prospective Title II Applicants by SSA Workers.*—When an individual can demonstrate to the satisfaction of the Secretary that he failed to apply for title II or title XVI benefits because he received incorrect information from SSA concerning his eligibility, the individual would be deemed to have applied for benefits on the later of (i) the date on which the incorrect information was provided, or (ii) the date on which the individual met all requirements for entitlement to benefits.

k. *Interviews on Time-Sensitive Transactions.*—When an individual visits a field office during its normal business hours because (i) he received a notice from SSA concerning title II or title XVI benefits which included a time limit for a response, or (ii) his title II or title XVI benefit check was lost, stolen, or not received, the Secretary would be required to assure that the individual receives a face-to-face interview with an SSA employee concerning the matter before the close of the business day.

Effective Date

a. *Recovery of Overpayments.*—The provision would apply to adjustments made, and recoveries obtained, on or after January 1, 1990.

b. *SSA Telephone Service.*—The telephone demonstration projects required by the provision would be required to be initiated within six months of the date of enactment of this Act.

c. *Correction of Earnings Records.*—The provision would be effective upon enactment.

d. *Standards Applicable in Determinations of Fault, Good Faith, and Good Cause.*—The provision would apply to determinations made on or after January 1, 1990.

e. *Assistance to the Homeless.*—The program of assistance to the homeless would be established no later than 180 days after the date of enactment of this Act.

f. *General Notice Requirements.*—The provision would apply to notices issued on or after January 1, 1990. The required report on foreign language notices would be due July 1, 1990.

g. *Notices to the Blind.*—The provision would apply to notices issued on or after January 1, 1990.

h. *Representation of Claimants.*—The provision requiring an electronic list of claimants' legal representatives would be effective July 1, 1990; the provision requiring notification of options for legal representation would apply with respect to adverse determinations made on or after January 1, 1990.

i. *Appeal Versus Reapplication.*—The provision would apply to adverse determinations made on or after January 1, 1990.

j. *Misinformation Given to Prospective Title II Applicants by SSA Workers.*—The provision would apply with respect to benefits for months after December, 1989.

k. *Interviews on Time-Sensitive Requests.*—The provision would apply to visits to SSA field offices made on or after January 1, 1990.

3. Improvements in the Representative Payee System (Sections 10031-10033)

Current Law

Under current law, the Secretary of Health and Human Services may appoint a relative or some other person (known as a "representative payee") to receive social security benefit payments on behalf of a beneficiary whenever it appears to the Secretary that the appointment of a representative payee would be in the best interest of the beneficiary.

The Secretary is required to investigate each individual applying to be a representative payee either prior to, or within 45 days after, the Secretary certifies payment of the benefit to that individual. Present law does not specify what shall be included in the investigation.

The Secretary is required to maintain a system of accountability monitoring under which each representative payee is required to report not less than annually regarding the use of the payments. The Secretary is required to review the reports and identify instances where payments are not being properly used.

Any individual convicted of a felony under section 208 or section 1632 of the Social Security Act may not be certified as a representative payee.

Proposal

a. *Investigations of Representative Payee Applicants.*—During the investigation of the representative payee applicant, the Secretary would be required to: (1) require the representative payee applicant to submit documented proof of identity; (2) verify the social security account number or employer identification number of the representative payee applicant; (3) determine whether the representative payee applicant has been convicted of a social security felony under section 208 or section 1632 of the Social Security Act; and (4) determine whether the representative payee applicant had ever been dismissed as a representative payee for misuse of a beneficiary's funds. An individual who had been convicted of a felony under section 208 or section 1632 or dismissed as a representative payee for misuse of the benefit payment would not be permitted to be certi-

fied as a representative payee on or after July 1, 1990. The Secretary would be permitted to issue regulations under which an exemption from the prohibition against certification in the case of misuse would be granted on a case-by-case basis, if the exemption would be in the best interest of the beneficiary. However, the Committee intends that the exemption would be granted only in rare instances.

The Secretary would be required to terminate payments to a representative payee where the Secretary found that the representative payee had misused the benefit payments, to maintain a list of those terminated for misuse on or after July 1, 1990, and to provide such list to local field offices. Under current SSA policy, misuse is defined as converting benefit payments for personal use, or otherwise diverting the payments in bad faith with a reckless indifference to the welfare and interests of the beneficiary. The Committee expects the Secretary to apply this definition under this provision.

Advocacy groups for the elderly and the Social Security Administration's (SSA's) own field representatives have testified before the Subcommittee on Social Security and the Subcommittee on Human Resources regarding the lack of a meaningful investigation of representative payee applicants by SSA. For this reason, the Committee feels it necessary to place minimum requirements for the investigation of representative payee applicants in statute. In addition, the Committee expects SSA to monitor more closely local field office compliance with policy set forth in its Procedures and Operations Manual Systems (POMS) when determining an individual's need for a representative payee as well as when determining which representative payee applicant is best suited to serve as representative payee for an individual.

The Secretary would be required to maintain a centralized, current file readily retrievable by all local SSA offices of: (1) the address and social security account number (or employer identification number) of each representative payee; and (2) the address and social security account number of each beneficiary for whom each representative payee is providing services as representative payee. In addition, local service offices would be required to maintain a list of all public agencies and community-based non-profit social service agencies qualified to serve as a representative payee in the area served by such office.

b. *Withholding of Benefits.*—In cases where the Secretary is unable to find a representative payee, and the Secretary determines it to be in the best interest of the beneficiary to withhold direct payment to the beneficiary, the Secretary would be permitted to do so for up to two months. Not later than the expiration of the two-month period, the Secretary would be required to begin direct payment to the beneficiary starting with the current month's benefit unless the beneficiary has been declared legally incompetent or is under age 15. Retroactive benefits would be withheld until a representative payee has been appointed or the Secretary determines that a suitable representative payee cannot be found. Retroactive benefits would be paid over such period as the Secretary determines is in the best interest of the beneficiary.

It is not the intention of the Committee to encourage SSA to withhold benefits from a beneficiary whom the Secretary has deter-

mined to need a representative payee. The beneficiary should be paid directly if at all possible, especially if the beneficiary had been using the benefit payment to meet immediate needs such as shelter, food and clothing.

In addition, the Committee does not wish SSA to view the two-month withholding period as a routinely acceptable length of time in which to find a representative payee. The Committee expects SSA to make every effort to find a qualified representative payee for an individual as quickly as possible.

c. *High-Risk Representative Payees.*—The Secretary would be required to study and provide recommendations as to the feasibility and desirability of formulating stricter accounting requirements for all high-risk representative payees and providing for more stringent review of all accountings from such representative payees. The Secretary would be required to define as high-risk representative payees: (1) non-relative representative payees who do not live with the beneficiary; (2) those who regularly serve as a representative payee for three or more beneficiaries (under title II, title XVI, or a combination thereof) and who are not related to such beneficiaries; and (3) any other group determined by the Secretary to be high-risk.

The purpose of the provision is to identify groups or individuals serving as representative payees who may be likely to misuse or improperly use benefit payments. In particular, the Committee expects SSA to examine board and care operators, nursing homes, and individuals who are not related to the beneficiary. The provision does not apply to Federal or State governmental institutions.

d. *Fee for Representative Payee Services.*—Community-based non-profit social service agencies which serve more than five beneficiaries, and are not creditors of the beneficiary, would be allowed to collect a fee from the beneficiary's social security payment for providing representative payee services. The maximum fee would be established in regulations by the Secretary and would be limited to expenses incurred in providing services to the beneficiary. Such fee could include both the direct cost of services as well as overhead costs.

The purpose of this provision is to provide representative payee services of last resort for those individuals for whom finding a volunteer representative payee is difficult. Individuals who are mentally retarded, mentally ill, alcoholics or drug abusers are the most vulnerable members of society, yet in many cases, these individuals have no family members or friends to assist them.

In the past, SSA allowed certain community-based non-profit groups, such as those that provide guardian services to large numbers of the elderly and disabled, to receive a small fee for services, including overhead. SSA has discontinued this practice, citing a lack of statutory authority. The Committee wishes to provide authority for a small, specific group of organizations to collect a fee for services. In no way does the Committee intend to permit the proliferation of non-profit organizations instituted expressly for the purpose of providing representative payee services in order to obtain a fee.

The term "community-based, non-profit, social service agencies" means non-profit social service agencies which are representative

of communities or significant segments of communities and regularly provide services for those in need. Guardian, Inc., of Calhoun County, Michigan, is an example of a non-profit organization which regularly provides representative payee services. The Salvation Army, Catholic Charities, and Lutheran Social Services are examples of agencies providing social services to the needy.

Qualified organizations which charge or collect, or make arrangements to charge or collect, a fee in excess of the maximum fee established by the Secretary, would be guilty of a misdemeanor punishable by a fine not exceeding $500, or imprisonment not exceeding one year, or both.

Currently, SSA permits a representative payee to be reimbursed from the beneficiary's check for actual out-of-pocket expenses incurred on behalf of the beneficiary. These expenses include items such as stamps, envelopes, cab fare or long distance phone calls. It is the intention of the Committee that such representative payees would continue to be reimbursed in this manner. The Committee does not intend these representative payees to receive a fee for services.

e. *Studies and Demonstration Projects.*—(i) The Secretary would be required to enter into demonstration arrangements with not fewer than two states under which the Secretary would send to such states a list of all addresses where OASDI and SSI benefit payments are received by more than five unrelated beneficiaries. The Secretary would be required to send the information to the agencies primarily responsible for regulating care facilities or for providing adult or child protective services in the participating states.

The purpose of this demonstration project is to determine whether providing such information to the state protective service agencies would be useful in locating unlicensed board and care homes.

(ii) The Secretary would be required to develop and implement demonstration projects, in not fewer than two states, whereby all representative payee applicants would be screened for past convictions through the Federal Bureau of Investigation's Interstate Identification Index.

The demonstration project would provide information needed to determine: (1) the percentage of representative payee applicants who had been convicted of felony or misdemeanor violations; (2) the type of representative payee applicant (if any) most likely to have a felony or misdemeanor conviction; (3) the suitability of individuals with prior convictions to serve as representative payees; and (4) the circumstances under which such applicants could be allowed to serve as representative payees.

The information obtained from this demonstration project would assist the Committee in determining whether there is a need to screen all representative payee applicants for convictions or limit the criminal background checks to certain types of representative payee applicants.

Although under current law an individual convicted of a felony under section 208 or section 1632 of the Social Security Act may not serve as a representative payee, the Committee has determined that SSA maintains no list of those convicted. As part of a demonstration project, the provision would require SSA to develop and

maintain such a list and make it readily available to local field offices.

The Secretary would be required to report to the Committee on Ways and Means and the Committee on Finance concerning the demonstration projects, together with any recommendations, not later than July 1, 1991.

(iii) The Secretary of Health and Human Services, in consultation with the Secretary of the Treasury and the Attorney General, would be required to study the feasibility of establishing and maintaining a list of the names and social security account numbers of those who have been convicted of social security check fraud violations under section 495 of title 18 of the U.S. Code. The study would also require the Secretary to consider the feasibility of providing such a list to the social security field offices in order to assist claims representatives in the investigation of representative payee applicants. The Secretary would be required to report the results of the study, together with any recommendations, to the Committee on Ways and Means and the Committee on Finance no later than July 1, 1990.

Law enforcement agencies do not report violations under section 495 of title 18 of the U.S. Code to either SSA or the Department of Health and Human Services Inspector General. As a result, SSA and the HHS IG are often unaware of investigations, arrests and convictions of individuals for violations under this section and therefore fail to obtain restitution or prevent those convicted of such violations from serving as representative payees.

To obviate the need for law enforcement, the Committee would require the Secretary to negotiate memoranda of understanding with the appropriate law enforcement agencies.

Effective Date

In general, the provisions would be effective July 1, 1990.

4. Statement of Trust Fund Liabilities in Trustees' Report (Section 10041)

Current Law

The Trustees of the Old-Age and Survivors Insurance and Disability Insurance Trust Funds are required by law to report annually on the actuarial status of the funds. The annual report of the Trustees includes a statement of the present value of the income to, outgo from, and balance in the trust funds measured over periods of 25, 50 and 75 years, expressed as a percentage of payroll.

Proposal

The Trustees would be required to include in their report a statement of the income to, outgo from, and balance in the trust funds measured over periods of 25, 50 and 75 years, expressed both as a percent of payroll and in dollar amounts. The analysis would also include (1) the actuarial present value of expected future taxable payroll over each of the three periods, and (2) the present-value actuarial balance, expressed as a percent of the present value of future outgo. The present-value actuarial balance would be determined by adding the present value of the expected future income

to the assets of the fund at the beginning of the measurement period and subtracting the present value of the expected future outgo.

The above requirement would result in a statement in the Trustees' report of the unfunded liabilities of the OASDI trust funds based upon an "open group" analysis of the funds, expressed both in terms of percent of payroll and in dollars.

An "open group" analysis is based on the assumption that future workers will be covered by the program as they enter the labor force. The Committee has required the Trustees to provide an "open group" analysis because the Committee believes that a "closed group" analysis, which is based on the assumption that no workers would be covered in the future other than those who are age 15 or over at the beginning of the measurement period, does not reflect the basis on which the OASDI program is financed.

Effective Date

The provision would be effective for annual reports of the Trustees beginning with the 1990 report.

5. Payment of Benefits to a Child Adopted after a Parent's Entitlement to Retirement or Disability Benefits (Section 10051)

Current Law

A child adopted before a worker becomes entitled to disability or retirement benefits is eligible for child's insurance benefits. A child (other than the worker's stepchild) adopted after a worker's entitlement is not eligible for social security benefits unless he or she was living with the worker, and dependent on the worker for half support, for the year prior to the worker's entitlement.

Proposal

A child adopted after a worker becomes entitled to retirement or disability benefits would be eligible for child's insurance benefits regardless of whether he or she was living with, and dependent on, the worker prior to the worker's entitlement.

Effective Date

The provision would be effective with respect to benefits payable for months after December, 1989, but only on the basis of applications filed on or after January 1, 1990.

6. Extension of Social Security Coverage Exemption for Members of Certain Religious Faiths (Section 10052)

Current Law

Self-employed workers may claim an exemption from social security coverage if they are members of a religious sect or division that is conscientiously opposed to the acceptance of public or private insurance benefits, if they have waived all benefits under titles II and XVIII, and if the sect or division has been in existence since December 31, 1950, and provides for the care of its dependent members. In addition, in cases where a self-employed individual has employees and both employer and employee meet the condi-

tions listed above, the employee may claim an exemption from social security coverage. This optional exemption applies to both the employer and employee portions of the social security tax.

Proposal

The religious exemption from social security coverage would be extended in two ways. First, it would be available to employees of partnerships in which each partner holds a religious exemption from social security coverage. Second, it would be available to workers in churches and church-controlled non-profit organizations who are treated as self-employed because the employing church or organization has exercised its option not to pay the employer portion of the social security tax. (In both cases, the worker would be required to be a member of the religious sect or division in order to receive the exemption.)

Effective Date

The first provision would be effective as if included in the Technical and Miscellaneous Revenue Act of 1988. The second would be effective for tax years beginning on or after January 1, 1990.

7. Prohibition of Termination of Coverage of U.S. Citizens and Residents Employed Abroad by a Foreign Affiliate of an American Employer (Section 10053)

Current Law

U.S. citizens and residents employed abroad by a foreign affiliate of an American employer are covered by social security at the option of the American employer through an agreement between the American employer and the Secretary of the Treasury. The American employer can terminate this coverage by giving two years advance notice after the agreement has been in effect for at least eight years. The Social Security Amendments of 1983 prohibited states and non-profit organizations from terminating the social security protection of their employees, but failed to repeal the similar authority available to American employers whose foreign affiliates employ U.S. citizens and residents.

Proposal

American employers' option to terminate the social security coverage of workers in their foreign affiliates would be eliminated.

Effective Date

The provision would be effective with respect to any coverage agreement in effect on or after June 15, 1989, for which there is no notice of termination in effect on this date.

8. Creation of Work Incentives for Disabled Adult Children (Sections 10061–10064)

Current Law

Disabled social security beneficiaries who attempt to work are provided with a trial work period of up to nine months, during which earnings cause no reduction in their benefits. By regulation,

months which count toward completion of this trial work period are those in which a beneficiary earns $75 or more. If the Secretary determines that a beneficiary is engaging in Substantial Gainful Activity (SGA) in the month following completion of the trial work period, benefits are suspended two months later. (SGA is currently defined by regulation as earnings of $300 per month. However, in a Notice of Proposed Rulemaking in July 1989, the Administration announced that it would raise SGA to $500 per month, effective January 1990. In addition, the $75 trigger point for a month of trial work would be raised to $200.)

At the end of the trial work period, individuals who continue to have a disabling impairment enter a 36-month Extended Period of Eligibility (EPE). During the last 33 of these 36 months, benefits can be paid for any month during which earnings drop below SGA without the need for a new application and disability determination.

For individuals who continue to have a disabling impairment, medicare coverage continues for a minimum of 39 months after the completion of a successful trial work period, or a minimum of three months past the end of the EPE.

In general, individuals who have earnings that exceed SGA at the end of an EPE can reapply for disability benefits during the following five years if they have a disabling impairment and their earnings fall below SGA. Individuals who return to the disability rolls during this five-year period are not subject to either the five-month disability waiting period or the 24-month medicare waiting period, nor are they eligible for a new trial work period or EPE. Former beneficiaries whose earnings drop below SGA after this five-year period and who have a disabling impairment can also become reentitled to disability benefits (and medicare) by filing a new application. However, such applicants are subject to a new five-month disability waiting period and, unless the impairment for the new period is the same as (or directly related to) the impairment in the previous period, to a new 24-month medicare waiting period. Such individuals are also eligible for a new trial work period and EPE.

Disabled Adult Children (DAC's) whose earnings exceed SGA upon completion of an EPE and who have a disabling impairment are subject to a different set of re-application requirements. If such individuals' earnings drop below SGA during the seven years following the end of their EPE, they can reapply for benefits without being subject to the 24-month waiting period for medicare. (DAC's are never subject to a disability insurance waiting period.) Such individuals will also receive a new trial work period and EPE. After this seven-year period, former DAC beneficiaries may apply for disability benefits on their own work record but cannot re-establish their eligibility for such benefits as DAC's.

Proposal

The provision would alter existing work incentives for Disabled Adult Children (DAC's) by replacing the trial work period and EPE with a system of ongoing, partial benefit payments. Under this system, $85 in earnings plus impairment-related work expenses would be disregarded in determining a DAC's monthly benefit. For

earnings which exceed these disregarded amounts, benefits would then be reduced by $1 for each additional $2 earned. For DAC's who are also entitled to disability benefits based on their own work record, the entire amount of the benefit they receive would be subject to this system of partial benefit payments. This system of partial benefit payments would continue so long as the DAC's disabling impairment did not cease. Medicare coverage would continue for a minimum of 48 months past the first month in which the individual engages in SGA (i.e., under current regulations, has earnings which exceed $300 per month).

During the five years which follow termination of medicare benefits, DAC's who have a disabling impairment and whose earnings fall below SGA could reapply for medicare without being subject to a new 24-month waiting period. Such individuals would continue to receive medicare so long as their earnings remained below SGA. After the end of this five-year period, individuals who have a disabling impairment could also reapply for medicare if their earnings fell below SGA. If the new impairment were the same as (or directly related to) the original impairment, the individual would not be subject to a new 24-month medicare waiting period. He would, however, be subject to the medicare waiting period if he reapplied on the basis of a different disabling impairment after the five-year period. Months counting toward completion of this period would be those in which the DAC received a cash disability insurance benefit.

There are two reasons for this targeted change in the disability insurance (DI) program. First, the Committee is concerned about the potential cost of an across-the-board change in DI work incentives. That is, by attracting disabled individuals who are now working to the DI rolls, a universal DI work incentive program could place heavy demands on the disability trust fund and, in the long run, pose a threat to the financial solvency of the program. Because DAC's tend to be disabled from birth or early childhood, their rates of workforce participation are significantly lower than those for individuals who become disabled in later years. As a result, the establishment of a work incentive program for DAC's is unlikely to attract to the DI rolls a significant number of additional disabled individuals who are now working but have not applied for DI benefits.

Second, were it not for their eligibility for DI benefits as a result of the death, disability, or retirement of a parent, many DAC's would be eligible for Supplemental Security Income (SSI) and thereby eligible for the existing 1619 work incentive program under SSI. Thus, this provision would establish a work incentive for large numbers of individuals who are currently being barred from participation in the 1619 program by their title II eligibility.

In addition to applying to DACs' benefits, this system of partial benefit payments would apply to any social security benefits earned by DAC's based on their own work effort.

Two groups of DAC's who would otherwise be disadvantaged by these changes would be excluded from the change. These are: (1) DAC's who are disabled by reason of blindness, and (2) those entitled to benefits in June of 1990 who have attempted to work but whose earnings have not reached SGA.

Effective Date

In general, the provision would be effective for benefits paid after June 1990. For DAC beneficiaries engaged in a period of trial work consisting of two or more consecutive months as of June, 1990, the provision would take effect beginning with the first month that follows this consecutive trial work period.

9. Continuation of Disability Benefits During Appeal (Section 10071)

Current Law

A disability insurance (DI) beneficiary who is determined to be no longer disabled may appeal the determination sequentially through three appellate levels within the Social Security Administration (SSA): a reconsideration, usually conducted by the State Disability Determination Service that rendered the initial unfavorable determination; a hearing before an SSA administrative law judge (ALJ); and a review by a member of SSA's Appeals Council.

The beneficiary has the option of having his or her benefits continued through the hearing stage of appeal. If the earlier unfavorable determinations are upheld by the ALJ, the benefits are subject to recovery by the agency. (If an appeal is made in good faith, benefit repayment may be waived.) Medicare eligibility is also continued, but medicare benefits are not subject to recovery.

The Technical and Miscellaneous Revenue Act of 1988 extended this provision for one year. The Act authorized the payment of interim benefits to persons in the process of appealing termination decisions made on or before December 31, 1989. Such payments may continue through June 30, 1990 (i.e., through the July 1990 check).

Proposal

The provision would be made permanent. Thus, the beneficiary would have the option of having his or her DI and medicare benefits continued through the hearing stage of appeal. The DI benefits would be subject to recovery where the ALJ upheld the earlier unfavorable decision. The medicare benefits would not be subject to subsequent recovery.

Effective Date

The provision would be effective upon enactment.

10. Repeal of Carryover Reduction in Retirement or Disability Insurance Benefits Due to Receipt of Widow(er)'s Benefits before Age 62 (Section 10072)

Current Law

If a widow(er) receives actuarially reduced benefits before age 62 and then applies for retirement or disability benefits, the new benefit is subject to a "carryover" reduction. This reduction reflects the fact that social security benefits were already being paid at a reduced rate before the beneficiary filed for retirement or disability benefits. The amount of the carryover reduction, which must be computed manually, is determined according to an unusually complex and error-prone formula. The widow(er) receives the retire-

ment or disability benefit reduced by the carryover reduction, plus any additional widow(er)'s benefit necessary to bring the total benefit amount up to the level of the widow(er)'s benefit if it is larger than the retirement or disability benefit. Since the widow(er)'s benefit in most cases is larger than the retirement or disability benefit, the amount of the carryover reduction usually has no effect on the total benefit received.

Proposal

The widow's carryover reduction would be eliminated. That is, the retirement or disability benefit received by a widow(er) would not be subject to a carryover reduction because the beneficiary received widow(er)'s benefits before age 62, although the new retirement benefit would be subject to actuarial reduction if claimed before the normal retirement age.

Effective Date

In the case of retirement benefits, the provision would be effective for individuals who attain the age of 62 on or after January 1, 1990. In the case of disability benefits, the provision would be effective for individuals who attain the age of 62 and become disabled on or after January 1, 1990.

11. Preeffectuation Review of Favorable Decisions by the Social Security Administration (Section 10073)

Current Law

The Social Security Disability Amendments of 1980 require the Secretary of Health and Human Services (HHS) to review 65 percent of favorable title II decisions made by State Disability Determination Services (DDS's) each year prior to their effectuation. The review applies to favorable decisions on initial claims, on reconsiderations, and on continuing disability investigations. At the Social Security Administration's (SSA's) current volume of applications and appeals, the agency is required to conduct about 450,000 preeffectuation reviews annually.

The Committee on Ways and Means approved the 65 percent requirement in 1980 as a means of promoting uniformity and accuracy in favorable disability decisions. At that time, the Committee noted that:

> . . . in some instances reviewing this percentage of cases may not be cost effective—a lower or higher percentage may be prudent. If the Secretary finds this to be the case, we would expect him to report his findings to [the] Committee in an expeditious manner. (H. Rept. 96-100, p. 10)

Proposal

The percentage of favorable state agency decisions that the Secretary must review would be reduced from 65 percent across-the-board to 50 percent of allowances and 25 percent of continuances. The 50 percent requirement would apply to both initial allowances and allowances upon reconsideration. To the extent feasible, the reviews would focus on allowances and continuances that are likely to be incorrect.

Since 1981, the Secretary has offered several proposals for reducing the preeffectuation review requirement. The Committee's approval of this reduction is based on a recognition of SSA's enhanced capacity, compared with 1980, to identify the general types of approvals and continuances that are most likely to be incorrect. Given this enhanced capacity, the Committee believes that it is possible to maintain current levels of accuracy, and possibly even to improve upon them, by targeting preeffectuation reviews on error-prone cases. The Committee intends to monitor SSA's implementation of this reduced requirement carefully to assure that accuracy levels do not deteriorate as a result of its enactment.

Effective Date

The provision would apply to reviews of state agency determinations made after fiscal year 1989.

12. Recovery of Overpayments from Former Social Security Beneficiaries (Section 10074)

Current Law

A federal agency that is owed a past-due, legally enforceable debt, other than a title II overpayment, can collect it by having the Internal Revenue Service (IRS) withhold or reduce the debtor's income tax refund. To obtain repayment via a tax refund offset, the agency to which the debt is owed must:

(i) notify the individual of its intention to recover the debt through the tax system,

(ii) provide the individual with at least 60 days to present evidence that all or part of the debt is not past-due or not legally enforceable, and

(iii) consider any evidence presented by the individual and make a final determination that the debt is in fact owed and legally enforceable.

After the agency notifies the IRS of its final determination, the IRS reduces the amount of the individual's income tax refund, if any; pays this amount to the agency; and notifies the individual of the amount by which his tax refund has been reduced to repay his debt.

Proposal

The prohibition against recovering title II overpayments via a tax refund offset would be eliminated for former beneficiaries. (Current beneficiaries would continue to be exempt from the tax refund offset program.)

After being informed by the Social Security Administration (SSA) of its intention to recover an overpayment via a tax refund offset, former beneficiaries who are eligible to apply for a waiver of the overpayment would be given the opportunity to do so. In addition, the IRS would be required to establish a procedure by which a spouse could prevent his or her share of a joint tax refund from being withheld in an overpayment recovery action. The IRS would also be required to notify individuals who file joint returns of this procedure when it informs them that it is withholding their tax refund. The Committee urges SSA to cooperate with the IRS and

Treasury in devising this procedure in a way which will avoid cash-flow difficulties at the Treasury if significant numbers of spouses refile their taxes to obtain their share of a joint refund after it had been credited to the social security trust funds.

The Committee intends that SSA and IRS work together to implement this provision expeditiously so that it can take effect for tax year 1989. The Committee hopes that SSA will begin preparing for implementation by determining what information the IRS needs in order to make the tax refund offset program for title II overpayments operational before the end of this calendar year.

Effective Date

The provision would take effect January 1, 1990 and would remain in effect as long as the existing, government-wide offset remains in effect (currently, until January 10, 1994).

13. Use of Social Security Number by Certain Legalized Aliens (Section 10075)

Current Law

The use of a false social security number or social security card or the misreporting of social security covered earnings, with intent to deceive, is a felony under section 208 of the Social Security Act, punishable by a maximum penalty of up to $250,000 or up to 5 years imprisonment. The Immigration Reform and Control Act of 1986 (IRCA) extended amnesty and the opportunity to obtain legal status to certain illegal aliens who had been resident and working in the United States for a substantial period of time. However, persons legalized under IRCA are still subject to prosecution for use of a false social security number or card under section 208 of the Social Security Act. As a result, alien workers who are granted temporary or permanent legal resident status under IRCA, and who apply for a correct social security number or attempt to correct their earnings records with the Social Security Administration, may be subject to prosecution as a result of their previous use of a false number or card.

Proposal

The provision would amend the Social Security Act to provide that aliens who, under IRCA and section 902 of the Foreign Relations Authorization Act for Fiscal Years 1988 and 1989, were granted legal status would not be prosecuted under certain criminal provisions of the Social Security Act, as described in section 208, by virtue of having used a false social security number or card or having misreported earnings with intent to deceive, during the period prior to, or within 30 days after enactment of, this provision. The exemption would not apply to those who sold social security cards, possessed social security cards with intent to sell, possessed counterfeit social security cards with intent to sell or counterfeited social security cards with intent to sell.

The purpose of IRCA is to give most illegal aliens who had been long established in the United States (generally present since January 1, 1982) and who are contributing members of the society an opportunity to become legal residents and lead normal lives. The

use of false social security numbers was a common practice among illegal aliens attempting to work in the United States.

When this population was given amnesty from prosecution for violation of the immigration laws, the fact that they could still be prosecuted for use of a false social security number or card, even after obtaining temporary or permanent resident status, was not addressed. As a result, most of the legalized population is still technically subject to prosecution and loss of legal status as soon as they attempt to obtain a legal social security number, which is essential for work in the United States, and to correct their earnings records. Many aliens who have applied for or have been granted amnesty have not yet corrected their social security numbers for fear of prosecution under section 208.

The Committee recognizes that recent cuts in staffing levels may make it difficult for SSA to absorb the anticipated increase in workload. Thus, additional resources may be required, over a short period, to prevent a deterioration of services.

The provision would make the Social Security Act consistent with the amnesty provisions of IRCA by providing amnesty from prosecution for use of false social security numbers during the period prior to, or within 30 days after, enactment of this provision. The Committee believes that individuals who are provided exemption from prosecution under this provision should not be considered to have exhibited moral turpitude with respect to the exempted acts for purposes of determinations made by the Immigration and Naturalization Service.

Effective Date

The provision would be effective for fraudulent use which occurred prior to, or within 30 days after, enactment.

14. Increase in the Retirement Test for Workers Age 65–69 (Section 10076)

Current Law

In 1989, individuals age 65–69 may earn up to $8,880 in wages or self-employment income annually and still be treated as retired; that is, they will have no reduction in their social security benefit as a result of earnings at or below this exempt amount. The exempt amount is automatically adjusted each year to reflect the change in average wages in the economy. The retirement test for those age 65–69 is projected to rise to $9,360 in 1990 and to $9,840 in 1991. The retirement test for those under age 65 is currently $6,480 and is projected to rise to $6,840 in 1990.

For earnings in excess of these amounts, $1 of benefits is withheld for each $2 of earnings. Beginning in 1990, beneficiaries age 65–69 will lose only $1 in benefits for every $3 in earnings in excess of the limit. Persons age 70 years and older are not subject to the retirement test.

Proposal

The provision would increase the retirement test applied to those age 65–69 by $360 in 1990 and by an additional $240 in 1991. These increases would be in addition to the automatic annual increases

reflecting wage growth in the economy. The resulting exempt amounts are projected to be $9,720 in 1990 and $10,440 in 1991. These ad hoc increases would be included permanently in the exempt amount so that automatic increases in future years would be calculated based on an inclusion of these ad hoc increases.

The Congressional Budget Office (CBO) would be required to study: (a) the distribution of benefit increases by various earnings categories resulting from the elimination of, or alternative increases in, the retirement test, (b) the impact on the OASI trust fund of such alternatives, and (c) the impact on labor force participation of such alternatives. It is the intention of the Committee that the Social Security Administration will cooperate in this effort by providing CBO with the benefit and earnings data necessary to complete the study.

Effective Date

The provision would be effective for taxable years ending after 1989. The study would be due April 1, 1990.

15. Increase in the Special Minimum Benefit (Section 10077)

Current Law

The special minimum benefit is designed to provide to workers who have many years of work at low wages a minimum social security benefit. The special minimum benefit is computed by multiplying the number of years of coverage earned by the individual toward the special minimum, in excess of 10 and up to 30, by $9.00 for years before 1979 and by $11.50 for 1979 and after. For 1979 and after, the $11.50 is subject to cost-of-living adjustments.

An individual earns a year of coverage toward the special minimum for the years 1937–1950 by dividing the total amount of wages or self-employment income credited in those years by $900. However, the total number of years awarded cannot exceed 14 years. For 1951–1978, the individual earns a year of coverage for each year in which he or she has wages or self-employment income of at least 25 percent of the social security contribution and benefit base for that year and, for years after 1978, at least 25 percent of the old-law contribution and benefit base for that year. The amount of earnings needed to acquire a year of coverage in 1989 is $8,925 (in 1990, it is projected to be $9,375).

Proposal

The provision would: (a) increase the special minimum benefit and (b) reduce the amount of wages needed to earn a year of coverage toward the special minimum.

The special minimum base amount, which is multiplied by the number of years of coverage earned by an individual to determine his or her special minimum benefit, would be increased in 1990 by $1.70. This would provide an individual who had acquired 30 years of coverage under the special minimum benefit and retired at age 65 in 1990 with a benefit increase of about $35 a month. Under the provision, such individual's benefit would be increased from $5,256 (which is 85 percent of the 1990 poverty level) to about $5,676 (which is 92 percent of the 1990 poverty level). As under current

law, benefits for individuals with less than 30 years of coverage would be lower than benefits for those with the full 30 years.

The wages or self-employment income required to earn a year of coverage would be reduced from 25 percent of the old-law contribution and benefit base (projected to be $9,375 in 1990) to 15 percent of the old-law contribution and benefit base (projected to be $5,625 in 1990).

Because the minimum wage has not been increased since 1980 while the social security contribution and benefit base has been indexed to wage increases, the level of wages required to earn a year of coverage has exceeded the minimum wage in every year since 1983. The provision would make it possible once again for a minimum-wage earner to earn years of coverage toward the special minimum.

Finally, the provision would provide for continued medicaid eligibility for those individuals who might otherwise lose eligibility for medicaid as a result of this increase.

Effective Date

The provision would increase the special minimum benefit with respect to benefits for months after December, 1989. The provision reducing the amount of wages needed to earn a year of coverage would be effective for years of coverage earned after 1989.

16. Repeal of Retroactive Benefits for Certain Categories of Individuals (Section 10078)

Current Law

Under present law, certain individuals are permitted to receive benefits for up to six months prior to their application for benefits if they were otherwise eligible for benefits for that period. In general, retroactive benefits cannot be paid if, as a result, it would cause a reduction in future monthly benefits (i.e., by subjecting the benefits to actuarial reduction because the beneficiary received retirement or survivors' benefits for months before age 65). There are, however, four categories of individuals eligible for reduced benefits who are eligible for retroactive benefits.

Proposal

The provision would eliminate eligibility for retroactive benefits for two of the categories of individuals eligible for reduced benefits: (1) those with dependents entitled to unreduced benefits and (2) those with pre-retirement earnings over the amount allowed under the retirement test who may use the retroactive benefits to charge off their excess earnings.

Effective Date

The provision would be effective with respect to applications for benefits filed on or after January 1, 1990.

17. Inclusion of Employer Cost of Group-Term Life Insurance in Compensation under the Railroad Retirement Tax Act (Section 10081)

Current Law

The Federal Insurance Contributions Act (FICA), which pertains to the Old-Age, Survivors and Disability Insurance program, and the Railroad Retirement Tax Act (RRTA), which pertains to the railroad retirement program, both define which types of remuneration are to be considered "wages" or "compensation" under the respective acts and therefore are to be subject to payroll taxes.

Under FICA, employer-paid premiums for life insurance are generally excluded from the definition of wages, except for the value of employer-paid premiums for group-term life insurance coverage in excess of $50,000, which is included in the definition of wages and thus is subject to payroll taxes. RRTA makes no reference to life insurance in its definition of compensation. However, Internal Revenue Service regulations provide for the exclusion of life insurance premiums generally under RRTA.

Proposal

The value of employer-paid premiums for group-term life insurance coverage in excess of $50,000 would be included in the definition of compensation under RRTA and would therefore be subject to railroad retirement payroll taxes. Because RRTA does not specifically refer to life insurance, it would also be amended to exclude generally from the definition of compensation the value of employer-paid life insurance premiums. In this way, the definitions of compensation under RRTA and wages under FICA would be brought into conformity with respect to the treatment of life insurance premiums.

Effective Date

The provision would be effective with respect to coverage in effect after December 31, 1989, except in the case of former employees who separated from employment on or before December 31, 1989. Due to confusion about the taxable status of this remuneration, some employers may have withheld and paid payroll taxes on remuneration paid before January 1, 1990. It is the long-standing practice of the Railroad Retirement Board to credit to an employee for benefit purposes any amounts on which taxes were paid. Because these amounts would already have been credited for benefit purposes, and because it is likely that some employees would already have begun receiving benefits based on the crediting of such amounts, no refund of taxes paid on remuneration paid before January 1, 1990, would be made.

18. Inclusion of Deferred Compensation Arrangements, Including 401(k) Plans, in Compensation under the Railroad Retirement Tax Act (Section 10082)

Current Law

Under the Federal Insurance Contributions Act (FICA), which pertains to social security, employer-sponsored tax-qualified pen-

sion plans are generally excluded from the definition of wages under the act and thus are not subject to FICA taxation. There are two exceptions to this general exclusion.

The first exception is for qualified cash or deferred arrangements (described in section 401(k) of the Internal Revenue Code). Under a cash or deferred arrangement forming a part of a qualified profit-sharing or stock bonus plan, a covered employee may elect either to have the employer contribute an amount to the plan on the employee's behalf or to receive such amount directly in cash. Amounts contributed to the plan pursuant to the election are treated as employer contributions. These amounts are includible as wages and are subject to FICA taxation.

The second exception is for deferred compensation plans other than those specifically provided for in the general exclusion for tax-qualified pension plans. They are referred to as "nonqualified deferred compensation plans". Amounts contributed to these types of plans are includible as wages. They are subject to FICA taxation when the services are performed or when there is no substantial risk of forfeiture of the rights to such amounts, whichever is later.

The Railroad Retirement Tax Act (RRTA) does not refer to either pensions or deferred compensation arrangements in its definition of compensation subject to payroll taxation.

Proposal

RRTA would be amended to bring the treatment of deferred compensation arrangements, and pensions generally, into conformity with their treatment under FICA. That is, employer-sponsored tax-qualified pensions would be specifically excluded from the definition of compensation under RRTA and would therefore not be subject to railroad retirement payroll taxes. However, contributions to qualified 401(k) cash or deferred arrangements and contributions to nonqualified deferred compensation plans would both be included in compensation (and would therefore be subject to railroad retirement payroll taxes) to the same extent they are now included in wages for FICA tax purposes.

Effective Date

With respect to pensions generally, the provision would be effective for remuneration paid after December 31, 1989. With respect to deferred compensation arrangements, the provision would be effective for remuneration paid after December 31, 1989, (including remuneration paid after December 31, 1989, which is for services performed before January 1, 1990) with the following two exceptions: (1) with respect to qualified 401(k) cash or deferred arrangements, a transition rule is provided to exclude certain remuneration paid after December 31, 1989, if paid pursuant to certain elective deferrals made before January 1, 1990; and (2) in the case of certain agreements in existence on June 15, 1989, between a nonqualified deferred compensation plan and an individual, the provision would only apply to services performed after December 31, 1989. Due to confusion about the taxable status of this remuneration, some employers may have withheld and paid payroll taxes on remuneration paid before January 1, 1990. It is the long-standing practice of the Railroad Retirement Board to credit to an employee

for benefit purposes any amounts on which taxes were paid. Because these amounts would already have been credited for benefit purposes, and because it is likely that some employees would already have begun receiving benefits based on the crediting of such amounts, no refund of taxes paid on remuneration paid before January 1, 1990, would be made.

19. Codification of the Rowan Decision with Respect to Railroad Retirement (Section 10083)

Current Law

In a 1981 case, *Rowan Companies, Inc.* v. *United States,* the Supreme Court ruled that the definition of "wages" for Federal Insurance Contributions Act (FICA) purposes must be interpreted in regulations in the same manner as for income-tax withholding purposes. At issue in *Rowan Companies, Inc.* was the treatment of meals and lodging provided for the convenience of the employer. The 1983 Social Security Act Amendments codified the Court's decision with respect to meals and lodging, but in all other cases stated that nothing in the regulations prescribed for the purposes of income tax withholding which provides an exclusion from "wages" shall be construed to require a similar exclusion from "wages" in the regulations prescribed for the purposes of FICA. Similar language was not included in the Railroad Retirement Tax Act (RRTA).

Proposal

RRTA would be amended to state that, except in the case of meals and lodging provided for the convenience of the employer and excludible for the purposes of income tax withholding, nothing in the regulations prescribed for the purposes of income tax withholding which provides an exclusion from "wages" shall be construed to require a similar exclusion from "compensation" in the regulations prescribed for the purposes of RRTA.

Effective Date

The provision would be effective for remuneration paid after December 31, 1989.

20. One-year Extension of General Fund Transfers to Railroad Retirement Tier II Trust Fund (Section 10084)

Current Law

The proceeds from the taxation of railroad retirement Tier II benefits are transferred from the General Fund of the Treasury into the Railroad Retirement Account. This transfer applies only to proceeds from the taxation of benefits which are received prior to October 1, 1989. Proceeds from the taxation of benefits received after this date will remain in the General Fund.

Proposal

The transfer of proceeds from the taxation of railroad retirement Tier II benefits from the General Fund into the Railroad Retirement Account would be extended for one year, to apply to benefits

received prior to October 1, 1990—the same date that the Commission on Railroad Retirement Reform is scheduled to file its report and recommendations. The continuation of this transfer is estimated to result in an additional deposit into the Railroad Retirement Account of $183 million.

Effective Date

The proposal would be effective on October 1, 1989.

21. Include Certain Deferred Compensation in Calculation of Average Wages under the Social Security Act (Section 10079)

Current Law

The social security contribution and benefit base (the maximum amount of wages subject to social security payroll taxes), the benefit formula, and certain other social security program amounts are increased each year in accordance with the increase in the average of total wages reported to the Secretary of the Treasury for income tax purposes. Although certain types of deferred compensation are subject to social security taxes, these deferred amounts are not taxable for income tax purposes. Consequently, they are not included in total wages and therefore are not counted in calculating the average wage for social security purposes. Types of deferred compensation which are not counted in average wages include elective deferrals under a qualified cash or deferred arrangement as defined in section 401(k) of the Code.

Proposal

Although certain deferred compensation is not considered wages for income tax purposes, such compensation is subject to social security payroll taxes and is part of the overall wage package of the employee. Thus, the Committee believes it appropriate to count certain deferred compensation in calculating the increase in average wages for purposes of the social security program.

For purposes of measuring the annual increase in average wages, average wages would include certain deferred compensation, including 401(k) plans. The provision would have the effect of increasing average wages at a higher rate than such average wages would otherwise have increased. This will result in an increase in the social security contribution and benefit base and an increase in benefits paid to future social security beneficiaries.

The provision would provide for a transition with respect to benefit calculations. For purposes of determining the contribution and benefit base, an estimate of deferred compensation would be included in average wages beginning with 1988 wages. However, for purposes of benefit computations, actual deferred compensation amounts would be included in average wages when data regarding such amounts first become available, beginning with 1990 wages. Because of this transitional provision, the inclusion of deferred compensation in average wages would not affect benefit calculations until 1993, so as to avoid any abrupt increase in benefit levels.

Effective Date

For purposes of determining the contribution and benefit base, the provision would include in average wages an estimate of deferred compensation for 1988 and 1989. The amount of the estimate included would result in an initial increase in average wages which would be about 2 percentage points higher than the increase which would have resulted under present law. The actual amount of deferred compensation would be used beginning in 1990.

For purposes of benefit computations, the provision would include actual deferred compensation amounts in average wages beginning with 1990 wages.

22. Treatment of Refunds by Employers under the Medicare Catastrophic Coverage Act of 1988 for FICA and Social Security Benefit Purposes and for Other Purposes (Section 10054)

Current Law

The Medicare Catastrophic Coverage Act of 1988 includes a maintenance-of-effort provision which requires that employers who offer health insurance benefits which overlap the new medicare benefits must provide either additional benefits or a refund to individuals covered by the employer's plan during the first two years the Act is in effect. The amount of the refund is estimated to be, on average, $65 per person per year.

Proposal

The provision provides that refunds to individuals by employers under the maintenance-of-effort provision of the Medicare Catastrophic Coverage Act of 1988 would be excluded from wages for FICA and FUTA tax purposes and from compensation for railroad retirement and railroad unemployment insurance tax purposes. By excluding these amounts, the Committee intends that such amounts will not be taken into account in calculating average wages for purposes of determining the social security contribution and benefit base, the railroad retirement contribution and benefit base, and other social security and railroad retirement amounts, and for purposes of the federal-state unemployment insurance system and the railroad unemployment insurance program. Without this provision, the estimated 3 million W-2 wage statements showing $65 in wages (reflecting the number of retirees who are expected to receive employer refunds) would have a significant impact on the year-to-year increase in average wages, resulting in a lower-than-expected increase in the contribution and benefit base and other program amounts.

Effective Date

The provision would be effective for the 2 years that employers are required to make the refund payments, 1989 and 1990, and for the years during which the contribution and benefit base and other program amounts would be affected by the increase in 1989 and 1990 average wages, 1991 and 1992

Subtitle B. Medicare

Part A—Provisions Relating to Part A of the Medicare Program

SUBPART 1—PAYMENT FOR INPATIENT HOSPITAL SERVICES

1. Reductions in Payments for Capital-Related Costs of Inpatient Hospital Services for Fiscal Year 1990 (Sec. 10101 of the Bill)

Current Law

(a) Payment for Capital-related Costs—Capital-related costs (including depreciation, interest, and rent) are excluded from the prospective payment system (PPS) until September 30, 1991. Until that time, capital costs continue to be reimbursed on a cost basis.

The Omnibus Budget Reconciliation Act of 1987 (OBRA '87) reduced payment amounts for capital-related costs for Prospective Payment System (PPS) hospitals by twelve percent for fiscal year 1988 beginning January 1, 1988, and fifteen percent for fiscal year 1989. The legislation exempts sole community hospitals from capital-related payment reductions. Current law would pay PPS hospitals 100 percent of their capital-related costs in fiscal year 1990.

(b) GAO Study of Cost of Low Occupancy—No provision.

Proposal

(a) Payment for Capital-related Costs—Capital-related payment amounts would be reduced by fifteen percent in fiscal year 1990. Sole community providers would continue to be exempted from the reductions.

(b) GAO Study of Costs of Low Occupancy—The General Accounting Office would be directed to study the effect of low occupancy on hospital costs. The study would include, at a minimum, the effect on health care system costs and individual hospital costs, the relationship of fixed and variable costs in hospitals, the extent to which closure of unneeded beds or consolidation of hospitals could result in savings to Medicare, and other relevant issues, including recommendations for changes in current policy in this area. The GAO would report by October 1, 1990.

Effective Date

Paragraph (a) is effective for portions of cost reporting periods or discharges (as the case may be) occurring during fiscal year 1990. Paragraph (b) is effective upon enactment.

2. Prospective Payment Hospitals (Sec. 10102 of the Bill)

Current Law

(a) Reduction in Hospital Update Factors—Current law provides that for fiscal year 1990 and subsequent years hospitals payments per discharge for all PPS hospitals will be increased at a rate equal to the hospital market basket percentage increase. The hospital market basket index is an inflation index developed by the Secretary to reflect increases in the costs of goods and services purchased by hospitals.

The Secretary is required to recommend to the Congress an appropriate factor to be used to update the large urban, other urban, and rural standardized amounts which are the basis for payment for hospitals in each type of area. The recommendation must take into account amounts necessary for the effective and efficient delivery of medically appropriate and necessary care of high quality. The Secretary has recommended an update of the market basket minus 1.5 percentage points in fiscal year 1990. The Secretary has also noted his belief that differential updates for hospitals in rural, large urban, and other urban areas would be more appropriate than a single uniform update.

(b) Annual Recalibration of DRG Weights on Budget-Neutral Basis—The Secretary is required to adjust the DRG classifications and weighting factors annually beginning in fiscal year 1988.

(c) Increase in Disproportionate Share Adjustment—Disproportionate share payments are made to a hospital if its share of low income patients equals or exceeds fifteen percent for an urban hospital with 100 or more beds or a rural hospital with 500 or more beds, forty percent for an urban hospital with less than 100 beds, or forty-five percent for a rural hospital, including rural referral centers, of less than 500 beds. The adjustment is increased by 0.5 percentage points for each 1.0 percentage point increase in the proportion of low income patients. The current formula for such payments to urban hospitals with more than 100 beds and for rural hospitals with more than 500 beds is $(P-15).5+2.5$ where P represents the hospital's disproportionate share percentage. Urban hospitals with less than 100 beds receive an adjustment equal to five percent and rural hospitals with less than 500 beds receive an adjustment equal to four percent.

Certain other hospitals qualify for a disproportionate share adjustment if the hospital is in an urban area, has more than 100 beds, and can demonstrate that its net inpatient care revenues from other than Medicare and Medicaid payable by State and local governments for indigent care exceed thirty percent of the hospital's net revenue. These hospitals receive a disproportionate share adjustment of twenty-five percent.

(d) Increase in Payments to Rural Hospitals—As described above, current law would increase payments to rural PPS hospitals at the rate of increase in the market basket.

(e) Three-year Extension of Regional Referral Center Classification—Hospitals may be classified as rural regional referral centers based upon size, case mix intensity, number of discharges, and operating characteristics. In addition, the Omnibus Budget Reconciliation Act of 1986 (OBRA '86) extended the classification of certain rural hospitals as rural regional referral centers through fiscal year 1989 based upon these hospitals having been previously designated as regional referral centers.

(f) Criteria and Payment for Sole Community Hospitals—Sole community hospitals are those which, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals as determined by the Secretary, are the sole source of hospital care available to individuals in a geographic area. If a hospital chooses to be designated as a sole community

provider, it receives payment based seventy-five percent on hospital-specific costs, and twenty-five percent on regional rates.

(g) Geographic Classification of Hospitals—Hospitals are classified as urban if the hospital is within an area classified as a Metropolitan Statistical Area (MSA) or if the county in which the hospital is located is adjacent to two or more MSAs, meets certain other criteria, and meets criteria regarding commuting from the adjacent rural county to the MSAs. All other hospitals are classified as rural. The Secretary has no discretion to modify these areas. Under current law the Secretary has discretion to establish geographic areas for purposes of adjusting for differential wage levels, but the Secretary has generally chosen to use MSAs as the basis for the wage adjustment.

If in the case of a rural county adjacent to two or more MSAs which is reclassified as part of one of the adjacent urban areas, the application of the standards results in a reduction in the wage index for an urban area, the Secretary is required to compute wage indices separately for the original urban counties and for the rural counties added as a result of the reclassification. If the application of the standards causes a reduction in the wage index for rural areas, the Secretary is required to compute the wage index for the affected rural areas as if the provision had not been enacted.

(h) Essential Access Community Hospital (EACH) Demonstration Program—OBRA '87 authorized appropriations from the Part A Trust Fund of $15 million for the Rural Transition Grant Program which supports grants to private not-for-profit rural hospitals of up to $50,000 per year for up to two years for strengthening the financial and managerial ability of isolated and financially distressed rural hospitals.

(i) Study of Differences in PPS Standardized Amounts—No provision.

(j) Uniform Reporting Requirements for Certain Hospitals—OBRA '87 directed the Secretary to develop a uniform hospital reporting demonstration project in two states. In those states, California and Colorado, hospitals are required to report hospital statistical and cost information using a uniform reporting format, developed by the Secretary.

Proposal

(a) Reduction in Hospital Update Factors—The hospital update factors for fiscal year 1990 would be set in order to achieve the same reduction in payments as if the base had been decreased by 1.35 percent, as follows:

Large urban: market basket minus 1.25 percentage points
Other urban: market basket minus 1.75 percentage points
Rural: market basket minus 0.75 percentage points

However, rural payments would be increased by the provision below, thus achieving a higher update.

CBO presently estimates that the market basket will increase 5.4 percentage points in fiscal year 1990.

(b) Annual Recalibration of DRG Weights on Budget-Neutral Basis—In recalibrating the DRG weights on an annual basis, the

Secretary would be required to do so on a budget neutral basis for fiscal year 1990 and for each fiscal year thereafter.

The Committee notes that this provision is intended to clarify current law. It is the Committee's view that the Secretary's proposal published May 27, 1989 to reduce the DRG weights by 1.35 percentage points and consequently reduce hospital payments, violates section 4039(d) of the Omnibus Reconciliation Act of 1987, as amended by section 426(e) of the Medicare Catastrophic Coverage Act of 1988, which probibits the Secretary from issuing a notice of proposed rule making which is estimated by the Secretary to reduce net expenditures by more than $50 million prior to October 15, 1989, unless required to implement specific provision of statute.

Although section 1886(d)(4)(C) requires the Secretary to adjust DRG weights at least annually, the adjustment is required in order to reflect changes in relative use of hospital resources, not an absolute reduction in weights as the Secretary has proposed. Since the absolute reduction is not required by a specific provision of law, it is a violation of the prohibition on reductions in payments.

(c) Increase in Disproportionate Share Adjustment—The disproportionate share adjustment would be increased for urban hospitals over 100 beds by increasing the multiplier in the formula from .5 to .6 resulting in a formula of (P−15).6+2.5. For hospitals for which the disproportionate patient percentage exceeded 20.2, the adjustment would be increased further. For the portion of a hospital's number of low-income patients necessary to reach the 20.2 threshold, the adjustment would be calculated using the formula used for hospitals below the threshold. For the portion of a hospital's low-income patients above the threshold, the multiplier would be increased to .7, resulting in the following formula for these hospitals: (P−20.2).7+5.62. Hospitals which qualify for a disproportionate share adjustment based upon revenue for indigent care received from State and local governments would receive a disproportionate share adjustment of 30 percent.

Regional Referral Center hospitals would be treated in the same manner as urban hospitals with such hospitals over 100 beds receiving an adjustment based on the formulas described above except that the current threshold for a disproportionate share adjustment to rural hospitals (45 percent) would be retained. This results in the formula (P−50.2) (0.7)+7.12 for hospitals with a disproportionate patient percentage above 50.2, and (P−45) 0.6+4.0 for hospitals below that amount.

(d) Increase in Rural Payments—The update for rural hospitals would be increased by 2.75 percentage points above the level achieved by the previous provision, thus achieving an update of the market basket plus two percentage points.

(e) Treatment of Regional Referral Centers—Regional referral center hospitals for which designation as such was extended pursuant to OBRA '86 section 9302(d)(2) as of September 30, 1989 would continue to be designated as such for a three-year period.

(f) Criteria and Payment for Sole Community Hospitals—All hospitals more than thirty-five miles from another hospital (as determined by the Secretary) would be eligible for designation as sole community provider hospitals.

Payment to designated hospitals would be through prospectively-determined rates based on the higher of: 100 percent hospital-specific costs determined using costs reported for the hospital's cost reporting period beginning in fiscal year 1982; 100 percent hospital-specific costs based on the hospital's cost report for fiscal year 1987; or, Federal prospective payment system rates. Payments based upon hospital-specific costs would be updated using the update factor used to update the rural standardized amounts under the prospective payment system. Sole community hospitals would continue to be eligible for a volume adjustment and would continue to be exempted from reductions in capital payments.

Current sole community provider hospitals which do not meet the new criterion would continue to qualify for payments as under current law. As under current law, the Secretary would continue to have discretion to discontinue the designation of these hospitals if the hospitals no longer met the criteria in effect prior to the date of enactment of this provision.

(g) Geographic Classification of Hospitals—The Secretary would be required to establish a process through which a hospital could apply for changes in the status of the geographic area in which the hospital is located, pertaining to rural counties seeking to be reclassified as urban, or urban counties seeking to be classified as large urban or pertaining to changes in urban wage area designation. The Secretary would be required to publish instructions for application by hospitals for such changes within six months of enactment. Any change in classification would be on a budget neutral basis. If a reclassification resulted in a reduction in the wage index for an urban area by more than two percentage points, the Secretary would be directed to treat the reclassified county as a separate urban area. In addition, if a reclassification under this provision or the provision of current law regarding the treatment of rural counties adjacent to two or more MSAs resulted in a wage index for the county lower than the rural wage index for the State, the Secretary would be directed to apply the State rural wage index to that county.

The Committee intends that changes in classification could apply only to whole counties and that the authority to change a county's status could only be approved based upon significant justification of substantial changes in the circumstances leading to the original classification, such as very large changes in population not yet enumerated through the decennial census or very large changes in relative wages, although other factors might, in very limited circumstances, lead to a change.

(h) Essential Access Community Hospital (EACH) Demonstration Program—The Secretary would be authorized to establish an EACH demonstration program in up to ten states. The Committee intends that the Secretary would develop the program with advice from the Office of Rural Health Policy.

Participating States would apply to the Secretary (in a form and manner specified by the Secretary) for support of activities to foster the creation of EACH networks in the State. In applying the State would be required to consult with the State hospital association and rural hospitals in the State, although the Committee does

not intend that such consultation could constitute a veto of the State's proposal to the Secretary.

The State's responsibilities under the demonstration program would include development of a rural health plan for the State which: (1) provides for the creation of rural health networks; (2) promotes regionalization of rural health services; (3) improves access to hospital and other health services for rural residents; and (4) enhances the provision of emergency and other transportation services related to health care.

The State would designate EACH hospitals and provide support to hospitals in the development of rural health networks of EACH hospitals and rural primary care hospitals, although participation by hospitals in the development of such networks would be voluntary. Although the State would have flexibility in developing rural health networks to protect access to health and hospital services for rural citizens of the State, the Committee intends that EACH networks would include at least one EACH hospital or rural referral center with one or more rural primary care hospitals connected to the hospital through referral agreements, communications systems, including, as feasible, telemetry systems and systems for electronic sharing of patient data, and emergency and non-emergency transportation. In some states it may be feasible for an urban hospital to function as the central component of a network. Given concerns about possible violations of anti-trust statutes, it is anticipated that State health and licensing authorities would be directly involved in the creation of rural networks as part of the demonstration.

EACH hospitals could be no less than thirty-five miles from another EACH hospital, a rural referral center, or an urban hospital which meets the criteria for a referral center, although the Secretary could waive this criterion if the State proposed different criteria in its application and the Secretary approved. In addition, EACH hospitals could have no less than seventy-five beds (unless no other hospital was within thirty-five miles or the Secretary granted a waiver to assure access) and meet such other criteria as a State deemed useful and to which the Secretary agreed.

EACH hospitals would be required: (1) to provide emergency and back-up services for its network and throughout the service area; (2) to agree to accept transfers from primary care hospitals in the network and throughout the hospital's service area; (3) to provide staff privileges to physicians in the service area providing care at rural primary care hospitals; and (4) to agree to other responsibilities which the State and/or the Secretary may identify.

Rural primary care hospitals would be defined as hospitals which apply to a State participating in the demonstration for support to become and operate as such, although specific designation and reimbursement would be subject to the agreement of the Secretary. Demonstration states would be expected to give priority to rural primary care hospitals participating in a network with EACH hospitals or rural referral centers, but could designate rural primary care hospitals which were not part of a network.

Rural primary care hospitals would cease providing inpatient acute care other than on a temporary basis (unless this requirement was waived by the Secretary in order to test an alternative

model for the delivery of rural hospital services). In general, these hospitals would include no more than six holding beds for patients requiring immediate inpatient care waiting to be transferred to a hospital. Patients could not be cared for in these beds for more than seventy-two hours, except in exceptional cases, such as longer stays due to inclement weather or other compelling reason precluding transfer. Twenty-four hour emergency care necessary to stabilize emergency patients would be required. Rural primary care hospitals would be required to have transfer agreements and other necessary arrangements with the other members of its network, particularly the acute-care hospital, and would be required to participate, as appropriate, in the network's communication system, including systems for electronic sharing of patient data, including telemetry and medical records.

Rural primary care hospitals would have flexibility with respect to staffing as special staffing requirements would apply, including that a physician's assistant or nurse practitioner could supervise holding beds, subject to physician oversight. If the rural primary care hospital chose to provide long-term care, it could do so under current law as a free-standing skilled nursing facility and would be required to meet the conditions of participation for such facilities.

Under the demonstration EACH hospitals would be reimbursed as sole community providers. To the extent that an EACH hospital incurred additional cost, such as costs for establishing a system to receive and send telemetry data or to provide emergency back-up, the Secretary would be authorized to add such costs to the hospital's base year costs used to determine payments to the hospital, if the Secretary determined that such costs would create a permanent increase in the hospital's costs.

Rural primary care hospitals would be reimbursed for Part A services to patients in holding beds on a 100 percent hospital-specific cost basis, subject to the current target rate of increase limits of section 1886(b) with the base year being the first year of operation as a rural primary care hospital. The Secretary would be authorized to develop a prospective payment methodology for holding bed services.

The current Rural Transition Grant Program would be modified by the EACH Demonstration Program. The authorization of appropriations would be increased to $40 million, extended through fiscal year 1992, and separated into three parts.

The first part, authorized at $10 million, would support grants of up to $50,000 to not-for-profit rural hospitals or a consortia of such hospitals for the purposes of the current Rural Transition Grant Program or for the purpose of planning by hospitals for the creation of a rural health network or planning for a transition to a rural primary care hospital. Such grants could be made to hospitals in states not participating in the EACH demonstration, but would require review and comment by the Governor of the State in which the hospital is located.

The second part, authorized at $15 million, would support grants of up to $200,000 to not-for-profit rural hospitals and consortia of such hospitals and would support implementation of a conversion to a rural primary care hospital or the creation of a network. Grant funds could be used for the capital costs of conversion from a

hospital to a rural primary care hospital; the capital costs of preparing a hospital to function as the central component of a network, as for example, the expansion of a hospital's emergency department; the costs of development of communications systems, the costs of development of emergency transportation systems, and other similar and related purposes.

Grants would be available only in states participating in the EACH demonstration, and hospital applications would have to be consistent with plans developed by the State. Participating states would have to approve applications from hospitals and rural primary care hospitals for implementation grants. Grants could be made to any hospital which participated in a network whether or not the hospital was an EACH hospital. Rural primary care hospitals would not be required to be a member of a network in order to be eligible for funding.

The third part, authorized at $15 million, would support grants to States for their activities under the demonstration, relating to planning and implementing a rural health care plan and rural health networks, convening of involved hospitals, local governmental officials, and citizens, designating hospitals as EACH hospitals and as rural primary care hospitals, and to develop and support communication and emergency transportation systems. Such development and support of communication and emergency transportation systems could include the purchase of relevant equipment and vehicles appropriate to this purpose.

(i) Study of Differences in PPS Standardized Amounts—The Secretary would be required to analyze Medicare's current differential in standardized amounts and to evaluate whether the differential could be eliminated with either the addition of further adjustments or changes in current adjustments. If the Secretary so recommended, he would be required to make recommendations regarding a transition to a single national rate. The Secretary would be required to address at a minimum appropriate adjustments for differences in the severity of illness of patients currently assigned to the same diagnosis related group, as well as other adjustments which he found appropriate to reflect differences in cost in different types of areas. The Prospective Payment Assessment Commission (ProPAC) would be required to evaluate the Secretary's findings and recommendations, if any. The study by the Secretary would be required to be complete by October 1, 1990. ProPAC would be required to report by April 1, 1991.

(j) Hospital Reporting—Hospitals receiving disproportionate adjustments, regional referral centers, sole community providers, and EACH hospitals would be required to report statistics and costs using the uniform hospital report developed by the Secretary in the hospital reporting demonstration project.

Effective Date

Paragraphs (a), (c), (d), and the second subparagraph of (g) are effective for discharges occurring on or after October 1, 1989. Paragraph (e) is effective October 1, 1989. Paragraphs (b), (h), (i), and the first subparagraph of (g) are effective upon enactment. Paragraphs (f) and (j) are effective for cost reporting periods beginning on or after October 1, 1989.

3. PPS-Exempt Hospitals (Sec. 10103 of the Bill)

Current Law

(a) Exemption of Cancer Hospitals from Prospective Payment System—The Secretary is directed to provide for such exceptions and adjustments as he deems appropriate with respect to hospitals involved extensively in treatment for and research on cancer. The Secretary has chosen to pay cancer center hospitals as if they were exempt from PPS for purposes of operating cost reimbursement. However, they are treated similarly to PPS hospitals for purposes of periodic interim payments and for capital payments.

(b) Rebasing of Certain PPS-Exempt Hospital Payments—PPS-exempt hospitals are reimbursed using a system of target amounts which are defined as the hospital's base-year costs inflated by a rate of increase limit. Hospitals below the target amount receive a bonus. The current base year for determining target amounts is generally cost reporting periods beginning in fiscal year 1982.

(c) Applications for Adjustments to the Target Amounts—The Secretary is directed to provide an exemption from, or an exception and adjustment to, a hospital's target rate if events beyond the hospital's control, or extraordinary circumstances, including changes in case mix and volume, or the closure or another hospital, cause a distortion in the hospital's costs.

Proposal

(a) Comprehensive Cancer Center Hospitals—Comprehensive Cancer Center Hospitals would be exempted permanently from PPS, if they are designated by the Secretary as comprehensive cancer center hospitals and clinical cancer research centers under current authority by December 31, 1990. For purposes of payment of capital-related costs, for hospitals designated prior to June 1, 1989, such designation as PPS-exempt hospitals would be retroactive to October 1, 1986. ProPAC would be directed to add cancer hospitals to its on-going study of payment to PPS-exempt hospitals.

(b) Rebasing of Certain PPS-exempt Hospital Payments—The base year for determining target amounts for cancer center hospitals would be cost reporting periods beginning in fiscal year 1987, except that if the use of the hospital's current base year and the intervening updates between the base year and 1987 would have created a higher target amount, the higher target amount would be used as the base.

(c) Applications for Adjustments to the Target Amounts—The Secretary would be required to publish within 180 days of enactment instructions to hospitals and fiscal intermediaries pertaining to the application process for an exception or adjustment to the target amounts.

The Committee is concerned that, with respect to adjustments to the target rate for a long term hospitals required by section 104(c)(2) of the Medicare Catastrophic Coverage Act (MCCA), the Secretary has chosen not to include in the calculation of the adjustment days of care attributable to patients who had exhausted their Medicare benefits prior to admission to the long term hospital, although such days, as a result of the enactment of section 104(c)(2) of MCCA, would now be a covered benefit under Medicare. The

Committee expects that the Secretary would use his authority under section 1886(b)(4)(A) of the Social Security Act to account for legitimate changes in length-of-stay caused by the enactment of MCCA if the calculation based on the Secretary's current methodology does not adequately account for such changes. For example, the Secretary could provide an adjustment based upon actual experience since the enactment of MCCA.

Effective Date

Paragraph (a) is effective for cost reporting periods beginning on or after October 1, 1989, except for purposes of periodic interim payments, effective thirty days after enactment and for capital payments effective for cost reporting periods beginning on or after October 1, 1986. Paragraph (b) is effective for cost reporting periods beginning on or after October 1, 1989. Paragraph (c) is effective upon enactment.

SUBPART 2—OTHER PROVISIONS

4. Payments for Hospice Care (Sec. 10111 of the Bill)

Current Law

(a) Increase in Current Rates—A Part A beneficiary who is terminally ill may elect to receive hospice services for two ninety day periods and one subsequent thirty day period for a total of 210 days during an individual's lifetime. Beneficiaries making this election must choose to receive services through a hospice and give up most other Medicare benefits. The period of coverage may be extended beyond the 210 day period if the beneficiary's physician or hospice director recertifies that the beneficiary is still terminally ill.

The Department of Health and Human Services (HHS) implemented a prospective payment methodology for hospice care. Under this methodology, hospices are paid one of several predetermined rates for each day a Medicare beneficiary is under the care of the hospice. The rates vary according to the level of care furnished to the beneficiary.

Four basic payment categories are used for reimbursing hospices. The payment rates are national rates which are adjusted by the Bureau of Labor Statistics wage index for an area. The rates are as follows: 1) routine home care day—$63.17; 2) continuous home care day—$368.67; 3) inpatient respite care day—$65.33, and 4) general inpatient care day—$281.00.

No adjustments are made to compensate hospice providers for extraordinarily high cost cases.

(b) Study of Methods to Compensate Hospices for Higher-Cost Care—No provision.

Proposal

(a) Increase in Current Rates—Hospice payment rates would be increased by twenty percent effective October 1, 1989 to reflect increases in inflation since the rates were last adjusted by Congress in 1986. In subsequent years, the payment rates would be indexed to the hospital market basket.

(b) Study of Methods to Compensate Hospices for Higher-Cost Care—The Secretary would be directed to conduct a study of high cost Medicare beneficiaries that receive hospice care under the Medicare program and to evaluate the ability of hospices to provide care to high cost Medicare beneficiaries. The Secretary would report to the Committees with recommendations to compensate hospice providers for such high cost Medicare beneficiaries by October 1, 1990.

Effective Date

October 1, 1989.

5. Miscellaneous and Technical Provisions Relating to Part A (Sec. 10112 of the Bill)

Current Law

(a) Hospital Obligations with Respect to Treatment of Emergency Conditions and Indigent Care—Medicare-participating hospitals are not required to participate in the Medicaid program, nor inform beneficiaries if they do. Hospitals transferring patients are required to provide the receiving facility with appropriate medical records of the examination and treatment effected at the transferring hospital. As a condition of participation in Medicare, hospitals are required to comply with the requirements of the emergency patient protection provisions, to the extent applicable. Hospitals are not required to inform patients of the hospital's obligations under the emergency patient protection provisions.

(b) Medicare Buy-in for Continued Benefits for Disabled Individuals—Social Security Disability Insurance (SSDI) beneficiaries who return to work stop receiving cash benefits after a twelve month trial work and transition period and stop receiving Medicare benefits after an additional thirty-six months of extended period of eligibility is exhausted.

(c) Release and Use of Hospital Accreditation Surveys—A hospital may be deemed to meet the conditions of participation for Medicare if the hospital is accredited as a hospital by the Joint Commission on Accreditation of Hospitals (now referred to as the Joint Commission on Accreditation of Health Organizations (JCAHO)) and the hospital agrees to authorize JCAHO to release a copy of the hospital's most current survey if the hospital is the subject of a validation survey. Validation surveys are performed on a sample basis or if allegations about quality problems are made with respect to a specific hospital. The Secretary is prohibited from disclosing any information from a JCAHO survey. The Secretary may only take action to remove a hospital from Medicare due to serious deficiencies in quality based on the findings of a validation survey.

(d) Intermediate Sanctions for Psychiatric Hospitals—The Secretary may refuse to renew or may terminate a hospital's provider agreement with Medicare if the Secretary determines that the hospital no longer meets the conditions of participation, the provisions of its provider agreement, the provisions of Title XVIII and regulations issued under its authority, or with a corrective action plan, or the hospital has been excluded from the program as a result of a violation of the anti-fraud and abuse requirements.

(e) Medical Necessity Certification of Skilled Nursing Facility Services by Nurse Practitioners and Clinical Nurse Specialists—Medicare requires that payment for certain covered services, including skilled nursing facility (SNF) care, may be made to a provider of services only if there is a physician's certification concerning the medical necessity of the services furnished and, in certain circumstances, only if there is a physician's recertification of the continued need for the covered services.

With respect to skilled nursing facilities, the required certification must indicate that the individual needs skilled nursing care or other skilled services on a daily basis, and that the skilled services can be provided in a skilled nursing facility or on an inpatient basis. The recertification must include a written indication of the reasons for continued need of SNF services and an estimate of the amount the individual will need to remain in the SNF. The first recertification must be made no later than the fourteenth day of SNF care, and subsequent recertifications at intervals of not more than thirty days.

(f) Eligibility of Merged or Consolidated Hospitals for Periodic Interim Payments—Prospective Payment System hospitals receive periodic interim payments only if a hospital had a disproportionate share adjustment percentage of at least 5.1 during fiscal year 1987 or was a rural hospital with less than 100 beds, and was receiving periodic interim payments as of June 30, 1987.

(g) Extension of Waiver for Finger Lakes Area Hospital's Corporation (FLAHC)—The Secretary may provide that payment to hospitals in a State may be made consistent with a State hospital reimbursement system rather than under Medicare's reimbursement system. For certain State reimbursement systems approved by the Secretary prior to the date of enactment of the Social Security Amendments of 1983, the Secretary is required to continue the use of a State system if the State so requests and, for the first three cost reporting periods beginning on or after October 1, 1983, the increase in payments for hospital inpatient care under the State system is less than the national increase in payments for inpatient care. At the end of the three-year period the Secretary may choose to evaluate the State system based on whether, for 36-month periods, the amount of payments to hospitals under the State system exceeds those which would have been made under the national system.

There are two such waivers at present: Maryland and New York. The New York waiver covers only the four counties participating in the Finger Lakes Area Hospital's Corporation. FLAHC is the sole rural hospital payment demonstration.

(h) Clarification of Continuation of August 1987 Hospital Bad Debt Recognition Policy—Under current regulation the Medicare program makes payments to hospitals to reimburse hospitals for Medicare bad debt, defined as the unrecovered costs associated with unpaid Medicare deductible and coinsurance. In order for unpaid deductible and coinsurance to be considered a bad debt, the bad debt must be related to covered services furnished to a Medicare beneficiary and the hospital must meet certain collection criteria.

OBRA '87 directed the Secretary to continue payments for Medicare bad debt under policy in effect at that time. The Technical and Miscellaneous Revenue Act of 1988 further clarified this policy by specifying that criteria for indigency determination procedures, for record keeping, and for determining whether to refer a claim to an external collection agency were also to be considered an integral part of the policy in effect at that time, and thus also not subject to change.

(i) Use of More Recent Data Regarding Routine Service Costs of Skilled Nursing Costs—The Secretary determines the amount of payments to skilled nursing facilities for routine service costs. For free-standing skilled nursing facilities in urban and rural areas, the limits are set at 112 percent of the mean operating costs of urban and rural free-standing facilities, respectively. Limits for urban and rural hospital-based facilities are set at the appropriate free-standing limit, plus 50 percent of the difference between the free-standing limit and 112 percent of the mean operating costs for hospital-based facilities. An amount will be added to the hospital-based facility limit to account for cost differences between hospital-based facilities and free-standing facilities that are attributable to excess overhead allocations.

Currently, Medicare cost limits for skilled nursing facilities are based upon cost reports for cost reporting periods ending between October 1, 1982 and September 30, 1983.

(j) Permitting Dentists to Serve as Hospital Medical Director—Under the current Medicare conditions of participation for hospitals only a physician may be medical staff director of a hospital.

(k) GAO Study of Hospital-based and Free-standing Skilled Nursing Facilities—No provision.

Proposal

(a) Hospital Obligations with Respect to Treatment of Emergency Conditions and Indigent Care—As a condition of participation in Medicare hospitals would be required to adopt and enforce a policy to maintain compliance with the patient protection provisions of the statute.

Hospitals which transferred emergency patients and the hospital receiving the patient would be required to maintain records of transfers (or copies) for a period of five years. Hospitals would be required to post conspicuously a sign (in a form determined by the Secretary) in any emergency department specifying the rights of individuals with respect to examination and treatment for emergency conditions and would be required to post conspicuously a sign (in a form determined by the Secretary) indicating whether or not the hospital participates in the Medicaid program.

Hospitals would also be required to maintain a list of the physicians who are on-call for duty after initial examination to provide medical services necessary to stabilizing an individual with an emergency medical condition, if such services are needed by that individual.

ProPAC would be directed to develop a method for calculating the amount of uncompensated care provided by a hospital. ProPAC would be directed to do so in a manner consistent with the defini-

tion of bad debt and charity care developed by the Secretary under the hospital uniform reporting demonstration project.

(b) Medicare Buy-in for Continued Benefits for Disabled Individuals—Social Security Disability Insurance (SSDI) beneficiaries would be allowed to purchase Medicare coverage after they have worked a full forty-eight months and have exhausted their extended period of Medicare eligibility.

(c) Release and Use of Hospital Accreditation Surveys—Each hospital which is deemed to meet the conditions of participation in Medicare due to accreditation by the JCAHO would be required to agree in general to release by JCAHO to the Secretary of all accreditation surveys and other related information. However, this information would be limited to accreditation reports and other reports directly related to an accreditation report, including corrective action plans, as requested by the Secretary.

As authorized by the hospitals, the JCAHO would be explicitly required to release surveys and related information to the Secretary. The Secretary would be authorized to withdraw deemed status from a hospital based on any information he has received as to significant deficiencies, rather than only on information discovered in a validation survey. The Secretary would only be authorized to release accreditation reports and related information if the material related to an enforcement action taken by the Secretary.

(d) Intermediate Sanctions for Psychiatric Hospitals—If the Secretary finds that a psychiatric hospital no longer meets the conditions of participation but that the violations do not pose an immediate risk to the health and safety of the hospital's patients, the Secretary would be authorized to impose on the hospital the intermediate sanction of terminating payment for new patients.

(e) Medical Necessity Certification of Skilled Nursing Facility Services by Nurse Practitioners and Clinical Nurse Specialists—Nurse practitioners and clinical nurse specialists would be authorized to carry out certification and recertification activities for Medicare beneficiaries in skilled nursing facilities (SNFs) in collaboration with a physician.

(f) Periodic Interim Payment for Merged Hospitals—A hospital currently receiving periodic interim payments which merged with another hospital, thus creating a new entity, would continue to receive periodic interim payments if both of the new entity's hospital campuses would qualify for periodic interim payments due to each having a disproportionate share adjustment percentage above 5.1 if assessed separately as of the time when the merger occurs.

(g) Extension of Waiver for Finger Lakes Area Hospital's Corporation (FLAHC)—The test for continuation of the FLAHC waiver would be modified such that aggregate payments made by Medicare under the FLAHC system since October 1, 1984 would be compared to payments made since that date under the national system.

(h) Hospital Bad Debt Collection Policies—The existing prohibition on changes in bad debt collection policy would be further clarified by specifying that if a fiscal intermediary had accepted a hospital's bad debt collection policy prior to August 1, 1987, in accordance with the rules in effect at that time with respect to criteria for indigency determination procedures, for record keeping, and for determining whether to refer a claim to an external collection

agency, the Secretary could not direct the hospital to change its policy, nor collect from the hospital based upon the expectation of a change in the hospital's collection policy.

(i) Use of More Recent Data Regarding Routine Service Costs of Skilled Nursing Costs—The Secretary would be required to make adjustments to cost limits for SNFs using cost reports for cost reporting periods beginning not earlier than October 1, 1985.

(j) Dentists as Hospital Medical Directors—If not inconsistent with State law, a dentist could be a medical staff director of a hospital.

(k) GAO Study of Hospital-based and Free-standing Skilled Nursing Facilities—The GAO would conduct a study to assess differences in costs and case-mix between free-standing and hospital-based skilled nursing facilities. The GAO would make recommendations concerning the payment differential between free-standing and hospital-based skilled nursing facilities. The GAO would submit results of the study to the Committee by June 1, 1990.

Effective Date

Paragraph (a) is effective on the first day of the first month 180 days after the date of enactment. Paragraph (b) is effective on the date of enactment or, if later, October 1, 1989. Paragraph (f) is effective for discharges on or after October 1, 1989. Paragraph (h) is effective as if included in the Omnibus Reconciliation Act of 1987. Paragraphs (c), (d), (e), (g), (i), (j), and (k) are effective upon enactment.

Part B—Provisions Relating to Part B of the Medicare Program

Subpart 1—Payment for Physician Services

6. Reduction in Payments for Certain Procedures (Section 10121 of the Bill)

Current Law

(a) Overpriced Procedures—OBRA '86 provided for a ten percent across the board reduction in the prevailing charges for cataract surgery. OBRA '87 provided for reductions in the prevailing charges of eleven procedures by two percent plus a sliding scale reduction of up to fifteen percent. Prevailing charges for overpriced procedures could not be reduced below eighty-five percent of the national average reduced prevailing charge. The overpriced procedures were identified by the Physician Payment Review Commission (PhysPRC).

Special Limits on Actual Charges—OBRA '86 provided for special limits on the actual charges for procedures whose prevailing charges had been subject to reductions under the Secretary's authority to impose reductions for "inherent reasonableness." These special limits were imposed on the actual charges for overpriced procedures reduced under OBRA '86 and OBRA '87. These special limits provided that during the first year following a reduction in overpriced procedures, actual charges were limited to halfway between 125 percent of the reduced prevailing charge and the previous year's limit on actual charges, known as the maximum actual

allowable charge (MAAC) limit. In the second year, the special limit on actual charges is 125 percent of the reduced prevailing charge.

(b) Reductions in Payments Under the Radiology Fee Schedule—OBRA '87 established a fee schedule for radiology services based on a relative value scale. Payments for radiology services are based on the lesser of 1) actual charges and 2) a local conversion factor times the number of relative value units assigned to each procedure. The fee schedule applies to services provided by radiologists (board-certified or board-eligible radiologists), or to physicians for whom one-half of their Medicare charges are for radiology services.

Radiology services billed by other physicians are reimbursed under the "usual, customary, and prevailing" reasonable charge methodology.

Special Limits on Actual Charges—Actual charges for services reimbursed under the radiology fee schedule are limited to 125 percent of the fee schedule amount in 1989, 120 percent in 1990, and 115 percent in 1991.

OBRA '86 provided for special limits on the actual charges for procedures whose prevailing charges had been subject to reductions under the Secretary's "inherent reasonableness" authority. These special limits were imposed on the actual charges for overpriced procedures reduced under OBRA '86 and OBRA '87. These special limits provided that during the first year following a reduction in overpriced procedures, actual charges were limited to halfway between 125 percent of the reduced prevailing and the previous year's limit on actual charges. In the second year, the special limit on actual charges is 125 percent of the reduced prevailing charge.

(c) Anesthesiology Services—OBRA '87 provided for the development and establishment of an anesthesiology fee schedule based on a relative value scale for services rendered on or after January 1, 1989. OBRA '86 provided for direct reimbursement for the services of certified registered nurse anesthetists (CRNAs). Under regulations implementing the fee schedules for both anesthesiologists and CRNAs, the time for anesthesiology services is billed in fifteen-minute or thirty-minute units, with partial units rounded up to the next full unit.

Proposal

(a) Overpriced Procedures—Procedures would be identified as overpriced based on a comparison of PhysPRC simulated Resource Based Relative Value Scale (RB RVS) fees with estimated national average allowed charges. Procedures more than fifteen percent overpriced, relative to the RB RVS fees, and procedures that are closely related to the primary overpriced procedure would be considered overpriced and subject to reductions under this provision.

The amount of the reduction for each procedure in each locality would be determined as follows: 1) 1989 national weighted average prevailing charges for the identified procedures would be reduced by the percentage difference between the estimated RB RVS national fees and the national average allowed payment amount; 2) local adjusted RB RVS fees would be calculated by adjusting the overhead proportion (forty-six percent) of the national weighted average reduced prevailing charge by a geographic practice cost index

(GPCI); 3) the local prevailing charge for the service would be reduced by one-half the difference between the calculated local RB RVS fee and the local prevailing charge, up to a maximum of fifteen percent. If the local prevailing charge is less than the local RB RVS fee, the local prevailing charge would not be changed. These calculations would be based on the best available data and estimates.

The list of overpriced procedures, the amounts by which they are overpriced, and the geographic practice cost index would be those procedures, percentages, and index values specified in Appendix A of the explanation of Subtitle B of Title X (Committee on Ways and Means) contained in the report of the Committee on the Budget.

Special Limits on Actual Charges—The actual charges for services whose prevailing charges would be reduced under this provision would be subject to the same special limits on actual charges imposed on overpriced procedures under OBRA '86 and OBRA '87. The special limits on actual charges would not apply for services in localities wherein the prevailing charge was not reduced because it was at or below the estimated local RB RVS fee. The authority regarding these special limits would be extended, consistent with the compatible section in the physician payment reform provision.

(b) Reductions in Payments under the Radiology Fee Schedule—The local conversion factors used for payments under the radiology fee schedule would be reduced by up to fifteen percent. The amount of the reduction in each locality would be calculated as follows: 1) the 1989 national average conversion factor would be reduced by eight percent; 2) a local reduced conversion factor amount would be estimated by adjusting the overhead portion (forty-six percent) of the reduced national average conversion factor by a GPCI; and 3) the local conversion factor would be reduced to the calculated local amount, up to a maximum reduction of fifteen percent. If the local conversion factor was less than the calculated local amount, the local conversion factor would not be changed.

Portable x-ray services would be exempt from the reduction, and the Secretary would conduct a study comparing the costs and payments for these services. The Secretary would report his findings and recommendations within one year of enactment.

The GPCI used in calculating the local reduced conversion factor would be the index values specified in Appendix A of the explanation of Subtitle B of Title X (Committee on Ways and Means) contained in the report of the Committee on the Budget.

The prevailing charges of radiology services not reimbursed under the fee schedule would be reduced to the fee schedule amount.

Special Limits on Actual Charges—The actual charges for radiology services not billed under the fee schedule whose prevailing charges would be reduced under this provision would be subject to the same special limits on actual charges imposed on overpriced procedures under OBRA '86 and OBRA '87. The special limits on actual charges would not apply for radiology services not billed under the fee schedule in localities where the prevailing charges were not reduced because they were at or below the reduced radiology fee schedule amount.

(c) Anesthesiology Services—The time for anesthesiology services provided by physician anesthesiologists and CRNAs would be billed based on actual time. In addition, the development and implementation of the fee schedule for anesthesiology services under OBRA '87 would be codified.

The Committee intends that in implementing this provision, the Secretary would provide for billing the actual time using fractional units of the fifteen and thirty minute time units currently in use.

Effective Date

Effective for services provided on or after April 1, 1990.

7. Reduction in Percentage Increase in the Medicare Economic Index (Section 10122 of the Bill)

Current Law

(a) Update—Customary and prevailing charge screens, fee schedules and MAAC limits on actual charges are updated January 1 of each year. In general, prevailing charges are updated by the percentage change in the Medicare Economic Index (MEI).

(b) Participation Agreements—Prior to each update, there is a participation period during which physicians and suppliers may elect to become participating physicians, thereby agreeing to accept assignment on all Medicare claims during the following participation period, usually one year in length.

Proposal

(a) Update—The update for all reasonable charge fee screens, fee schedules, and maximum allowable actual charge limits and other limits on actual charges would be delayed three months, to April 1, 1990. This delay would apply to all services paid on a reasonable charge or fee schedule basis and subject to an update by the MEI except for ambulance services.

Primary care services would be updated by the full amount of the MEI. The MEI update on April 1, 1990, would be two percent for other services, except radiology, anesthesiology, and services identified in this act as overpriced which would not be updated.

(b) Participation Agreements—Agreements in effect on December 31, 1989, would remain in effect for the three month period beginning January 1, 1990, unless the physician or supplier requests it be terminated. The participation period for 1990 would be the nine month period beginning April 1, 1990.

Effective Date

On enactment.

8. Physician Payment Reform (Section 10123 of the Bill)

Current Law

(a) Resource Based Relative Value Scale (RB RVS)—Payments to physicians are currently made under a reasonable charge methodology known as a "usual, customary and reasonable (UCR) charge system. Under this system, the reasonable charge recognized by Medicare is the lesser of the actual charge for the service, the phy-

sician's own customary charge for the service, and the prevailing charge for the service by similar physicians in the same locality. The customary and prevailing charge screens are based on historical charge data. Radiology and anesthesiology claims are paid under uniform national relative value scales, with varying conversion factors among geographic localities. Medicare payments are eighty percent of the recognized reasonable charge amount.

(b) Overhead and Malpractice Components—No provision.

(c) Geographic Adjustment of Overhead and Malpractice Components—The current geographic variation in fees is due to historical patterns of charges under the UCR payment system.

(d) Conversion Factor—No provision.

(e) Phase In—No provision.

(f) Information on RB RVS Fees to Physicians—Prior to each participation period, the carriers mail a report to each physician that describes any limits on actual charges that may apply during the subsequent participation period.

(g) Expenditure Target—No provision.

(h) Updating Fees Under Expenditure Target Limit—Physician's customary charges are updated each year to reflect increases in physician's actual charges during a prior period. Prevailing charges are set by determining the level at which it exceeds seventy-five percent of customary charges. The increase in prevailing charges is limited by aggregate changes in the Medicare Economic Index (MEI) since a base year.

(i) Reporting Requirements for Carriers—The Secretary has provided for the establishment of performance standards for carriers and fiscal intermediaries who process Medicare claims. These standards are included within an evaluation plan known as the Contractor Performance and Evaluation Program (CPEP).

(j) Limits on Actual Charges—Nonparticipating physicians and suppliers may submit claims on either an assigned or unassigned basis. For unassigned claims, the beneficiary is liable for the difference between the Medicare reasonable charge and the actual charge for the service.

OBRA '86 provided for limits on the actual charges by nonparticipating physicians. These limits are known as Maximum Allowable Actual Charges (MAAC). Physicians with actual charges for a particular service below 115 percent of the prevailing charge during a base period will have a MAAC for that service of 115 percent of the prevailing charge for nonparticipating physicians in 1990. Physicians with higher charges for a particular service during the base period may have a MAAC above 115 percent of the prevailing charge for nonparticipating physicians.

OBRA '87 provided for special limits on actual charges for radiology services paid under the radiology fee schedule and provided by nonparticipating physicians. The limits on actual charges for radiology services is 125 percent of the radiology fee schedule amount in 1989, 120 percent of the fee schedule amount in 1990, and 115 percent in 1991.

(k) GAO Study of Malpractice Component and Alternative Malpractice Resolution Procedures—No provision.

(l) Studies of Payments to Risk-contracting Organizations and Carve-Out from Expenditure Target System—Tax Equity and

Fiscal Responsibility Act of 1982 (TEFRA) provided for payments to qualified health maintenance organizations on a monthly basis per beneficiary enrolled in each plan. The amount of the monthly capitation payment is based on the Adjusted Average Per Capita Cost (AAPCC). The AAPCC reflects Medicare expenditures in each locality for services provided by physicians and providers billing on a fee-for-service basis.

(m) Study of Electronic Billing—No provision.

(n) PhysPRC Study of Expenditure Targets—No provision.

(o) PhysPRC Study of Payment of Overhead—No provision.

Proposal

(a) Resource Based Relative Value Scale Fee Schedule—The Secretary would establish a Resource Based Relative Value Scale (RB RVS) fee schedule as the basis of payment for physician services under Medicare. For each procedure, the RB RVS fee schedule fee amount would be equal to the sum of three components, each times its respective conversion factor; 1) a relative work component established by the Secretary using the findings of the Hsiao Relative Value Study at Harvard University that reflects the time and intensity of physician resources used to provide the service; 2) an overhead component that reflects the overhead expenses (non-physician inputs) associated with providing each service, excluding malpractices expenses; and 3) a malpractice component that reflects malpractice expenses for each service. The three components of the RB RVS fee schedule would be combined using the "additive" model recommended by PhysPRC.

The relative work component would reflect activities prior to and after direct patient contact. For surgical procedures, the RB RVS would be based on a global fee concept that reflects a uniform definition of services included within each billable service. The Secretary would have discretion to establish the uniform national definitions of global surgical services and to establish an appropriate coding structure for physican visits. The RB RVS fees would not vary by physician specialty.

The Secretary would develop the RB RVS based on the results of the Hsiao study, as modified by PhysPRC, and other appropriate data. The Secretary would have discretion in establishing the RB RVS for low volume services and other services not considered in the Hsiao study. The Secretary would have authority to make necessary assumptions in the calculations needed to establish the RB RVS fee schedule. The Secretary would have discretion to establish ancillary policies to make the fee schedule operational, such as policies regarding modifiers and local codes. The Committee intends that the Secretary would consider the special circumstances of rural independent laboratories in determining the geographic adjustment in fees under the RB RVS.

Medicare payment would be eighty percent of the lesser of the actual charge and the RB RVS fee schedule amount, or the recognized fee schedule payment amount during the phase-in. The RB RVS fee schedule amount for primary care services provided in class one or class two health manpower shortage areas would be 105 percent of the amount that would otherwise apply. The RB RVS fee schedule, and the recognized fee schedule payment

amount during the phase-in, for nonparticipating physicians would be ninety-five percent of the amount that would apply for participating physicians as provided in current law.

(b) Overhead and Malpractice Components—The total of the overhead and malpractice components would represent forty-six percent of the overall fee on a national average basis. The portion of each service acccunted for by overhead and malpractice would be based on the average proportion of total practice revenues by specialty that each component represents, weighted by the proporation of Medicare services provided by each specialty. In establishing these figures, the Secretary would have discretion to use appropriate practice cost factors for specialities for which no relieable data exist, or to make appropriate adjustments for low volume procedures.

(c) Geographic Adjustment of Overhead and Malpractice Components—Local RB RVS fee schedule amounts would be based on the national RB RVS adjusted by a geographic practice cost index (GPCI) value for each payment area. The GPCI adjustment would apply only to overhead and malpractice components of the fee.

The GPCI would reflect geographic differences in the cost of practice among payment areas. Each metropolitan statistical area (MSA) would be a separate payment area. All counties in each State not in an MSA would be a separate payment area.

The Secretary would provide for a separate geographic adjustment for the malpractice component of the RB RVS fee schedule. The Committee intends that the Secretary could use the same GPCI adjustment for the overhead and malpractice components, pending further study and development of data sources.

(d) Conversion Factors—The initial conversion factors would be determined by the Secretary and would be budget neutral to the estimated aggregate payments that would otherwise be made. Beginning in 1992, the conversion factors would be updated according to the expenditure target system described in items (g) and (h) below. The Secretary would be authorized to make adjustments to the conversion factors each year during the phase-in to maintain budget neutrality to the total amounts that would otherwise be paid.

(e) Phase In—The Secretary would determine average prevailing charges in each payment area, adjusted to reflect payments for services with charges below the prevailing charge level in the first year. If the average adjusted prevailing charge in an area is within fifteen percent of the RB RVS fee schedule amount, the amount recognized for payment would be the RB RVS fee schedule amount.

For services more than fifteen percent above the RB RVS fee schedule amount, the Medicare recognized fee schedule amount would be the average adjusted prevailing amount decreased by fifteen percent in the first year. This amount would be reduced by an additional fifteen percent each year until the RB RVS fee schedule amount is reached.

For services more than fifteen percent below the RB RVS fee schedule amount, the Medicare recognized fee schedule amount would be the average adjusted prevailing amount increased by fifteen percent in the first year. This amount would be increased by

an additional fifteen percent each year until the RB RVS fee schedule amount is reached.

The phase-in would end on December 31, 1995. For all services provided on or after January 1, 1996, the recognized payment amount would be the RB RVS fee schedule.

(f) Information on RB RVS Fees to Physicians—Prior to the initial implementation of the RB RVS fee schedule, the Secretary would provide for a mailing to each physician that lists the RB RVS fees for commonly billed procedures in the payment area in which the physician is located. The list would indicate which fees are subject to the fifteen percent limit on annual changes, the applicable extra billing limits, and would provide estimates of the budget neutral fees that would be recognized for each such service in the locality in the subsequent two years. This mailing could be coordinated with letters to physicians regarding enrollment as participating physicians.

(g) Expenditure Targets—Beginning with fiscal year 1990, expenditure targets would be set for each fiscal year. The expenditure targets would reflect expenditures incurred during a prior period, increased by target rates of growth. Services covered by the targets would include all physician services, services commonly performed in physician offices (including all diagnostic laboratory and x-ray services), and services provided by non-physicians that are commonly performed by physicians. The targets would exclude expenditures for capitation payments made to Section 1876 risk-contracting Health Maintenance Organizations.

For fiscal year 1990, the rates of growth in the expenditure targets would be the estimated percentage increases in expenditures between fiscal year 1989, and estimated expenditures in fiscal year 1990 (decreased by provisions in this legislation), minus 0.5 percent. The Committee believes that this would result in overall growth in expenditures for services covered by the targets of 10.0 percent.

The Secretary would publish targets for the increase in expenditures for surgical services, and for such other categories of physician services as he determines to be appropriate, for fiscal year 1990.

Each year beginning in 1990, the Secretary would, by February 1, recommend to the Congress rates of growth in the expenditure targets for the following fiscal year. In making his recommendations, the Secretary would consider inflation, growth and aging in the covered population, changes in medical technology, evidence of unnecessary utilization of services, evidence of lack of adequate access, and such other factors as the Secretary may consider appropriate.

The Committee intends that, in developing his recommendation for expenditure targets for fiscal year 1991, the Secretary would confer with the associations representing the major medical and surgical specialties. Following these consultations, the Secretary would, as a part of his recommendation on the targets for fiscal year 1991, recommend separate targets for surgical services and for other categories of physician services as the Secretary determines are appropriate.

PhysPRC would review the Secretary's recommendations and, by May 1, make its own recommendation to Congress on the rates of growth in the expenditure targets for the following fiscal year.

The rates of growth in the expenditure targets each fiscal year would be enacted by Congress in statute. If no target rates of growth are enacted, the targets for that fiscal year would be equal to the prior year's targets, increased by the rate of general inflation (CPI) during the prior year and the predicted rate of increase in the population enrolled in Part B, but not enrolled with a Section 1876 risk-contracting Health Maintenance Organization.

After the end of each target period, the Secretary would be authorized to adjust the targets to reflect enrollment in risk-contracting plans that differs from the basis used in setting the targets.

For the purposes of estimating budget baselines, the Office of Management and Budget (OMB) and the Congressional Budget Office (CBO) would assume that future expenditure targets would be equal to the level of expenditures are projected to be incurred for services within the target.

(h) Updating Fees Under Expenditure Target Limits—Beginning in 1992, the RB RVS fee schedule and other services included under the expenditure target system would be updated by the MEI (or other update index that may apply), increased or decreased by the percentage by which actual expenditures differed from the target amounts during the target period as enacted by Congress. By February 1 of each year, the Secretary would recommend updates for the following calendar year based on the expenditures incurred during the target period ending the prior September 30th.

The Secretary would be given discretion to recommend differential updates or other adjustments to the fee schedule, by procedure or by groups of procedures. In making these recommendations, the Secretary would consider evidence of changes in volume or access to services in determining the need for such differential updates, performance relative to the published estimates of expected growth by categories of services, including surgical services, and such other factors as the Secretary may consider to be appropriate.

In determining any differential update or adjustment, the Secretary would be permitted to use such data as he deems appropriate. The recommended differential updates and adjustments would be budget neutral to an overall update subject to performance relative to the expenditure target.

PhysPRC would review the Secretary's recommended updates and adjustments and would make its recommendations to Congress by May 1 of each year.

Congress would enact the updates each year after reviewing the recommendations of the Secretary and PhysPRC. In the event Congress does not enact updates, the Secretary would publish the final updates and adjustments by November 15 of each year. The overall effect of the final update and differential procedure updates and adjustments would be budget neutral to the aggregate update subject to performance relative to the expenditure targets.

(i) Reporting Requirements for Carriers—The Secretary would establish requirements for carriers that would provide for monthly reporting to the Health Care Financing Administration (HCFA) on expenditures and volume of services within each target, by proce-

dure and physician specialty within each payment area. HCFA would establish procedures for providing such data on a monthly basis to PhysPRC, CBO, Congressional Research Service (CRS) and the Committee within thirty days. The Secretary would include appropriate standards for reporting these data in the Contractor Performance and Evaluation Program (CPEP) used to evaluate carrier performance.

(j) Limits on Actual Charges—Provisions establishing the MAAC limits and special limits on overpriced procedures would be extended through December 31, 1990, without regard to when the Secretary issues his report on the RB RVS. Beginning January 1, 1991, new limits would be established on the actual charges of nonparticipating physicians.

For physicians with MAAC limits at or below 125 percent of the recognized payment amount for nonparticipating physicians in 1990, the limit on actual charges in 1991 would be the same percentage above the recognized payment amount as during 1990. For physicians with MAAC limits above 125 percent in 1990, the limit on actual charges in 1991 would be 125 percent of the recognized payment amount for nonparticipating physicians.

For physicians with limits on actual charges at or below 120 percent of the recognized payment amount for nonparticipating physicians in 1991, the limit on actual charges in 1992 would be the same percentage above the recognized payment amount as during 1991. For physicians with limits on actual charges above 120 percent in 1991, the limit on actual charges in 1992 would be 120 percent of the recognized payment amount for nonparticipating physicians.

The limits on actual charges for all nonparticipating physicians in 1993 would be 115 percent of recognized payment amount for nonparticipating physicians in 1993.

The Secretary would monitor changes in participation rates, extra billing amounts and assignment rates. The monitoring by the Secretary would be done by specialty, type of service, and geographic area. The Secretary would make annual reports to Congress regarding whether there are changes in assignment and participation rates, and in extra billing amounts. If significant changes occur, the Secretary would develop a plan for addressing the shifts and submit his recommendations regarding such plan to Congress. PhysPRC would review the Secretary's plan and recommendations and submit its comments to the Congress.

The Committee intends that nothing in this section would prejudice the right of any State to require assignment on Medicare claims as a condition of licensure in the State.

(k) GAO Study of Malpractice Component and Alternative Malpractice Resolution Procedures—The GAO would conduct a study of alternative methods of paying physicians for Medicare's share of malpractice expenses.

The study would include consideration of paying these expenses on a "pass through" basis. The "pass through" approach would include requiring cost reports from each physician that describe total practice costs and revenues and Medicare's share of such costs and revenues. Medicare's payment would then be based on its share of malpractice expenses, paid on either an annual or quarterly basis.

This study would also consider the potential impact of paying for malpractice expenses on a "pass through" basis on malpractice premiums.

The GAO study would also include examination of alternative malpractice claims resolution procedures for Medicare patients, including arbitration and no-fault procedures.

The GAO would report its findings and recommendations to the Committee by April 1, 1991.

(l) Studies of Payments to Risk-contracting Organizations and Carve Out from Expenditure Target System—(1) Study of Payments to Risk-contracting Plans—The Secretary would conduct a study of how payments under the Medicare RB RVS fee schedule, including adjustments in payments due to the expenditure target system, would effect payments to risk-contracting health maintenance organizations (HMOs). The Secretary would make recommendations to Congress regarding any modifications to the existing methodology for paying for services in risk-contracting organizations by April 1, 1990. (2) Study of Carve-Out From Expenditure Target System—The Secretary would study and report on the feasibility and design of a carve-out for managed health care organizations from the expenditure target system. The study would consider alternative definitions of these entities, what requirements should be considered to insure that they would not underserve their patients, and what requirements should be considered to insure that these organizations could not shift care outside the organization in order to avoid having the services count toward the organization's target. The Secretary also would report on the potential impact of such a policy on program expenditures and services. The Secretary would submit the results of this study and his recommendations to Congress by April 1, 1990.

(m) Study of Electronic Billing—The Secretary would study the feasibility and costs of providing for electronic submission of claims from participating physicians. The study should specifically consider options that include next day payment for claims processed entirely by computer, direct deposit, and providing participating physicians with equipment and software to facilitate electronic submission of claims. The study may include consideration of other options for such a system.

The Secretary would report his findings and recommendations to Congress by January 1, 1991.

(n) PhysPRC Study of Expenditure Targets—PhysPRC would study the feasibility of establishing separate expenditure targets by geographic area (region, State or smaller area), by specialty or groups of specialties, or both. PhysPRC would also consider establishing expenditure targets by type of procedure, such as primary care, surgery, services of hospital-based physicians, and other inpatient services. PhysPRC would also study the scope of services included and excluded from the expenditure target and make recommendations on any services that should be added to or deleted from the target system. In making its recommendations, PhysPRC should consider administrative issues.

PhysPRC would report its findings and recommendations to the Committee by May 1, 1990.

(o) PhysPRC Study of Payment for Overhead—PhysPRC would study how the overhead component could vary between procedures or procedure groups and report its recommendations to the Committee by May 1, 1990.

Effective Date

Paragraphs (a) through (e) are effective for services provided on or after October 1, 1991. Paragraph (h) is effective for updates to the fee schedule on or after January 1, 1992. All other paragraphs are effective upon enactment.

9. Miscellaneous Provisions Relating to Payment for Physician Services (Section 10124 of the Bill)

Current Law

(a) New Physician Customary Charges—OBRA '87 provides that the customary charge screens of new physicians are set at a level no higher than eighty percent of the prevailing charge, as limited by the MEI, until the physician has been in practice long enough to accumulate sufficient charge data for the customary charge to be based on actual charge data. The limit does not apply to primary care services and services furnished in a rural health manpower shortage area.

(b) Designated Specialties—Current regulations provide that carriers take into account the existing patterns of charges by physicians in different specialties when determining prevailing charges. Many carriers have different prevailing charges for the same service when provided by different specialties.

Proposal

(a) New Physician Customary Charges—The customary charges of new physicians limited under current law would be phased-in. They would not exceed eighty-five percent of the applicable prevailing charge for second year physicians, ninety percent for third year physicians, and ninety-five percent for fourth year physicians. These limits on customary charges would expire with implementation of the RB RVS fee schedule. Under the Committee proposal, the RB RVS would be implemented on October 1, 1991, and so these limits would expire on September 30, 1991.

(b) Designated Specialties—The Secretary would designate a specialty for each commonly billed service. The specialty designated for each service would be either the specialty that performs the service most frequently (or accounts for the largest amount of Medicare expenditures for the service) on a national basis, or the specialty that is the recognized expert in the procedure. The prevailing charge of this specialty would be a cap on the prevailing charges of other specialties for the same service.

The Committee intends that the Secretary would apply this provision to the highest volume surgical and diagnostic procedures, measured in terms of expenditures. The Committee expects that the Secretary would provide the necessary information to carriers to be incorporated in the April 1990 update. Calculations to establish the designated specialty would be based on the best available data and estimates.

Effective Dates

(a) New Physician Customary Charges—Applies to services provided on or after April 1, 1990.
(b) Designated Specialties—Applies to services provided on or after April 1, 1990.

SUBPART 2—PAYMENT FOR OTHER SERVICES

10. Payments for Capital for Hospital Outpatient Services (Section 10131 of the Bill)

Current Law

For hospital outpatient department services which are paid either on a reasonable cost basis or on the basis of a blend of reasonable costs and charges, Medicare pays for hospital capital allocated to the outpatient department of the hospital at 100 percent of costs.

Proposal

Medicare would pay for capital allocated to hospital outpatient departments at eighty-five percent of costs. When payments for hospital outpatient department services are paid on the basis of a blend, the cost portion of the blend would include allocated capital at eighty-five percent of costs.

Effective Date

Applies to payments for capital for hospital cost-reporting periods beginning during fiscal year 1990.

11. Durable Medical Equipment (Section 10132 of the Bill)

Current Law

(a) Durable Medical Equipment (DME) Rental Cap Items—OBRA '87 defined six categories of DME and established fee schedules for each category. Payment for items in the "rental cap" category is only on a rental basis. Items in this category include wheel chairs and hospital beds. The rental amount in 1989 is ten percent of the purchase price of the item based on average submitted charges during a twelve month base period ending June 30, 1987, and updated by the percent increase in the Consumer Price Index (CPI) for the six month period ending December, 1987. Rental payments are made for up to fifteen months, after which one payment is made every six months for servicing.
(b) DME Frequently Serviced Items—Items in the category known as "frequently serviced items" are made on a rental basis. These items are defined as equipment which requires frequent servicing to avoid danger to the patient and includes such items as ventilators, intermittent positive pressure breathing machines and vaporizers. Rental payments for these items are based on average allowed charges for the items during the same base period, updated by the percentage change in the CPI. There is no limit on the number of months that the rental payments are made for "frequently serviced items."

(c) Payment for Oxygen Equipment and Supplies—OBRA '87 established a fee schedule for oxygen equipment and supplies. Payment for oxygen supplies and equipment is made on a monthly basis.

(d) Parenteral and Enteral Equipment—Payments for parenteral and enteral equipment (intravenous poles and infusion pumps) are reimbursed on a reasonable charge basis, subject to certain special reimbursement limits.

(e) DME Update—Fee schedules for DME covered by section 1834(a) of the Social Security Act are updated each January 1 by the percentage change in the CPI for the twelve month period ending June 30 of the preceding year.

(f) National Cap on DME Fee Schedules—The DME fee schedules covered by section 1834(a) are currently based on carrier fee schedules.

(g) Inherent Reasonableness Authority—OBRA '87 provided that the Secretary was prohibited from using his "inherent reasonableness authority" to reduce payments for equipment paid under the fee schedules until January 1, 1991.

(h) Overpriced DME—No current provision.

(i) Limits on DME Suppliers—No current provision.

(j) Mandatory Assignment—DME claims may be submitted on either an assigned or nonassigned basis. DME suppliers may become participating suppliers by agreeing to accept assignment on all Medicare claims during a subsequent participation period. Diagnostic lab services are only a covered benefit if billed on an assigned basis. Physicians are prohibited from billing patients on a nonassigned basis for tests that would be covered if billed on an assigned basis. Physicians and suppliers who repeatedly bill patients for such tests on a nonassigned basis may be barred from the program for up to five years, are subject to civil money penalties of up to $2,000 per service billed on a nonassigned basis, or both.

(k) GAO Study of Standards for Appropriate Use of DME—No provision.

Proposal

(a) DME Rental Cap Items.—The fee schedules for all categories of DME would be based on average allowed charges, rather than average submitted charges, during the base period. Rental payments for "rental cap" items would be based on ten percent of the average allowed purchase price during the base period for the first three months of rental, and 7.5 percent of the average allowed purchase price during the fourth through fifteenth months of rental. No rental payments would be made after the fifteenth month.

The Secretary would be required to establish a reasonable useful lifetime for each item of rental DME. After an item has been rented for such period, a new cycle of rental payments could be made for necessary replacement equipment.

The Committee is concerned that the Health Care Financing Administration (HCFA) may have miscategorized motorized wheelchairs as "capped rental" rather than "routinely purchased." The Committee requests that HCFA review its categorization of motorized wheelchairs and provide justification for its decision, indicating in detail the basis for its categorization.

(b) DME Frequently Serviced Items—Rental payments for items in the category known as "frequently serviced items" would be limited to fifteen months. The Secretary would be required to establish a reasonable servicing fee for "frequently serviced items." This fee would be paid in the sixth month after rental payments cease and at six month intervals thereafter.

(c) Payment for Oxygen Equipment and Supplies—The fee schedule for oxygen equipment and supplies would be reduced by five percent.

(d) Enteral and Parenteral Equipment—Payments for enteral and parenteral equipment would be based on the same rules that apply to other items of DME. That is, they would be based on fee schedules derived from average allowed charges during the base period for the appropriate category of DME.

(e) DME Update—The update for the DME fee schedules would be delayed until April 1, 1990. The update would be two percent.

(f) National Cap on DME Fee Schedules—The DME fee schedule amounts for each item would be capped at ninety-five percent of the median of the carrier fee schedules.

(g) Inherent Reasonableness Authority—The provision prohibiting use of the "inherent reasonableness authority" before January 1, 1991 is amended to permit use of such authority on enactment of this bill. The Secretary would be required to publish a list of DME items that he considers to be overpriced. Three months following publication of such list, the fee schedule amounts for the items listed would be reduced by fifteen percent. After reviewing appropriate data on the price of motorized wheelchairs, the Secretary would have the discretion to reduce the price of motorized wheelchairs by fifteen percent.

(h) Overpriced DME—The fee schedule amounts for seatlift chairs, motorized scooters, and transcutaneous electrical nerve stimulation devices would be reduced by fifteen percent from levels that would otherwise apply.

(i) Limits on DME Suppliers—Suppliers would be prohibited from distributing to patients completed or partially completed Medicare medical necessity forms for commercial purposes. Suppliers who distribute such forms would be subject to civil monetary penalties up to $1,000 per form distributed.

The Secretary would require, by regulation, that as a condition of payment, suppliers would be required to disclose to Medicare carriers the identity of all persons with an ownership interest in the supplier (through equity, debt or other means) and to identify whether any such person is a physician. Carriers would be required to subject claims from DME suppliers with physician owners to a higher level of review than claims from other suppliers.

(j) Mandatory Assignment—Payments for DME equipment and supplies could only be made on an assigned basis. Suppliers would be prohibited from billing patients for equipment, supplies and servicing on a nonassigned basis. Suppliers who repeatedly bill patients for items, supplies and servicing on a nonassigned basis would be subject to exclusion from the program for up to five years, be subject to civil money penalties for each instance of billing on a nonassigned basis, or both.

(k) GAO Study of Standards for Appropriate Use of DME—The GAO would conduct a study of appropriate criteria for making determinations of medical necessity of durable medical equipment, including seatlift chairs. The GAO would convene a panel, including orthopedic, rehabilitation, arthritis and geriatric specialists and consumer representatives to provide recommendations of criteria for Medicare coverage of DME equipment and supplies. The GAO shall review and evaluate the use of the Certificates of Medical Necessity issued by HCFA and used in medical necessity determinations for DME claims. The GAO shall report its recommendations to the Committee by April 1, 1990.

Effective Dates

Items (g) and (k) are effective upon enactment. All other provisions are effective for services provided on or after April 1, 1990.

12. Clinical Diagnostic Laboratory Tests (Section 10133 of the Bill)

Current Law

(a) Laboratory Fee Schedule Update—The laboratory fee schedules are updated each January 1 by the annual percentage change in the CPI over the preceding calendar year.

(b) National Cap on Laboratory Fee Schedules—The local laboratory fee schedules are subject to a national cap for each service set at 100 percent of the median of all carrier-wide fee schedules. Payments for these services would be based on a national fee schedule, effective January 1, 1990.

(c) Modification of Payments for Trip Fees for Small Blood Labs—Section 1833(h)(3), as amended by section 8421 of the Technical and Miscellaneous Revenue Act of 1988, requires the Secretary to provide for a trip fee for qualifying laboratories to cover the transportation and personnel expenses for trained personnel to travel to the location of an individual to collect a sample for testing. Payments for trips by qualifying labs are for tests provided during the period beginning with April 1, 1989, and ending with December 31, 1990. To qualify for such payments, a lab must demonstrate to the Secretary that: 1) it is dependant on Medicare for eighty percent of its revenue; 2) that at least eighty-five percent of its gross revenues are attributable to tests provided to nursing home or home bound patients; and 3) that the laboratory provides such test for at least twenty percent of the nursing home in the State in which the laboratory is located.

Proposal

(a) Laboratory Fee Schedule Update—The laboratory fee schedule update would be reduced to two percent.

(b) National Cap on Laboratory Fee Schedules—The cap on laboratory fee schedules would be reduced to ninety-five percent of the national median of the carrier-wide fee schedules. The national fee schedule would be delayed for two years.

(c) Modification of Payments for Trip Fees for Small Blood Labs—The Secretary would be required to provide for an additional trip fee for qualifying laboratories to cover the transportation and personnel expenses for trained personnel to travel to a nursing

home or the home of a homebound individual to collect a sample for testing. To qualify for such payments, a lab must demonstrate to the Secretary that at least eighty-five percent of its Medicare revenues are attributable to tests provided to nursing home or homebound patients. Payments for such additional trips would only be made when the test is requested by the ordering physician on an emergency or "stat" basis.

Effective Date

Applies to services provided on or after January 1, 1990.

13. Mental Health Services (Section 10134 of the Bill)

Current Law

(a) Psychologists—Services provided by psychologists are covered in risk-contracting Health Maintenance Organizations (HMOs), community mental health centers and rural health clinics. Services of psychologists are not currently covered in other settings.

(b) Mental Health Limit—Medicare will pay only up to $1,100 in a calendar year for physician mental health services provided by either a psychiatrist or another doctor. In addition, there is a fifty percent co-payment required by the beneficiary for these services.

Proposal

(a) Psychologists—Payments would be made to psychologists for services in all settings. Psychologists would bill directly and be reimbursed on a reasonable charge basis. Psychologists could only bill for their services on an assignment-related basis. The Secretary would provide that psychologists would agree to consult a patient's physician within a reasonable period of time to consider potential physical conditions that may be contributing to the patient's symptoms. The Committee intends that such consult would not be a billable service.

The Committee intends that the Secretary would implement and enforce this requirement in a manner that considers issues of patient confidentiality. The Committee also intends that the patient's physician would not act as a gatekeeper.

(b) Mental Health Limit—The current $1,100 limit on mental health services would be eliminated.

Effective Date

January 1, 1990.

14. Certified Registered Nurse Anesthetists (Section 10135 of the Bill)

Current Law

Effective January 1, 1989, the services of certified registered nurse anesthetists (CRNAs) are paid under a fee schedule. The current fee schedule provides for separate conversion factors depending on whether the CRNA is medically directed by a supervising physician. The conversion factors also vary by geographic area. The current average conversion factors are approximately $8.50 per unit for medically directed CRNA services and $14.00 for non-medi-

cally directed CRNA services. Assignment is mandatory. The current rules for payment, under a notice of a proposed rule published January 26, 1989, also eliminate payments for medical direction when provided by the physician performing the surgery.

Proposal

The CRNA conversion factors would be set at national rates of $14 for medically directed services and $21 for non-medically directed services. The conversion factors would be subject to a cap in each local area equal to the conversion factor that applies for physician anesthesiology services. The cap would not apply to CRNA services provided in facilities in which there are no physician anesthesiologists providing anesthesiology services. The regulation eliminating fees for medical direction of CRNAs by the performing surgeon would be codified.

Effective Date

April 1, 1990.

15. Federally Qualified Health Center Services (Section 10136 of the Bill)

Current Law

Under regulation, Medicare currently makes payment to Federally Funded Health Centers (FFHC). In general, these centers are those health care clinics receiving grants under sections 329 and 330 of the Public Health Service (PHS) Act. These sections provide for grants under the Community Health Center and Migrant Health Center programs. Centers receiving grants to provide services to the homeless under section 340 of the PHS Act do not qualify as an FFHC unless they are also receiving grants under either section 329 or 340.

Centers receiving grants under these sections are required to charge low-income patients for services on the basis of a sliding fee scale. Medicare currently pays for services provided in these centers on the basis of the lesser of costs or charges, even when the charges have been adjusted under required PHS sliding fee scales for low-income patients.

Proposal

Medicare payments to FFHCs would be codified. FFHCs would be defined as: 1) centers receiving grants under any of sections 329, 330 and 340 of the PHS Act; 2) centers receiving payments as an FFHC as of January 1, 1989; and 3) centers that meet all PHS requirements to be eligible to receive such grants, whether or not they are actually receiving funds under these sections. The Secretary would be required to establish procedures for qualifying centers as meeting all of the PHS requirements.

Payment for services provided in FFHCs would be based on an all-inclusive rate established by the Secretary. Centers paid on a reasonable charge basis on January 1, 1989 could elect to continue receiving payments on that basis. Medicare would pay eighty percent of the all-inclusive rate without regard to the actual charge for the service. Payments would be made without regard to the

Part B deductible. Coinsurance amounts would be equal to the difference between the actual charge for the service and Medicare's payment, but not more than twenty percent of the all-inclusive rate. FFHCs would be given a safe harbor from criminal or civil violations under Medicare's anti-kickback rules where an FFHC gave a low-income beneficiary, who qualifies for services subsidized under the PHS Act, a partial or full waiver of Medicare coinsurance amounts based on a PHS mandated sliding fee scale.

Effective Date

January 1, 1990.

16. Miscellaneous and Technical Provisions Relating to Part B (Section 10137 of the Bill)

Current Law

(a) Coverage Under, and Payment for, Outpatient Rural Primary care Hospital Services Under Part B—Rural primary care hospital services are not authorized under current law.

(b) Modification of Payment for Therapeutic Shoes for Individuals with Severe Diabetic Foot Disease—OBRA '87 provided for a demonstration project of the cost-effectiveness of providing Medicare coverage of custom-molded and extra-depth shoes and inserts for diabetics. Coverage is limited to one therapeutic shoe insert per year. Depending on evaluations of the demonstration project, coverage of these items may become effective.

(c) Extension of Municipal Health Service Demonstration Projects—Current law provides for a Medicare waiver for certain municipal health centers established under grants from the Robert Wood Johnson Foundation. Waiver centers are in California, Maryland, Ohio and Wisconsin. The existing waiver provides for cost-based payment for an expanded range of outpatient services including preventive care, optometric care, dental services, and prescription drugs. The waiver is scheduled to expire on December 31, 1989.

(d) Study of Reimbursement for Ambulance Services—No provision.

(e) ProPAC Study of Payments for Services in Hospital Outpatient Departments—The Secretary is required to develop a prospective payment system for ambulatory surgery services furnished in hospital outpatient departments by 1989 and for all other services by 1991. ProPAC is required to provide its views on the Secretary's reports.

(f) PhysPRC Study of Payments for Assistants at Surgery—PhysPRC was established to make recommendations to Congress regarding payments for physician services.

(g) GAO Study of Payment for Services of Nurse Practitioners and Clinical Nurse Specialists—No provision.

(h) GAO Study of the Cost of Magnetic Resonance Imaging (MRI)—No provision.

Proposal

(a) Coverage Under, and Payment for, Outpatient Rural Primary care Hospital Services Under Part B—Rural primary care hospitals would be defined as hospitals which apply to a State participating

in the Essential Access Community Hospital (EACH) demonstration program for support to become and operate as such, although specific designation and reimbursement would be subject to the agreement of the Secretary. Demonstration States would be expected to give priority to rural primary care hospitals participating in a network with EACH hospitals or rural referral centers, but could designate rural primary care hospitals which were not part of a network.

Rural primary care hospitals would cease providing inpatient acute care other than on a temporary basis (unless this requirement was waived by the Secretary in order to test an alternative model for the delivery of rural hospital services). In general, these hospitals would include no more than six holding beds for patients requiring immediate inpatient care waiting to be transferred to a hospital. Patients could not be cared for in these beds for more than seventy-two hours, except in exceptional cases, such as longer stays due to inclement weather or other compelling reason precluding transfer. Twenty-four hour emergency care necessary to stabilize emergency patients would be required. Rural primary care hospitals would be required to have transfer agreements and other necessary arrangements with the other members of its network, particularly the hospital, and would be required to participate, as appropriate, in the network's communication system including systems for electronic sharing of patient data, including telemetry and medical records.

Rural primary care hospitals would have flexibility with respect to staffing as special staffing requirements would apply including that a physician's assistant or nurse practitioner could supervise holding beds, subject to physician oversight. If the rural primary care hospital chose to provide long-term care, it could do so under current law as a free-standing skilled nursing facility and would be required to meet the conditions of participation for such facilities.

Rural primary care hospitals would be reimbursed for Part B services, at the facility's option, based upon: 1) a cost-based facility fee exclusive of professional medical services otherwise reimbursed through charges; or 2) an all-inclusive rate including payment for both professional services and facility costs. The Secretary would be authorized to pay on either of these bases for three years while developing a fully prospective all-inclusive comprehensive payment system.

(b) Modification of Payment for Therapeutic Shoes for Individuals with Severe Diabetic Foot Disease—In the therapeutic shoe demonstration project, payment would be allowed annually for either one pair of custom-molded shoes with inserts and two additional pairs of inserts, or one pair of extra-depth shoes with up to three pairs of inserts for these shoes. The cost of custom-molded shoes with the initial insert is limited to $300, the cost of extra-depth shoes is limited to $100, and inserts are limited to $50 per pair.

The Secretary would be allowed to substitute the modification of custom-molded or extra-depth shoes for one or more pairs of shoe inserts, as long as no more would be spent than otherwise would have been spent for shoe inserts.

(c) Extension of Municipal Health Service Demonstration Projects—The existing waivers would be extended for four years, to December 31, 1993. HCFA would be required to study and report on the waiver program with respect to quality of health care, beneficiary costs, and such other factors as may be appropriate.

(d) Study of Reimbursement for Ambulance Services—The Secretary would conduct a study of the adequacy and appropriateness of payments for ambulance services. The study would examine: 1) the effect of current payments on the availability of ambulance services in rural areas; 2) the relationship of payments to the direct and indirect costs of providing services by level of services and by type of ambulance provider; and 3) comparisons of payments for ambulance services by public and private insurers. The Secretary would report his findings within one year of enactment. This report would include such recommendations as may be needed to ensure access to ambulance services in urban and rural areas.

(e) ProPAC Study of Payments for Services in Hospital Outpatient Departments—ProPAC would conduct a study of factors related to the rapid growth in payments for services provided in hospital outpatient departments. The study would include consideration of the effects on outpatient hospital costs of the stepdown method used to allocate hospital capital between inpatient and outpatient departments. The study also would assess the extent to which hospital outpatient costs were effected by implementation of the PPS and increased Peer Review Organization (PRO) reviews. ProPAC would report its findings from this phase of its study by March 1, 1990.

The second phase of this study would examine alternative methods for reimbursing hospitals for services in outpatient departments. Such alternative methods of payment would include prospective payment methods, fee schedules, and such other methods as ProPAC may consider appropriate. ProPAC would report its findings to the Committee, including recommendations on how the growth in payments for these services could be contained by March 1, 1991.

(f) PhysPRC Study of Payments for Assistants at Surgery—PhysPRC would conduct a study of payments for assistants at surgery. The study would examine: 1) the necessity and appropriateness of using an assistant at surgery, and 2) the use of physician and non-physician assistants at surgery. The Commission would report its findings and recommendations to the Committee by May 1, 1990.

(g) GAO Study of Payments for Services of Nurse Practitioners and Clinical Nurse Specialists—The GAO would conduct a study considering coverage and payment for the services of nurse practitioners under Medicare. This study would examine State licensing standards, education and certification requirements, the types of services provided to Medicare beneficiaries in different settings, current employment and compensation arrangements, and the cost-effectiveness of providing coverage for these services under Medicare. The study would also examine the experience under any applicable waivers that permit Medicare reimbursement for such providers.

(h) GAO Study of the Cost of Magnetic Resonance Imaging (MRI)—The GAO would conduct a study that compares payments and costs for MRI services. The GAO would report its findings and recommendations by July 1, 1990.

Effective Date

On enactment.

PART C—PROVISIONS RELATING TO PARTS A AND B OF MEDICARE

17. Payment Delay (Sec. 10151 of the Bill)

Current Law

Claims by providers for services rendered to Medicare beneficiaries received in fiscal year 1989 may not be paid after receipt before a period of fourteen days has expired. In addition, ninety-five percent of clean claims must be paid within twenty-five calendar days in fiscal year 1989 and twenty-four days in fiscal year 1990 for all but participating doctors. The ceilings for participating doctors are eighteen days in fiscal year 1989 and seventeen days in fiscal year 1990.

Proposal

Claims by providers received in fiscal year 1990 would be held sixteen days prior to payment. Ceilings would be extended to twenty-six days for all but participating physicians and twenty-one days in the case of participating physicians.

The Committee wishes to clarify with respect to payments by Medicare that providers may use Medicare receivables as collateral for agreements to provide immediate funds to providers, as long as payment by Medicare for services rendered by the provider is always made directly to the provider, except where a court order directs payment to another party. For example, a provider may agree with a lender or funder to remit receivables from Medicare as soon as they are received by the provider. In this case Medicare would not recognize any payment obligation to the lender or funder.

Effective Date

October 1, 1989.

18. Medicare as Secondary Payer (Sec. 10152 of the Bill)

Current Law

(a) Identification of Medicare Secondary Payer Situations—Medicare is a secondary payer under specified circumstances when individuals are covered by other third party payers. Medicare is secondary payer to automobile, medical, no-fault and liability insurance, and to employer health plans.

Medicare is secondary payer to certain employer health plans for aged and disabled beneficiaries. Medicare is also secondary payer to employer group health plans for items and services provided to end stage renal disease (ESRD) beneficiaries during the first twelve months of a beneficiary's entitlement to Medicare on the basis of ESRD.

The Department of Health and Human Services (HHS), through its contractors, currently identifies Medicare secondary payer cases in the following ways: 1) beneficiary questionnaires; 2) provider identification of third party coverage when services are provided; and 3) data transfers with other Federal and State agencies. According to HHS, approximately two-thirds of Medicare secondary payer cases are identified through these means. Under current law, HHS is unable to identify all Medicare secondary payer situations, principally because HHS is unable to identify cases in which Medicare beneficiaries have primary health coverage through a spouse's plan.

Medicare contractors are currently covered under the Privacy Act because they routinely handle beneficiary-specific information, including medical history and social security numbers. Medicare contractors are currently prohibited from unauthorized disclosure of this information, subject to criminal penalties.

(b) Uniform Enforcement and Coordination of Benefits—

(1) Prohibition of Liens Against Liability Insurance—Medicare is secondary payer to liability insurance. In cases involving liability insurance, providers are instructed to bill Medicare first for conditional payments, and Medicare subsequently recovers its costs from the liability insurer of the person who caused the injury.

(2) Excise Tax on Non-Complying Employers—A variety of penalties exist to enforce compliance with the secondary payer provisions. Employers who do not comply with the working disabled provisions are subject to an excise tax equal to twenty-five percent of the group health plans' expenses. Failure to comply with the working aged provisions is a violation of the Age Discrimination and Employment Act of 1967 as amended. Employers who violate the secondary payer provisions for ESRD beneficiaries can lose their tax deduction for group health expenses.

(3) Payments under Worker's Compensation and Liability Insurance Towards Deductibles—Although payments under the working aged, disabled and ESRD secondary payer provisions are made without regard to deductibles and coinsurance, payments from Workmen's Compensation or liability and related insurance are subject to deductibles and coinsurance.

(c) Special Enrollment Period for Disabled Employees—Aged individuals are currently entitled to a special enrollment period for Medicare if they are covered under a group health plan. Under current law, disabled individuals are entitled to a special enrollment period only if they are covered under a large group health plan.

(d) No Matching Based on Private Activities Required in Fiscal Intermediary Agreements and Carrier Contracts—Under current law, the Secretary may terminate an agreement with a fiscal intermediary or carrier if he finds, after applying standards and criteria regarding overall performance of claims processing and overall performance, that the agency has failed substantially to carry out the agreement, or the functions provided for in the agreement with the fiscal intermediary are disadvantageous or inconsistent with the efficient administration of Medicare.

(e) Treatment of Employment as a Member of a Religious Order—The Internal Revenue Code enables religious orders to con-

tribute social security payments on behalf of any members of the order, if the member 1) has taken a "vow of poverty," 2) performs tasks usually required of an active member of an order, and 3) is not considered retired because of old age or total disability. Such members of religious orders are considered to be "deemed employees."

Medicare is a secondary payer for aged individuals who have health insurance coverage from an employer. Religious orders are treated as employers under the Medicare secondary payer provision. Religious orders are therefore required to provide the same health insurance coverage for their members who are age sixty-five and older as they do for members under age sixty-five. If a member of a religious order elects Medicare as primary payer, and the order is a "deemed employer," the order would not be able to pay Medicare co-insurance and deductibles.

Proposal

(a) Identification of Medicare Secondary Payer Situations—The Internal Revenue Service (IRS) and the Social Security Administration (SSA) would provide information to the Health Care Financing Administration (HCFA) to improve identification and collection of Medicare secondary payer cases. SSA would provide the IRS, on an annual basis, the names and Social Security numbers of all Medicare beneficiaries. The IRS would provide SSA with a file of the names and Social Security numbers of all Medicare beneficiaries who filed a tax return for any specified year after 1986 no later than February 1, 1990. Information on spouses would be linked for individuals filing joint or individual returns. Ultimately, this information would be used by HCFA to identify beneficiaries that are covered by an employer health plan.

Information provided by IRS to SSA would be part of a match by SSA against the Master Earnings File to determine whether a W-2 had been filed for the beneficiary or the beneficiary's spouse. SSA would provide HCFA with a listing of all Medicare beneficiaries and their employed spouses, and the name of the beneficiary's or spouse's employer if: 1) the beneficiary and/or spouse filed a W-2, and 2) the beneficiary and/or spouse was employed by a large employer, defined as an employer who filed with twenty or more W-2s.

HCFA would use this listing provided by SSA to identify more thoroughly secondary payer cases, including Medicare beneficiaries with employer-provided health coverage through their own or their spouse's employment. HHS's contractors would use this new information to contact employers in writing to determine whether the employer provided health coverage, the type of coverage provided and the date of such coverage. Current restrictions on the disclosure of information under the Internal Revenue Code and the Privacy Act would also apply to the new information provided by SSA and IRS to HCFA.

Third party payers, such as Medicare carriers and employers, receiving taxpayer information would be subject to restrictions and safeguards on disclosure, and subject to penalties for unauthorized disclosure similar to those restrictions, safeguards and penalties

currently provided in the Internal Revenue Code with respect to other authorized recipients of taxpayer information.

To enable HHS to verify employer-provided health coverage, employers would be required to respond to HCFA inquiries within thirty days of receiving the letter. HCFA would pay as secondary payer on all claims for beneficiaries currently covered by an employer health plan. Any overpayments made by Medicare for such beneficiaries would also be recovered from liable parties according to existing rules governing Medicare Secondary Payer and overpayment recovery.

This provision would expire on September 30, 1991.

(b) Uniform Enforcement and Coordination of Benefits—The Medicare secondary payer provisions would be reorganized and consolidated. In addition to changes in the nature of such reorganization, the following new policies would be adopted.

(1) Prohibition of Liens Against Liability Insurance—The provider participation agreement, assignment agreement, and participating physician or supplier agreement apply not withstanding that the availability of payments primary to Medicare, such as certain employer group health plan coverage, precludes or reduces the possible Medicare payment for items and services. In these cases, in addition to collecting from Medicare the reduced program payment, if any, the provider, physician or supplier could charge the beneficiary, primary payer or other source to the extent of the available primary payment and only to that extent.

In cases where liability insurance is available to make a payment for items and services, Medicare payment would not be precluded or reduced. Medicare would pay its full benefits and would recover its payments from the liability insurer or any entity paid by the liability insurer. Since the full Medicare payment for items and services could still be made to a physician or provider or supplier, such physician, provider or supplier would be precluded from collecting from the beneficiary or other party anything more than the applicable Medicare deductible and coinsurance with respect to those items and services.

(2) Excise Tax on Non-Complying Employers—Non-complying employers would face an excise tax equal to twenty-five percent of the group health plans' expenses. The Secretary would have the right to action with provisions for double damages to enforce all secondary payer provisions.

(3) Payments Under Workmen's Compensation and Liability Insurance—Payments under Workmen's Compensation or liability and related insurance would be made without regard to the Medicare deductibles and coinsurance.

(c) Special Enrollment Period for Disabled Employees—The special enrollment period for the disabled covered by an employer health plan would be made comparable to the special enrollment period for the aged covered under a group health plan.

(d) Contractor Agreements and Contracts—The Secretary would be prohibited from requiring Medicare contractors to cross-match data files to identify secondary payer cases as a condition of remaining a contractor.

(e) Treatment of Employment as a Member of a Religious Order—Religious orders whose members take a "vow of poverty"

and who opt to contribute to Social Security would not be treated as employers for purposes of the Medicare secondary payer provisions.

Effective Date

Paragraphs (a), (b), (c), (d) and (f) are effective upon date of enactment. Paragraph (e) is effective in regard to enrollments and premiums for months occurring after the second calendar quarter beginning after the date of enactment. Paragraph (g) is effective October 1, 1990.

19. End Stage Renal Disease Services (Sec. 10153 of the Bill)

Current Law

(a) Maintenance of Composite Rate—Beneficiaries may elect to be paid for home dialysis services in one of two ways. Under Method I, hospital and free-standing facilities provide all home dialysis equipment, supplies and home support services, and are paid a composite rate that takes into account the proportion of patients dialyzing at home. Under the composite rate, the average base payment is $125 per treatment in free-standing facilities and $129 per treatment in hospital units. Beginning in fiscal year 1989, the Secretary of Health and Human Services has the authority to adjust payment rates.

(b) Requirements for Patients Dealing Directly with Medicare—Under Method II, the beneficiary makes his own arrangements to receive home dialysis equipment, supplies and support services. The beneficiary (or supplier if assignment is taken) is paid directly based upon itemized bills and reasonable charges.

(c) ESRD Patient Protection and Quality Assurance—The Secretary makes payments to providers of ESRD services and renal dialysis services which meet such requirements as by regulation provided. Over time, the Secretary has established regulations pertaining to standards for staff, physical plant and patient rights. In addition, to help assure the effective and efficient administration of ESRD benefits, the Secretary is authorized to establish ESRD network areas.

The network organizations are responsible for: 1) encouraging use of those treatment settings most compatible with the successful rehabilitation of the patients that are consistent with sound medical practice; 2) developing criteria and standards relating to quality and appropriateness of patient care; 3) evaluating the procedures by which facilities and providers in the network assess the appropriateness of patients for proposed treatment modalities; 4) implementing a procedure for evaluating and resolving patient grievances; 5) conducting on site reviews of facilities and providers as necessary as determined by a medical review board or the Secretary; 6) collecting, validating and analyzing data as necessary to prepare reports and to assure the maintenance of the ESRD registry; and 7) identifying facilities and providers that are not cooperating toward meeting network goals and assisting facilities in developing appropriate plans for correction.

If the Secretary determines that a facility or provider has consistently failed to cooperate with network plans and goals or to

follow the recommendations of the medical review board, he may terminate or withhold certification of such facility or provider until he determines that such provider or facility is making reasonable and appropriate efforts to cooperate with the network's plans and goals. If the Secretary determines that the facility's or provider's failure to cooperate with network plans does not jeopardize patient health or safety or justify termination of certification, he may, after reasonable notice to the facility or provider and to the public, impose other sanctions as he determines to be appropriate.

(d) Office of Technology Assessment (OTA) Study of costs of Treatments and Establishment of Composite Rate—No provision.

(e) Reports on Payment for Erythropoietin (EPO)—Certain drugs that are not self-administered are covered as part of the ESRD benefit. The costs of drugs that are consistently provided as part of the dialysis procedure are included in the composite rate. Other drugs, which are not consistently provided but are still medically necessary, are billed on a fee-for-service basis outside of the composite rate.

Proposal

(a) Maintenance of Composite Rate—The current Medicare composite payment rate for renal facilities would be maintained for fiscal year 1990.

(b) Requirements for Patients Dealing Directly with Medicare—The Method II payment rate, based upon itemized bills and reasonable charges, would be capped at the Method I composite level for free-standing facilities. Medicare beneficiaries who receive supplies and equipment that are reimbursed under Method II would be required to obtain a formal written agreement with one supplier and the supplier would be required to accept assignment. These beneficiaries would also be required to sign a written agreement with a local Medicare-approved ESRD facility, stating that the facility would provide all necessary home dialysis support services and would serve as back-up to in-facility dialysis services when necessary.

(c) ESRD Patient Protection and Quality Assurance—As a condition for participation, renal dialysis facilities and providers of services would be required to inform patients of their rights as soon as feasible but no later than thirty days after the beginning of a patient's dialysis program or course of treatment and upon the patient's reasonable request thereafter.

Facilities and providers would be required to inform patients of the following: 1) their rights regarding grievance procedures; 2) the services available in the facility and of related charges; 3) the facility's responsibility for continuing the patient in the dialysis program and of the specific circumstances that may result in termination of treatment; 4) the name of the physician who has primary responsibility for coordinating the patient's care and the names and professional relationship of any other physicians who treats the patient, and 5) information from the network organization about facilities inside the region that offer home or self-care dialysis and flexible arrangements for patients, and about facilities outside the region that are available to transient patients.

In addition, facilities would be required to inform patients, if requested, about the relationships of the facility to other organizations, corporations or institutions, including disclosure of any physicians involved in the patients' care who have a fiduciary relationship with the facility. Facilities would also be required, if requested, to provide patients with access to the patient's own medical records maintained by the facility in accordance with State law.

Each facility and provider of service would be required to inform patients at regular intervals, through a physician, about their medical condition, unless medically contraindicated. Facilities would be required to transmit information concerning the patient's medical condition to third parties if requested by the patient or if medically necessary.

On an annual basis, a facility would be required to provide an evaluation of the patient's suitability as a candidate for peritoneal or self-care dialysis, and would maintain appropriate documentation of the evaluation in the patient's medical record. A physician would also be required to provide each patient, except in the case of emergency, with as much information as possible about any proposed treatment, including any experimental procedure or procedure involving reuse, as the patient may need to give informed consent for treatment. Such information should include a description of the procedure or treatment, the medically significant risks involved in the procedure or treatment, alternative treatments or nontreatment and the risks associated with each, and the name of the person who would carry out the procedure or treatment.

The facility would be prohibited from refusing to treat a patient because the patient seeks other medical opinions.

The facility would allow patients to refuse treatment, without jeopardy to the facility, if the facility has informed the patient and the patient is aware of the medical consequences of refusing treatment, to the extent permitted by law.

The facility would be required to provide each patient with a written plan of care developed by the patient's physician which assures a reasonable continuity of care and which includes designation of the agreed-upon treatment modality, advance notice of the time and location of appointments for dialysis treatment, and designation of the physician responsible for the care.

Facilities and providers of service would be permitted to require patients to sign a statement that affirms that the patient has been informed of his or her rights, understands the various treatment options and has consented to the written plan of care.

Facilities would be required to treat each patient with consideration and respect and to promote each patient's rights, including the right to privacy with regard to accommodations, medical treatment and visits, and the right to receive services with reasonable accommodation of individual needs and preferences.

A facility would be permitted to transfer or discharge a patient only for medical reasons, the patient's welfare, the welfare of other patients or staff, for non-payment of fees or if the facility ceases to operate. Facilities would be required to provide each patient with advance notice of a transfer or discharge. Facilities would be permitted to transfer a patient if: 1) such patient is new or medically unstable and the facility is required either contractually or under

State or local law to transfer such a patient to another setting, or 2) if, in accordance with the facility's written policy regarding routine transfers or discharges; however, grounds for discharge or transfer in the written policy would not include: (i) the filing of a grievance or legal complaint; (ii) refusal to agree to reuse of artificial kidneys or other supplies, if the patient's refusal is based upon the written advice of a nephrologist indicating overriding medical reasons that preclude reuse.

A facility would be required to ensure the confidential treatment of the patient's personal and medical records, and would not be permitted to not release any such records to any person outside the facility without the patient's consent, except in the case of the patient's transfer to another health care institution as required for the proper administration of the ESRD program.

A facility would be required to provide, during dialysis treatment at the facility, for a registered professional nurse experienced in dialysis therapy to direct technicians providing treatment.

A facility would be prohibited from interfering with the right of patients to form patient councils or committees to discuss common concerns.

Facilities that provide services to a significant number of patients whose primary language is not English would be required to ensure that information is provided in a language and in a form that is understood by such patients.

Where necessary, the rights of patients would be extended to persons who have legal responsibility to make decisions regarding medical care on behalf of the patient.

Facilities would be required to establish policies and procedures for the resolution of patients' concerns and conflicts. Facilities would be required to permit patients to state grievances and recommend changes in policies and services without fear of reprisal.

Each State would be responsible for certifying the compliance of renal dialysis facilities and providers of services providing renal dialysis services with the requirements of the ESRD program. States would conduct, in collaboration with the network administrative organization, periodic educational programs for the staff and patients of such facilities in order to present current regulations, procedures and policies. The States would assure that the network administrative organizations receive survey findings for facilities and providers of service found to be out of compliance.

Facilities would be surveyed by States on an annual basis beginning in 1992 and without any prior notice to the facility. Upon change of ownership, administration or management, States would be permitted to conduct a standard survey within two months of such change.

The standard survey would include an assessment of the quality of care furnished, an assessment of the facility's internal quality assurance program and a review of the facility's staffing, in-service training, and if appropriate, contracts with consultants. Also included in the survey, for a sample of patients, would be a review of the facility's written plan of care and a review of patient records for items such as potential for transplantation or home care, excessive or unnecessary dialysis, hospitalizations, recurrent pericarditis and infections. The survey would also include a review of the facili-

ty's compliance with requirements regarding patient's rights. Surveys would include interviews with patients to evaluate satisfaction with the care provided. Finally, to evaluate quality of care, the survey would review the records of a sample of patients who experienced one or more adverse outcome, e.g., the patient was admitted to a hospital or died during treatment.

Facilities found to be out of compliance with the standard survey would be subjected to an extended survey. The extended survey would be conducted no later than two weeks after completing the standard survey. Any other facility may, at the Secretary's or the State's discretion, be subject to an extended survey.

The extended survey would review and identify the policies, procedures and quality assurance systems that produced such substandard quality of care and would determine whether the facility was in compliance with standards. The extended survey would evaluate the extent to which the facility had developed a plan of correction and had acted to implement such a plan.

Each State and the Secretary would be required to make available to the public information regarding all surveys and certifications of facilities, including statements of deficiencies and copies of cost reports.

States would be required to notify the physician responsible for each patient's care if the State's survey determines that the facility has provided substandard quality of care. The State would notify the physician if and when the facility has established a plan to correct deficiencies.

If the State finds, based upon the standard or extended survey, that the facility or provider of service does not meet specified standards, and that the facility's deficiencies do not jeopardize the health and safety of its residents, the Secretary would be authorized to take one of the following actions: 1) denial of payment; 2) impose civil monetary penalties; or 3) appoint a temporary manager.

If the State finds, based upon the standard or extended survey, that the facility or provider of service does not meet specified standards, and that the facility's deficiencies jeopardize the health and safety of its residents, the Secretary would take immediate action to remove the jeopardy and correct deficiencies, and would be authorized to terminate the facility's participation or deny payments, impose civil monetary penalties, and appoint a temporary manager to assure the health and safety of the patients. The temporary manager would have minimum qualifications of being an experienced facility administrator or licensed nephrologist within the State. These enforcement provisions would be effective beginning with the survey of facilities, beginning in 1992.

The Secretary would be required to establish an eleven member advisory panel, comprised of an ESRD patient, a nephrologist, a renal facility administrator, a transplant surgeon, a nephrology nurse, a dialysis technician, a nephrology social worker, a renal nutritionist, a representative of a network administrative organization and at least one expert in quality assessment and assurance. The advisory panel would make recommendations to the Secretary regarding quality standards for the various methods of treatment of ESRD by December 31, 1990.

The advisory board would develop and test protocols for standard and extended surveys, develop minimum qualifications for members of survey teams, and develop uniform national instructional guidelines for surveyors and renal dialysis facilities and providers of services.

The advisory board would make recommendations to the Secretary by December 31, 1990, concerning standards, protocols, qualifications and guidelines. The Secretary would implement recommendations as he deems appropriate by January 1, 1992, and notify the Committee on Ways and Means upon date of implementation. In 1992, and in 1994, the advisory board would report to the Secretary with recommendations to update quality standards, an assessment of the implementation of patient protection and quality assurance recommendations, and an assessment of the extent to which recommendations concerning patient protection and quality assurance should be revised.

States would be encouraged to make annual awards of excellence to facilities that have achieved outstanding quality on the basis of standards established by the states.

Upon request, the Network Administrative Organizations would assist those facilities, providers and suppliers found out of compliance with quality standards to develop appropriate plans for correction. The Network Administrative Organizations would develop network goals with respect to the placement of patients in self-care settings and transplantation, with special attention to correcting underrepresentation of minorities in transplantation and self-care options, and the participation of patients in vocational rehabilitation programs.

The Network Administrative Organizations would conduct studies to verify that facilities are assessing patients for appropriate placement in the most medically suitable modality for the patient and to determine the number of patients who have returned to employment. The Networks would also verify the implementation of an internal grievance mechanism by each facility, and furnish to the States the findings of the investigations of patient grievances that indicate noncompliance with quality standards.

The Network Administrative Organizations would collect, validate and analyze data necessary to assure the maintenance of an ESRD registry and to help develop or evaluate indices of quality care. The Networks would submit annual reports to the Secretary that would include a statement of the network's goals and data on the network's performance in meeting its goals, and other information that the Secretary may require. Provisions relating the networks would be effective six months after date of enactment.

(d) OTA Study of Costs of Treatments and Establishment of Composite Rates—The OTA would conduct a study to determine the costs of providing various modalities of dialysis treatment to Medicare beneficiaries and would recommend the level at which the composite rate should be established in fiscal year 1991 and the methodology for establishing updates thereafter. The report would be submitted to the Committee by June 1, 1990.

(e) Reports on Payment for Erythropoietin (EPO)—The Secretary would report to the Committee concerning the methodology and rationale for establishing the payment rate for erythropoietin used to

treat ESRD patients. The report would include a summary of information provided by the manufacturer and used by the Secretary to develop the payment rate. The report would include a plan for monitoring the appropriateness of rates in the future. The report would be due on April 1, 1990.

The GAO would review the Secretary's findings and report to the Committees by June 1, 1990. The OTA would report on alternative acquisition and reimbursement strategies to reduce expenditures for certain drugs without sacrifice to quality of care.

Effective Date

Paragraphs (a), (c), (d), and (e) are effective upon date of enactment. Paragraph (b) is effective on October 1, 1989.

20. Medical Care Quality Research and Improvement (Sec. 10154 of the Bill)

Current Law

OBRA '86 provided for the establishment of a patient outcome assessment research program, administered by the National Center for Health Services Research and Health Care Technology. This program includes: reorganization of Medicare claims data, assessments of medical care, evaluations of patient outcomes, and other activities. OBRA '86 authorized to be appropriated from the Medicare Trust Funds $6 million for fiscal year 1987, and $7.5 million for each of fiscal year 1988 and fiscal year 1989. These authorization amounts were increased by the Technical and Miscellaneous Revenue Act of 1988 and the authorization was extended through fiscal year 1991.

Proposal

(a) Research Program on Outcomes and Effectiveness Research—The Secretary would establish and fund a program of research on outcomes, effectiveness and appropriateness of medical care. The research program would include: 1) reviews of existing research findings; 2) review of existing methodologies that use large data bases in conducting such research, development of new research methodologies, including data-based methodologies, and methodologies that measure clinical and functional status of patients; 3) grants and contracts to research centers and other research entities for research on outcomes, effectiveness and appropriate treatment options for specific conditions, including research on the appropriate use of prescription drugs; 4) projects that demonstrate the use of claims data and data on clinical and functional status for outcomes, effectiveness and appropriateness research; 5) establishment of a process to assure that new information and medical innovation are addressed, in a timely fashion, and incorporated in the research program when appropriate; 6) projects that supplement existing data bases; and 7) projects that design and develop new data bases for use in outcomes and effectiveness research.

The Committee intends that the Secretary would provide for the involvement of non-physician professionals on the advisory council, and consultation with non-physician professionals on research on

outcomes and effectiveness and on development of guidelines related to services provided by such professionals.

(b) Standards for Data Bases—The Secretary would develop: 1) uniform definitions of data to be collected and used in describing patient's clinical and functional status; 2) uniform standards for the security, confidentiality, accuracy and maintenance of data; and 3) linkages and common reporting formats for HHS' administrative and clinical data bases.

The Secretary would submit a report to Congress on the feasibility of establishing data base linkages between administrative and clinical data bases in HHS and data bases in other Federal departments, including those maintained by the Department of Defense, Veterans' Administration, Office of Personnel Management, and between HHS and non-Federal entities.

(c) Education and Dissemination of Findings—The Secretary would provide for dissemination of the findings of the research and the guidelines, and to provide for the education of providers and others in the use of such research and information. In disseminating the findings and providing for the education, the Secretary would fund research on effective means to educate providers, consumers and others in using the outcomes, effectiveness, and appropriateness research findings, and would develop a program for educating physicians, other providers, consumers, and physician managers within provider organizations. Additionally, the Secretary would develop appropriate relationships with professional medical societies, associations, and other relevant groups.

(d) Guideline Development—The Secretary would establish an ongoing program of financial support and oversight for the development of condition or procedure specific guidelines based on measurable outcomes and patient experience in forms appropriate for use in educational programs and for reviews of the quality and appropriateness of medical care. The alternative forms may include practice parameters. The ongoing program for development of practice guidelines should provide for updating the guidelines to reflect changes in technology and appropriate medical practice.

(e) Demonstration Project--By 1991, HCFA would establish a Medicare demonstration program for evaluation of practice guidelines for at least three conditions—conditions which account for a significant portion of Medicare expenditures, and for which there are significant variations in the frequency and type of interventions. The Secretary would develop an evaluation methodology for the demonstration project, and would provide for an evaluation of the demonstration as a model for broad scale implementation.

(f) Report to Congress—The Secretary would submit an annual report to Congress by February 1 of each year (beginning with 1991) on the progress of the program, on the program's effects on medical care, including the effects on medical care provided to Medicare beneficiaries. The first report would be due one year after enactment.

(g) Advisory Council—The Secretary will develop a charter for and appoint membership to the eighteen member Advisory Council. The Council would assist and advise the Secretary on the program for medical outcomes, effectiveness and appropriateness research. Membership of the Council would consist of representatives from a

broad range of interested parties. The Committee intends that the Secretary would provide for members representing professional associations and medical societies; provider education associations; quality of care review entities and associations; health services research associations; consumers, health care insurers; employer groups; provider accreditation groups; hospital associations; medical product manufacturers; the Department of Defense; and the Veterans' Administration.

The Committee finds that the functions of the proposed advisory council are not and could not be performed by any agency, any existing advisory commission, or by enlarging the mandate of an existing advisory committee.

(h) Coordinating Group—A three-person Coordinating Group would be established. Membership of the group would include: the Administrator of HCFA; the Assistant Secretary for Planning and Evaluation (ASPE); and the Assistant Secretary for Health (ASH), who would serve as chair. The group would develop and submit to the Secretary an annual Department-wide coordinated research and program plan for each of the following elements: research, data development and information dissemination and guideline development. The Group would set the annual outcomes and effectiveness program agenda and priorities. The Group would determine the conditions for which would be the subject of the research and the conditions for which guidelines would be developed. Two-thirds of the conditions selected for study in the outcomes and effectiveness research program, and two-thirds of the conditions for which guidelines would be developed would have to have the concurrence of the HCFA administrator. The list of such conditions would be reported to the Secretary.

(i) Definitions—1) Outcomes Research: Research that focuses on the evaluation of a treatment or alternative treatments for a condition, and formally assesses the probabilities for the full spectrum of different outcomes and the value of these outcomes for patients, including mortality, morbidity, functional status, symptoms, and quality of life. 2) Effectiveness Research: Research that focuses on the uses of treatments for patients in typical clinical practice and the impact on outcome of the treatment of those patients, taking into account (to the extent relevant) patient conditions and local environment, and through routine monitoring and feedback of information to physicians and patients, on changes in the treatment to improve outcomes in such practice. 3) Appropriateness Research: Research, which may be based on outcomes research, effectiveness research, and/or a consensus of medical experts or expert judgment, that assesses treatments with respect to the characteristics of particular patients for which the treatments are effective.

(j) Budget—The outcome and effectiveness research program would be authorized for a period of five years, beginning in fiscal year 1990. In fiscal year 1990, two-thirds of the amounts appropriated would come from the Medicare Trust Funds, sixty percent from the Hospital Insurance Trust Fund and forty percent from the Supplementary Medical Insurance Trust Fund. The remaining amount would come from general revenues. The amounts authorized in each of the five years would be $72 million for fiscal year 1990, $110 million for fiscal year 1991, $170 million for fiscal year

1992, $225 million for fiscal year 1993, and $270 million for fiscal year 1994.

Of the amounts authorized for fiscal year 1990, one-third would be allocated for the research component, one-third for the data component, one-sixth to be distributed evenly among the information and educational component, including the evaluation of the information dissemination methodologies, and one-sixth for the guideline development component.

Effective Date

On enactment.

21. Medicare Hospital Patient Protection Amendments (Sec. 10155 of the Bill)

Current Law

(a) Scope of Hospital Responsibility for Screening—If an individual comes to the emergency department of a hospital, the hospital must provide medical screening within the capability of its emergency department to determine if the individual has an emergency medical condition or is in active labor. Within the capabilities of the staff and facilities available the hospital must provide medical services necessary to stabilize an individual or, if the benefits of transfer outweigh the risks, transfer the individual to another hospital.

(b) Informed Refusals of Treatment—A hospital is considered to meet the requirements for providing examinations or treatment or appropriate and necessary transfers if a patient (or a person acting on their behalf) refuses the examination or treatment or transfer.

(c) Authorization for Transfers—In general an unstable patient may not be transferred unless the patient's emergency medical condition has stabilized or the patient is no longer in active labor, or the patient requests that a transfer be effected, or a physician (or other qualified medical personnel when a physician is not readily available) has signed a certification that based upon the reasonable risks and benefits to the patient, and based upon the information available at the time, the medical benefits of transfer outweigh the risks.

(d) Requiring Maintenance of Records of Transfers—Hospitals transferring patients are required to provide the receiving facility with appropriate medical records of the examination and treatment provided at the transferring hospital.

(e) Enforcement—The standard of liability for hospitals and physicians for civil money penalties of up to $50,000 is that the statute is knowingly violated. Physicians are liable with respect to a hospital's violation of the law if the physician is an employee of, or under contract to, the hospital and if the physician had professional responsibility for the care of the individual with respect to whom a violation occurred.

(f) Additional Obligations—No provision.

(g) Change in Patient Terminology—Generally, the word "patient" is used in current law to describe an individual who is present for emergency services.

(h) Clarification of Emergency Medical Condition Definition—Emergency medical condition is defined in current law.

Proposal

(a) Scope of Hospital Responsibility for Screening—The amendment would clarify that a hospital's responsibility for initial treatment of emergency patients relates to the hospital's entire capabilities, not just the capacity of its emergency room.

(b) Informed Refusals of Treatment of Transfers—In the case of a patient (or a person acting on their behalf) who refused examination, treatment, or an appropriate and necessary transfer, the hospital would be required to explain the risks and benefits to the patient (or the person acting on their behalf) of the examination, treatment, or transfer, and take all reasonable steps to secure the patient's or person's written, informed consent to refuse such examination, treatment, or transfer.

Hospitals would be required to take all reasonable steps to obtain written informed consent from patients (or a person acting on their behalf) requesting to be transferred. Such consent should indicate that the patient was informed of the risks and benefits of transfer.

(c) Authorization for Transfers—The standard for transfer would be clarified to make clear that the benefits of treatment at another facility must be weighed against the risks of the transfer based upon information available at the time of transfer. In the case of a pregnant woman in labor, the risks and benefits to the unborn child would also have to be taken into account. A hospital would be required to provide whatever treatment was within its capability prior to transfer in order to reduce the risks of transfer. The transferring hospital would be required to outline the risks and benefits of transfer on the records it is required to send with the patient.

The provision regarding physician authorization for transfer would be clarified such that a qualified person other than a physician could authorize a transfer only in direct consultation with a physician, for example via telephone, and the physician when available would be required to countersign the certification.

(d) Requiring Maintenance of Records of Transfers—Transferring hospitals would be required to send with a transferred patient all medical records (or copies) related to the emergency condition for which the patient presented which were available at the time of transfer, including records of observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests, and the informed written consent or certification of the physician, as appropriate.

(e) Enforcement—The requirement that hospitals or physicians "knowingly" violate the law in order to be subject to civil monetary penalties would be deleted. The liability of physicians would be clarified to include on-call physicians as well as staff physicians. Hospitals would be required to maintain a list of on-call physicians immediately available to provide follow-up care.

Current law would be clarified to state specifically that hospitals are liable for the acts and omissions of the hospital's agents, and the physicians through whom the hospital carried out its duties under this provision. The Committee would note that hospitals have always been liable for the acts of the hospital's agents, includ-

ing physicians who provide examination and treatment at the hospital, and that this amendment is only intended to clarify current law in this regard.

Physician liability for violations would be clarified to include cases in which he or she 1) certified that the benefits of transfer outweighed the risks when the physician knew or should have known that they did not or 2) the physician misrepresents an individual's condition or other information, including a hospital's obligation under this section, as well as any other violation of the statute.

Physician liability would also be clarified such that if after the emergency room physician attempted to contact an on-call physician and the physician failed to appear, or refused to care for a patient, and if the emergency physician, weighing the benefits and the risks of transfer and treatment at another hospital, transferred the patient, the emergency physician would not be liable under the statute. However, the hospital or the on-call physician could be liable for penalties under the statute, including civil monetary penalties and removal from the Medicare program.

(f) Additional Obligations—Hospitals with specialized facilities such as burn units, shock-trauma units, neonatal intensive care units, or rural regional referral centers, would be required to accept patients needing such services. Hospitals could not delay necessary treatment in order to assess a patient's financial capability.

Hospitals would be prohibited from retaliating against, penalizing, or otherwise causing injury to a physician who refuses to transfer an unstable patient.

(g) Change in Patient Terminology—The term "patient" would be replaced with the term "individual."

(h) Clarification of Emergency Medical Condition Definition—The definitions of emergency medical condition, labor, stabilized condition, and the end of labor would be clarified.

Effective Date

The first day of the first month that begins 180 days after enactment.

22. Health Maintenance Organizations (Sec. 10156 of the Bill)

Current Law

(a) Regulation of Incentive Payments to Physicians—OBRA '86 prohibited payments to a physician, directly or indirectly, by a hospital, or by a Health Maintenance Organization (HMO) or other organization with a risk contract with Medicare or Medicaid, in order to reduce or limit services provided to beneficiaries or enrollees.

(b) Exclusions of Prisoners and Welfare Beneficiaries from Computation of the 50/50 Rule—At least fifty percent of the enrollment in a HMO or similar organization which contracts with Medicare on a risk basis must consist of other than Medicare and Medicaid beneficiaries.

(c) Disclosure of AAPCC Assumptions and Methodology—The Secretary is required to annually determine, and announce in a manner intended to provide notice to interested parties, a per

capita rate of payment for each class of beneficiaries enrolled with an HMO or similar organization on a risk basis. The per capita rate of payment must equal ninety-five percent of the adjusted average per capita cost (AAPCC) of providing Medicare services in a geographic area on a fee-for-service basis.

(d) Making Permanent Authority for Benefit Stabilization Fund—Each HMO must develop an adjusted community rate (ACR), an estimate of what it would charge a private member comparable to a Medicare beneficiary for the scope of services covered under its Medicare contract. If an HMO's ACR is lower than its average projected Medicare payment, the HMO must use the difference to fund supplemental benefits or accept a reduced capitation rate.

Alternatively, the HMO may request that a portion of the difference be deposited in a benefit stabilization fund (within the Part A and Part B Trust Funds). The fund may be drawn upon in a future year if the difference between the ACR and the Medicare capitation rate is insufficient to continue financing the HMO's package of supplemental benefits. A stabilization fund may not be established for any contract period more than six years after the enactment of the Deficit Reduction Act of 1984, or July 18, 1990.

Proposal

(a) Regulation of Incentive Payments to Physicians—The Secretary would be required to identify physician compensation arrangements which in his judgment may place individual physicians at excessive risk or liability and which may lead to the withholding or limiting of medically necessary services or to compromising enrollee access to services. In identifying such arrangements the Secretary would be required to consult with representatives of organizations with risk contracts under section 1876 and similar organizations. The Secretary would be required to publish descriptions of potentially high-risk compensation arrangements in the Federal Register within twelve months after the date of enactment. The Secretary would be authorized to collect such information as may be necessary to enforce this provision.

The Secretary could not approve a risk contract with an organization under section 1876 unless the organization certified to the Secretary that either the organization did not use any potentially high-risk physician compensation arrangements as identified by the Secretary; or, the organization provided information satisfactory to the Secretary describing in detail the physician compensation arrangements employed by the organization and the mechanisms employed by the organization to limit risk to the individual physician, including such mechanisms as stop-loss protection catastrophic insurance, and quality-assurance programs to allow the Secretary to assess whether such arrangements pose an excessive risk.

These requirements would apply to contracts between the organization and subcontractors, as well.

If the Secretary found that an organization 1) employed a high-risk physician compensation arrangement after certifying that it did not; 2) substantially changed a high-risk arrangement without submitting the required information to the Secretary or, 3) em-

ployed any arrangement which provided a direct and specific individual payment to a physician as an inducement to withhold or limit a specific medically necessary service to an identifiable patient, the organization would be subject to civil monetary penalties of up to $100,000 per each determination by the Secretary and intermediate sanctions, including suspending enrollments and suspending payments.

The Committee is concerned that PROs are not receiving needed discharge abstract information from the UB '82 uniform bill related to Medicare beneficiaries enrolled in HMOs and other organizations. In the Committee's view, HMOs and other organizations have a responsibility to insure that the PROs receive this information; therefore, the Committee would urge the Secretary to adopt a policy requiring HMOs to assure the submission of such discharge information as a condition of contracting with Medicare.

(b) Exclusions of Prisoners and Welfare Beneficiaries from Computation of the 50/50 Rule—Prisoners in a local or State prison or jail and persons for whom a local or State government purchases health benefits as part of a general welfare assistance program could not be counted as non-Medicare or Medicaid enrollees for purposes of meeting the fifty percent requirement.

(c) Disclosure of AAPCC Assumptions and Methodology—The Secretary would be required to disclose the methodology and assumptions used to determine the national per capita cost (USPCC) and adjusted average per capita costs (AAPCC) forty-five days prior to his announcement of the per capita rates. This provision is intended to provide adequate notice in order to allow for review and comment by affected organizations regarding the assumptions and methodology and the resulting USPCC and AAPCCs.

(d) Benefit Stabilization Fund—The authority to establish a benefit stabilization fund would be made permanent.

Effective Date

Paragraph (a) is effective for contracts entered into or changed after April 1, 1991. Paragraphs (b), (c), and (d) are effective upon enactment.

23. Physician Ownership of, and Referral to, Health Care Entities (Sec. 10157 of the Bill)

Current Law

Criminal penalties are provided for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce business reimbursed under the Medicare or State health care programs. The offense is classified as a felony and is punishable by fines of up to $25,000 and imprisonment for up to five years. Remuneration includes kickbacks, bribes, rebates, and any other payment made directly or indirectly, overtly or covertly, or in cash or in kind. Prohibited conduct includes not only remuneration intended to induce referrals of patients, but remuneration also intended to induce the purchasing, leasing, ordering, or arranging for any good, facility, service, or item paid by Medicare or State health care programs.

With respect to home health services, a physician who has a significant ownership interest in, or a significant financial or contractual relationship with, a home health agency may not certify regarding a patient's need for home health services.

The Medicare and Medicaid Patient and Program Protection Act of 1987 provided authority to the Inspector General to exclude a person or entity from participation in the Medicare and State health care programs if it is determined that the party is engaged in a prohibited remuneration scheme. The Act required the promulgation of regulations specifying those payment practices that will not be subject to criminal prosecution—so-called "safe harbors."

The Medicare Catastrophic Coverage Act of 1988 prohibited a home IV therapy provider from providing services to a Medicare beneficiary based on a referral from a physician who has an ownership interest in, or receives compensation from, the provider. The prohibition also applies to ownership or compensation arrangements involving an immediate family member of the referring physician. The referring physician is defined as the physician who prescribes the home intravenous (IV) drug therapy or establishes the plan of care for such therapy.

Several exceptions to this rule are provided: 1) ownership of publicly-traded stock purchased on terms available to the general public; 2) sole community rural home IV therapy providers; 3) compensation reasonably related to items or services actually provided by the physician which does not vary in proportion to the number of referrals made; 4) physicians whose only relationship with the provider is as an uncompensated officer or director of the provider; and 5) other exceptions established by the Secretary in regulation, for ownership or compensation arrangements which the Secretary determines do not pose a substantial risk of program abuse. Payment is denied for services provided pursuant to a prohibited referral. The home IV provider is also prohibited from billing for such services on an unassigned basis. A physician who knowingly and willfully makes a prohibited referral or a provider who knowingly and willfully accepts such a referral would be subject to civil monetary penalties of up to $15,000 for each such referral and/or exclusion from the Medicare program.

Proposal

(a) Prohibition of Certain Financial Arrangements Between Referring Physicians and Providers of Certain Medicare Covered Items and Services—In general a physician would be prohibited from referring a patient for a Medicare-covered service to a provider if the physician (or an immediate family member) had 1) an ownership or investment interest in the provider, or 2) other compensation arrangements with the provider. Providers would be prohibited from submitting any bills or claims for reimbursement for services provided pursuant to a prohibited referral. Ownership or investment interest would be through equity, debt, or other means.

(b) General Exceptions to Both Ownership and Compensation Arrangements—The restrictions on financial relationships between physicians and providers only apply in the case of referrals made by referring physicians. Services which would not be considered to

be a referral include: 1) services provided personally by or under the direct personal supervision of the physician or another physician in the same group practice; 2) services of a physicians assistant, a certified nurse midwife, or a psychologist provided by a practitioner who is employed by the referring physician, the physician's group practice, or another physician in the physician's group practice; or 3) services provided by a prepaid plan with a contract under sections 1876 or 1833 or a prepaid demonstration project.

The following types of consultations by certain specialists would not be considered to be referrals by a referring physician for this purpose: 1) a request by a radiologist for diagnostic imaging services; 2) a request by a physician specializing in the provision of radiation therapy services for such services; 3) a request by a pathologist for diagnostic clinical laboratory services; and 4) a request by a nephrologist for renal dialysis items and services.

The prescription of a drug by a physician would constitute a referral, but only if the physician directed the patient to a specific pharmacy, home intravenous drug therapy provider, or other entity dispensing a drug. A referral by a physician to a specialized cancer treatment pharmacy would not be considered to be a referral by a referring physician.

An exception would be provided for in-office ancillary services. The exception would apply if: 1) the services are personally provided by the physician or his or her employee under direct supervision or by a member of the same group practice; 2) were provided in a building in which the physician, or members of the same group, provide physician services; and, 3) were billed by the physician performing or supervising the services, or by a physician in the same group.

The Committee would note that the referral of a patient from a satellite office of a group to another office providing ancillary services would be excepted as long as any physician services were provided by the group in the building to which the patient was referred. The Committee intends that services in a building physically connected to the building housing the practice, or in the case of services provided by a mobile unit, immediately adjacent to the building housing the practice, would also be excepted under this provision.

In addition home IV drug therapy services would not be covered by this provision as physicians are already prohibited from referring for these services if they have an ownership interest under the provisions of section 1834(b)(3) enacted as part of the Medicare Catastrophic Coverage Act of 1988.

The Secretary could provide for other general exceptions if he found that other financial relationships did not pose a risk of program abuse.

(c) General Exception Related Only to Ownership of Publicly-traded Securities—An exception would be provided for investment in the publicly-traded securities of large corporations. To qualify for the exception, 1) the securities must be traded on the New York Stock Exchange, the American Exchange, or the NASDQ national market system; 2) the corporation must have had assets in excess of $100 million at the close of the most recent fiscal year, and 3) the physician must have purchased the securities on terms general-

ly available to the public. The exception would apply to ownership of shares, bonds, debentures, notes, and other investment securities.

(d) Additional Exceptions Related Only to Ownership or Investment Prohibition and Subject to Reporting and Disclosure—The following types of providers would not be considered to be an ownership or investment interest if the reporting and disclosure requirements described below were met:

1) disproportionate share hospitals with a disproportionate patient percentage greater than thirty-two (as defined for purposes of the prospective payment system under section 1886) and hospitals in Puerto Rico;

2) a hospital in which a physician has an ownership interest if: i) the physician had admitting privileges at the hospital, ii) the ownership interest is in the hospital as a whole, iii) the hospital as a whole is using the uniform cost reporting system developed by the Secretary under OBRA '87;

3) entities which were substantially in operation prior to March 1, 1989. Substantially in operation is defined as an entity which was: i) actually providing services; ii) had signed binding contracts for buildings or equipment needed to operate; or, iii) had received a certificate of need from a State authority designated to provide such certificates under State law. Prohibited compensation arrangements are not eligible for an exemption under this provision. These entities could not add any new referring physician investors (or their family members) after March 1, 1989.

The exception provided for entities in operation prior to March 1, 1989 would be only for the service or services or class of items which the facility was providing as of March 1, 1989. If a facility began providing a new service or class of items after that date, that service or those items would not be excepted under this provision. If the entity wanted to allow physicians with a financial relationship to refer to the entity for the new service or items, it would have to seek a case-by-case exception from the Secretary.

All entities excepted under this provision would be required to provide information regarding the ownership arrangements employed by the entity to the Secretary, including services provided, the names and all of the Medicare provider numbers of the referring physician investors, and any other information required by the Secretary to determine that the entity was not in violation of applicable law. The Secretary could require periodic reports from such entities in order to assess their continuing compliance with the law and could require an initial report from a new entity before operations commenced or within a specified period of time, such as thirty days after operations commenced. Physician investors referring to a facility excepted under this provision in which they had an ownership interest would be required to disclose their ownership to patients in a form and manner determined by the Secretary.

(e) Additional Exceptions Related Only to Ownership or Investment Prohibition and Subject to Reporting and Disclosure and Investment Standards—The following types of providers would not be considered to be an ownership or investment interest if the reporting and disclosure requirements which entities described in (d)

would be required to meet, as described above, and certain investment standards described below, were met:

1) any rural provider (as defined under section 1886(d);

2) an ambulatory surgery center (ASC) for services performed personally by the referring physician;

3) a facility providing lithotripsy services for services performed personally by the referring physician;

4) items or services provided by hospital joint ventures in which the hospital is the majority owner, the physician is authorized to perform services at the hospital, and the hospital reports its cost data for the venture and the hospital as a whole using the uniform cost reporting system developed by the Secretary under OBRA '87.

These entities would be required to meet the following investment standards:

1) Investment in the venture must be open to, and offered on terms no different than those offered to, investors other than investors in a position to make or to influence referrals or business to the entity;

2) The terms on which an investment interest is offered to an investor who is in a position to make or to influence referrals of business to the entity is not related to the previous or expected volume of referrals of business from that investor to the entity;

3) The investment must be bona fide (i.e., the investor must bear the full risk of loss that is related to his investment);

4) The capital investment of each referring physician investor must be paid in full by the referring physician at the time of investment. Such capital investment may not be borrowed from the entity or any entity related, directly or indirectly, to the entity;

5) The amount of payment in return for the investment interest is directly proportional to the amount of the capital investment of the referring physician investor;

6) The return on investment must be reasonable (taking into account both current return and increase in the value of the enterprise) in light of the amount invested, the risk of loss of that investment, and returns from investments in entities providing similar health services generally available to persons not in a position to make referrals or investments in other non health-related start-up ventures;

7) There is no requirement that the investor make or be in a position to make referrals of business to the entity as a condition for the person to continue as an investor;

8) Investors in the entity may not be encouraged, covertly or overtly, to order services or otherwise refer business to the entity, and the entity neither collects nor maintains information on the volume of referrals from investors other than information maintained in order to comply with applicable law including quality assurance requirements, and

9) The facility must disclose to patients the relevant charges for items and services provided by the entity and the professional qualifications of the entity to provide the services for which the patients are referred.

The Secretary would be authorized to withdraw the exception of an entity covered by this provision if he found that: 1) the entity had failed to disclose any circumstance causing the entity to be out

of compliance with an investment standard; 2) the entity had failed to disclose periodically information related to compliance with the investment standards; or 3) the entity was not in compliance with one of the standards. The Secretary's decision to withdraw an exception under this provision would be final and not subject to judicial review.

The Committee intends that the exemptions authorized under this provision for hospitals and hospital joint ventures in no way alters (or reflects on) the scope and application of the anti-kickback provisions in section 1128B of the Social Security Act.

The Committee does not intend that this provision should be construed as affecting, or in any way interfering, with the efforts of the Inspector General to enforce current law, such as cases described in the recent Fraud Alert issued by the Inspector General.

The Committee expects that if the Inspector General finds cases in which remuneration is being paid, directly or indirectly, covertly or overtly, for the purpose of inducing referrals to hospitals or hospital joint ventures, the Inspector General will take all necessary steps to enforce the law.

(f) Additional Case-by-Case Exceptions Related Only to Ownership or Investment Prohibition—Any entity with a business arrangement not otherwise excepted under this section would be able to apply to the Secretary for an exemption prior to entering into such an arrangement if the reporting and disclosure requirements which entities described in (d) and (e) would be required to meet, as described above, and the investment standards which entities described in (e) above were required to meet, were met and at least one of the following access, cost, or availability conditions were also met by the entity:

1) the services or items provided by a physician-owned entity would otherwise be unavailable to patients of the community which the entity would serve;

2) the items or services would be more convenient for patients (as defined by the Secretary in regulation based upon a reduction in travel time to the service for seventy-five percent of the patients of the service by thirty minutes or more, taking such factors as seasonal weather conditions into account); or

3) the items or services would be provided at a substantially lower per unit charge and at a substantially lower cost overall to the Medicare program than any similar service in the area served by the entity.

The Secretary's decision whether to approve an entity's application for an exception would be committed to agency discretion, and would not be reviewable. Only the Secretary or a party that is being sanctioned under this provision could introduce into evidence any written communication between the Secretary and that party related to its own exemption application. Any other written communication related to any other exemption application could not be introduced into evidence in any administrative or judicial proceeding.

An entity which received an exemption would be required to disclose to the Secretary any circumstance which would cause the arrangements to be out of compliance with any one of the standards which was the subject of the entity's approval. The Secretary

would be authorized to specify the form and manner of such disclosure, and could require the periodic submission of reports pertaining to the eligibility of any entity that previously received an approval. The Secretary, based on information received from the entity or from any other source, could revoke an entity's exemption approval if he determined that the entity no longer met any one of the conditions or standards which was the subject of the entity's approval. This decision would be committed to agency discretion and would not be reviewable. The Secretary would be authorized to charge an entity for the reasonable costs of processing an exemption application. Such fees would be dedicated to the office delegated with the responsibility of reviewing exemption waivers.

(g) Exceptions Relating to Other Compensation Arrangements—Exceptions would also be provided for certain other compensation arrangements. Rental of office space would be excluded based on several tests: 1) there would have to be a written lease agreement signed by the parties specifying the space to be covered by the lease; 2) the space would have to be dedicated for the exclusive use of the lessee; 3) the term of the agreement would have to be for at least one year; 4) the rent would have to be consistent with fair market value and aggregate payments may not vary directly or indirectly based on the volume or value of any referrals between the parties; 5) the arrangement would have to be pursuant to an agreement that would be considered to be commercially reasonable even if no referrals were made between the parties; and 6) the arrangement would have to comply with any other requirements the Secretary may establish by regulation to protect against program or patient abuse.

An exception would apply to employment and service arrangements involving referring physicians and hospitals. Physicians could be employed by hospitals or could provide administrative (or other services) under contract to the hospital. Conversely, hospitals could provide administrative or other support services to physicians. To qualify for the exception, the employment or service arrangement would: 1) have to be for identifiable services; 2) the amount of remuneration provided would have to be consistent with fair market value and could not be determined in a manner that took into account directly or indirectly the volume or value of any referrals made by the physician; 3) the arrangement would have to be pursuant to an agreement that would be considered to be commercially reasonable even if no referrals were made to the hospital, and 4) the arrangement met such other requirements as the Secretary imposed by regulation to protect against program or patient abuse. Compensation arrangements involving physician members of a group practice who are salaried by the group would also be excepted from the general rules on compensation arrangements.

An exception would permit non-hospital providers to employ (or contract with) referring physicians for specific identifiable administrative and medical services in three situations described below. Employment of a referring physician would not otherwise be permitted. Additionally, in each case, the employment arrangement would also be required to comply with requirements (2)–(4) of the paragraph above.

The three situations are: 1) a medical director of the provider pursuant to a requirement under Title XVIII of the Social Security Act that the provider have a medical director; 2) direct patient care services provided to a hospice patient pursuant to a contract with the hospice; and 3) non-hospital providers employing referring physicians to provide general administrative services in certain limited situations.

An exception would be made for physician recruitment by a hospital to induce a physician to relocate to an area if the physician is not required to refer patients to the hospital and the remuneration is not conditioned on referrals and meets such other requirements as the Secretary may prescribe.

An exception would be made for isolated transactions, such as a one-time sale of real or personal property. To qualify for an exception, the transaction would be required to comply with requirements (2)-(4) of the paragraph describing fair market value and reasonable compensation above.

The Committee intends that any prohibition, exemption, or exception authorized under this provision in no way alters (or reflects on) the scope and application of the anti-kickback provisions in section 1128B of the Social Security Act.

The Committee does not intend that this provision should be construed as affecting, or in any way interfering, with the efforts of the Inspector General to enforce current law, such as cases described in the recent Fraud Alert issued by the Inspector General.

In particular, entities which would be eligible for a specific exception or an exception due to having been substantially in operation prior to March 1, 1989 would be subject to all of the provisions of current law.

(h) Sanctions—Medicare payment would be denied for any item or service provided pursuant to a prohibited referral. A person who receives any payment from a Medicare beneficiary (including any coinsurance or deductible payments or any payment for an unassigned claim) for a service provided pursuant to a prohibited referral would be required to make a prompt refund to the beneficiary. Any physician who makes a referral that the physician knows or should have known is prohibited would be subject to civil money penalties and exclusion from the Medicare program if a claim or bill is submitted pursuant to such a referral. The provider submitting the bill or claim would be subject to the same penalties if the provider knew or should have known that the bill or claim was for a service provided pursuant to a prohibited referral. The civil money penalty would be up to $15,000 for each item or service provided pursuant to a prohibited referral plus an amount equal to twice the amount billed for the item or service. Circumvention schemes would be prohibited subject to civil money penalties of up to $100,000 and exclusion from the Medicare program.

Any person who knows or should know that a disclosure of any circumstances is required to be made to the Secretary regarding compliance with a circumstance or standard pursuant to which an exemption was granted by the Secretary and who fails to disclose, or causes the failure of such disclosure, is subject to civil monetary penalties of up to $10,000 per day for which disclosure is required to have been made, and to the extent such circumstances when

known to the Secretary results in his revocation of his approval of an exemption, such revocation is retroactive to the date disclosure was required to have been made, with payment not allowed from the effective date of revocation.

(i) Definitions—A "compensation arrangement" is any arrangement involving any remuneration between a physician (or immediate family member) and a provider. The term "remuneration" would include any remuneration, directly or indirectly, overtly or covertly, in cash or in kind, but would not include payment related to return on equity or return of equity to investors, including interested investors.

The term "employee" includes an individual who would be considered to be an employee under the usual common law rules applicable in determining the employer-employee relationship. The term "fair market value" means the value in arms length transactions, consistent with general market value without taking into account any additional value that might accrue as a result of the potential for referrals.

For purposes of this provision a group practice would be defined as: 1) a group of two or more physicians organized as a partnership, professional corporation, foundation, not-for-profit corporation, faculty practice plan, or similar association; 2) in which each physician who is a member of the group provides substantially the full range of services which the physician routinely provides through the joint use of shared office space, facilities, equipment, and personnel; 3) for which substantially all of the services of the physicians who are members of the group are provided through the group and are billed in the name of the group and amounts received are treated as receipts of the group; 4) in which the overhead expenses of and income from the practice are distributed in accordance with methods previously determined by members of the group, and 5) which meets such other standards as the Secretary may impose by regulation. In the case of a faculty practice plan associated with a teaching hospital in which physician members may provide a variety of different speciality services and provide professional services both within and outside the group, as well as performing other tasks such as research, the services provided within the group would be excepted from this provision.

The Secretary would be required to publish final regulations within 180 days after enactment.

The GAO would be directed to study the ownership of hospitals by referring physicians and joint ventures between hospitals and referring physicians and report to the Congress by May 15, 1990. The study would investigate: 1) the types of business arrangements; 2) the types of services offered; 3) the returns generally earned by physician investors; 4) the effect on hospital admissions overall and in communities served by physician-owned hospitals; 5) the effect on other hospitals in communities served by physician-owned hospitals; 6) the effect on utilization of services by Medicare beneficiaries; and 7) the effect on Medicare expenditures.

The Committee wishes to make clear that if the report by the GAO finds that referring physician ownership of hospitals or ownership interest by referring physicians in hospital joint ventures leads to inappropriate use of services or inappropriately alters ad-

mission or utilization patterns in favor of hospitals or services in which physicians have an ownership interest, it would be the Committee's intent to consider legislation banning referrals to hospitals or hospital joint ventures at the earliest possible date. Investors in such hospitals or ventures should take this possibility into account prior to investing in such arrangements.

Effective Date

Effective for referrals made on or after 180 days after the date of enactment, except that the effective date would be two years after the date of enactment in the case of compensation arrangements that were entered into and became legally binding before March 1, 1989.

24. Miscellaneous and Technical Provisions Relating to Parts A and B

Current Law

(a) Peer Review of Non-Physician Services—Peer Review Organizations (PRO) are entities composed of a substantial number of doctors of medicine and osteopathy who are representative of the practicing physicians in the area. These organizations review the quality and appropriateness of care provided to Medicare beneficiaries.

(b) Provider and Practitioner Right to Reconsideration of PRO Determination Before Notice to Beneficiary—PROs review the quality and appropriateness of care provided to Medicare beneficiaries. In reviewing care PROs may identify care that is either inappropriate or of substandard quality. After making such a finding, the PRO issues a preliminary notice to the provider or physician that care was inappropriate or of substandard quality. The PRO may issue a formal notification after the provider or practitioner has been provided an opportunity for discussion and review of the preliminary notification. The formal notification is also then sent to fiscal intermediaries, carriers and the patient, and payment for the service is denied. The patient and provider have sixty days to request reconsideration of the formal denial. If reconsideration is requested, the PRO must complete such reconsideration within thirty working days.

(c) Determining Eligibility of Home Health Agencies for Waiver of Liability for Denied Claims—Home health service providers may be protected from retroactive Medicare coverage denials through a provision establishing a waiver of liability. Such protection is granted to providers who have a favorable presumptive status. Favorable presumptive status is calculated based on a comparison of the number of home health visits for which claims are submitted for Medicare payment in a calendar quarter compared to the number of visits for which payment is denied. Where the calculated rate is 2.5 percent or less, favorable status is awarded.

(d) Extension of Authority to Contract With Fiscal Intermediaries and Contractors On Other Than A Cost Basis—The Secretary contracts with fiscal intermediaries and carriers to pay claims for benefits under Part A and Part B, respectively, of Medicare. Under authority included in the Deficit Reduction Act of 1984, the Secretary is authorized to terminate up to two fiscal intermediary and

two carrier contracts per year for cause and to replace those contractors with contracts in which reimbursement is on other than a cost basis.

(e) Expansion of Rural Health Medical Education Demonstration Project—OBRA '87 authorized four rural health medical education demonstration projects in which a sponsoring teaching hospital would place residents in a rural hospital. The costs associated with the residents are reimbursed through the sponsoring teaching hospital through payments for direct medical education.

(f) Cancer Center Treatment Demonstration Project and Study—No provision.

(g) Extension and Clarification of Prohibition on Cost Savings Policy Before Beginning of Fiscal Year—OBRA '87 prohibited the Secretary from issuing any regulation which affects the current services baseline for Medicare by more than $50 million prior to October 15, 1989, unless required by law.

(h) Long-term Care Study—No provision.

(i) Recognition of Costs of Certain Hospital-based Nursing Schools—The Technical and Miscellaneous Revenue Act of 1988 (TAMRA) required the Secretary to establish one joint undergraduate nursing education program and to include reasonable costs of education under the program as allowable costs under Medicare. These costs would include salaries, supervision, and classroom costs. The TAMRA provision was not to be construed as affecting generally the proper treatment of such expenses.

(j) Inner-City Hospital Triage Demonstration Project—No provision.

(k) GAO study of Home Health Agency Paperwork Requirements—No provision.

(l) GAO study of Administrative Costs of Medicare Program—No provision.

(m) GAO study of Long Term Care Insurance Standards—No provision.

Proposal

(a) Peer Review of Non-Physician Services—PROs would be required to have established procedures for involving professionals who are not doctors of medicine in the review of services provided within their professions.

(b) Provider and Practitioner Right to Reconsideration of PRO Determination Before Notice to Beneficiary—In the case of quality denials, PROs would be required to provide the physician or provider a reconsideration of the formal notification before notice is sent to patients, carriers or fiscal intermediaries. Such reconsiderations would not affect the right of a beneficiary to such reconsideration after receiving the formal notification. If a provider or practitioner is provided such reconsideration, it would be in lieu of any other reconsideration that would otherwise be made.

(c) Determining Eligibility of Home Health Agencies for Waiver of Liability for Denied Claims—For purposes of the presumptive waiver calculation, denials would not be treated as denied until either the home health agency fails to request reconsideration of the initial denial within the current sixty day period allowed for reconsideration, or the fiscal intermediary issues a decision on re-

consideration. The Secretary would be required to monitor the proportion of denied claims for which reconsideration was requested and to report to the Congress if the proportion of reconsidered denials is substantially increased.

(d) Extension of Authority to Contract With Fiscal Intermediaries and Contractors On Other Than A Cost Basis—The Secretary's authority under DEFRA would be extended for an additional four years with two modifications. The period of time during which fiscal intermediary and carrier performance would be measured would be defined as two years. In addition the Secretary would be authorized to enter into additional contracts on other than a cost basis if the contractor and the Secretary reached mutual agreement to do so. The Secretary could not condition contract renewal on a contractor so agreeing.

(e) Expansion of Rural Health Medical Education Demonstration Project—The number of sites under the demonstration would be increased from four to ten.

(f) Cancer Center Treatment Demonstration Project and Study—Cancer center treatment demonstration projects would be authorized in two cancer center hospitals. Under the demonstration reimbursement would be authorized for experimental treatment under research protocols which: 1) were registered, where appropriate, with the National Cancer Institute; 2) involved only drugs approved by the Food and Drug Administration for clinical trials, if experimental drugs were involved in the protocol; and 3) were approved by the hospital's patient protection committee. The Secretary would be required to designate the two demonstration project cancer center hospitals within one year of enactment.

The OTA would be directed to conduct a study of the appropriateness of Medicare reimbursement for experimental treatment under research protocols, including the costs of such reimbursement, whether reimbursement for experimental treatment under research protocols should be limited to the cancer center hospitals, and what controls should be placed on such reimbursement if it were to be authorized. As a condition of designation under the demonstration project, the two selected cancer center hospitals would be required to share data and other information as necessary with OTA. The study would be required to be completed by June 1, 1992.

(g) Extension and Clarification of Prohibition on Cost Savings Policies before Beginning of Fiscal Year—The current prohibition of issuance of regulations by the Secretary which affect the baseline by more than $50 million prior to October 15, 1989, unless required by law, would be extended and clarified. The Secretary would be required to propose any change in Medicare payments which would affect the baseline by more than $50 million in a notice of proposed rulemaking issued prior to May 15 of each year. The Secretary could not propose any change which affected the baseline by more than $50 million after that date. Unless specifically required by law, the Secretary could not issue a final notice regarding such proposed changes prior to October 15 of each year. The amendment would sunset on September 30, 1993.

(h) Long-term Care Study—HHS would contract with the National Academy of Sciences' Institute of Medicine (IOM) to conduct a

study to examine experiences of existing public and private long-term care programs and demonstration projects. The study would identify new benefits, programs, or payment methodologies and areas of knowledge that could be used to develop and provide long term care benefits for Medicare beneficiaries. The study would also address the extent to which Medicare coverage of new benefits would meet the needs of Medicare beneficiaries.

The programs and demonstrations to be reviewed by the IOM would include continuing care retirement communities, Medicaid waiver programs, Older Americans Act programs, Medicare demonstrations programs and other innovative public or privately financed long term care programs.

The IOM study would examine financing, coverage, and administrative issues related to long term care programs. The study would address the adequacy of personnel available to provide services. It would also evaluate the effectiveness with which public and private long term care programs: 1) recruit, train and retain personnel; 2) use functional status and disability measures to entitle beneficiaries to various levels of coverage, and 3) take into account the presence of family support and other informal caregivers.

The IOM would examine how new long term care benefits for Medicare beneficiaries could be designed to compliment programs already in place. The study would also identify areas where information important to successful implementation of a long term care benefit program under Medicare is either incomplete or unavailable.

The IOM study should make recommendations and report to the Congress no later than twenty-four months after the IOM signs a contract with HHS. The Secretary would be required to enter into appropriate arrangements to conduct the study no later than sixty days after enactment.

(i) Recognition of Costs of Certain Hospital-based Nursing Schools—Hospital-based Nursing Schools—The costs incurred by a hospital in training students of a hospital-based nursing school would be considered allowable costs if, prior to June 15, 1989, and thereafter, the hospital incurred substantial costs in training students and operating the school, the nursing school and the hospital share some common board members, and all instruction is provided at the hospital or in the immediate proximity of the hospital. The provision of TAMRA relating to hospital-based nursing schools would be made effective for cost reporting periods beginning in fiscal year 1986.

(j) Inner-City Hospital Triage Demonstration Project—The Secretary would be authorized to establish one project in an inner-city public hospital which has already established a triage effort. Highland General Hospital in Alameda County, California has established such an effort and the Committee intends that Alameda County should develop this project. Under the demonstration, the Secretary would be authorized to define as reasonable cost and pay on a cost pass-through basis, up to $500,000 per year in additional cost, the following: the cost of medical, nursing, and management personnel providing trauma and emergency services to patients who might otherwise be denied care through the triage system, as

well as the costs of operating the triage system, and the costs of training hospital personnel in its operation.

(k) GAO study of Home Health Agency Paperwork Requirements—The GAO would study the costs and justification for the current administrative requirements on Medicare certified home health agencies. The GAO study would also review the feasibility of eliminating the requirements for dual reporting to Medicare and Medicaid. The GAO would submit its report to the Committee by May 1, 1990.

(l) GAO study of Administrative Costs of Medicare Program—The GAO would be directed to conduct a review of the administrative burden of Medicare regulations and program requirements on providers of services, fiscal intermediaries, and carriers. The review would include an assessment of current administrative costs and trends in such costs since 1982 and a comparison of such costs to similar costs incurred in complying with the requirements of private health insurance programs. The report would be due to the Congress March 31, 1990.

(m) GAO study of Long Term Care Insurance Standards—The GAO would be directed to review standards that may be used by states to regulate private long term care insurance with respect to inflation protection, non-forfeiture benefits, and other consumer protection provisions and report to the Committee April 1, 1990.

The Committee intends that: 1) standards for inflation protection and non-forfeiture benefits are important considerations for consumer protection; 2) the National Association of Insurance Commissioners (NAIC) should act to address these considerations; 3) NAIC action with regard to these considerations would be preferable to Federal legislation; and 4) these issues should be addressed by State regulators.

Effective Date

Paragraph (a) is effective for contracts entered into after the date of enactment. Paragraph (b) shall apply to determinations by PROs with preliminary notifications made more than thirty days after enactment. Paragraph (c) is effective for quarters beginning on or after the date of enactment. Paragraph (d) is effective October 1, 1989. Paragraphs (e), (g), (h), (j), (k), (l), and (m) are effective upon enactment. Paragraph (i) is effective for cost reporting periods beginning on or after the date of enactment. Paragraph (f) is effective January 1, 1990.

Part D—Medicare Part B Basic Premium

25. Part B Premium (Sec. 10171 of the Bill)

Current Law

Part B is a voluntary program financed by premiums paid by aged, disabled and chronic renal disease enrollees, and by general revenues of the Federal government. The premium rate is derived annually based partly upon the projected costs of the program for the coming year. Under prior law, the premium rate was changed on July 1 of each year. The Social Security Amendments of 1983 moved the premium increase to January 1 of each year to coincide

with the changed date for the annual Social Security cash benefit cost-of-living adjustment (COLA).

Ordinarily, the premium rate is the lower of (1) an amount sufficient to cover one-half of the costs of the program for the aged, or (2) the current premium amount increased by the percentage by which cash benefits were increased under the COLA provisions of the Social Security program.

Low-income beneficiaries are protected from the full effect of premium increases by two provisions. First, premium increases are constrained to prevent social security benefits, from which the premiums are deducted, from declining in absolute amount. Second, the Medicare Catastrophic Coverage Act provided for Medicaid payment of premiums for individuals below the poverty line.

From 1984 through 1989, the premium was set at twenty-five percent of program costs for beneficiaries. The remaining seventy-five percent was covered by general revenues. In 1990, under current law, the premium increases would be calculated as they were prior to 1984.

In calendar year 1989, the basic Part B premium is $27.90. Beneficiaries are also liable for the catastrophic flat monthly premium which is $4.00 in 1989.

Proposal

The basic Part B premium would be set at twenty-five percent of program costs for calendar year 1990.

Effective Date

January 1, 1990.

Part E—Extension of COBRA Continuation Coverage for Disabled Employees

26. Extension of COBRA Continuation Coverage for Disabled Employees (Sec. 10181 of the Bill)

Current Law

Under Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), employers with twenty or more employees are required to provide certain employees and their families the option of purchasing continued health insurance coverage in the case of certain events. These events include: termination or reduction in hours of employment, death, divorce or legal separation, eligibility for Medicare, or the end of a child's dependency under a parent's health insurance policy. The maximum period of continuation coverage that may be elected is thirty-six months except in the case of termination of employment or reduction of hours for which the maximum period is eighteen months. COBRA allows the employer to charge the employee 102 percent of the premium cost for the continued health insurance.

Proposal

Individuals who obtain health insurance coverage under the COBRA provisions and are disabled under Title II of the Social Security Act could be eligible to extend the continuation period from

eighteen months to twenty-nine months. The premium for the eleven additional months would be set at 150 percent of the average cost of coverage for the employer rather than the 102 percent rate set for the initial eighteen months.

Effective Date

Date of enactment.

Appendix A, Subtitle B of Title X (Ways and Means)

LIST OF OVERPRICED PROCEDURES:

Code	Description	Percent difference
27125	Revise hip with prosthesis	−17
27126	Revise hip with prosthesis	−15
27127	Revise hip with prosthesis	−17
27130	Total hip joint replacement	−17
27134	Revise hip joint replacement	−19
27137	Revise hip joint component	−16
28292	Correction of bunion	−20
28296	Correction of bunion	−19
28297	Correction of bunion	−16
28299	Correction of bunion	−16
29870	Knee arthroscopy	−26
29871	Knee arthroscopy/drainage	−26
29872	Knee arthroscopy/drainage	−28
29874	Knee arthroscopy/surgery	−32
29875	Knee arthroscopy/surgery	−25
29876	Knee arthroscopy/surgery	−32
29877	Knee arthroscopy/surgery	−32
29879	Knee arthroscopy/surgery	−33
29880	Knee arthroscopy/surgery	−37
29881	Knee arthroscopy/surgery	−28
29882	Knee arthroscopy/surgery	−31
29884	Knee arthroscopy/surgery	−28
29886	Knee arthroscopy/surgery	−32
29887	Knee arthroscopy/surgery	−31
29889	Knee arthroscopy/surgery	−22
31000	Irrigation/maxillary sinus	−19
31001	Irrigation/maxillary sinuses	−20
31002	Irrigation/sphenoid sinus	−16
31020	Exploration maxillary sinus	−18
31021	Exploration of sinuses	−23
31030	Exploration Maxillary sinus	−25
31031	Exploration of sinuses	−26
31032	Explore sinus, remove polyps	−22
31033	Enter sinuses, remove polyps	−23
33206	Insertion of heart pacemaker	−35
33207	Insertion of heart pacemaker	−36
33208	Insertion of heart pacemaker	−35
33210	Insertion of heart electrode	−39
33212	Insertion of pulse generator	−33
33216	Revision implanted electrode	−38
33218	Repair pacemaker electrodes	−38
33219	Repair of pacemaker	−37
33232	Removal of pacemaker	−33
33405	Replacement of aortic valve	−23
33510	Coronary artery bypass	−28
33511	Coronary arteries bypass	−28
33512	Coronary arteries bypass	−29
33513	Coronary arteries bypass	−29
33514	Coronary arteries bypass	−29
33516	Coronary arteries bypass	−33

LIST OF OVERPRICED PROCEDURES:—Continued

Code	Description	Percent difference
35045	Repair defective arm artery	−15
35081	Repair defect of artery	−18
35082	Repair artery rupture: aorta	−19
35091	Repair defect of artery	−18
35102	Repair defect of artery	−16
35103	Repair artery rupture, groin	−18
35112	Repair artery rupture, spleen	−20
35122	Repair artery rupture, belly	−21
35132	Repair artery rupture, groin	−15
35141	Repair defect of artery	−16
35161	Repair defect of artery	−15
35301	Rechanneling of artery	−26
35311	Rechanneling of artery	−26
35321	Rechanneling of artery	−21
35331	Rechanneling of artery	−21
35341	Rechanneling of artery	−20
35351	Rechanneling of artery	−22
35355	Rechanneling of artery	−23
35361	Rechanneling of artery	−24
35363	Rechanneling of artery	−24
35371	Rechanneling of artery	−26
35372	Rechanneling of artery	−26
35381	Rechanneling of artery	−22
44950	Appendectomy	−20
44960	Appendectomy	−18
45378	Diagnostic colonoscopy	−28
45379	Colonoscopy	−23
45380	Colonoscopy and biopsy	−28
45382	Colonoscopy, control bleeding	−24
45383	Colonoscopy, lesion removal	−25
45385	Colonoscopy, lesion removal	−29
47600	Removal of gall bladder	−20
47605	Removal of gall bladder	−21
47610	Removal of gall bladder	−19
47620	Removal of gall bladder	−19
49500	Repair inguinal hernia	−22
49505	Repair inguinal hernia	−29
49510	Repair hernia, remove testis	−29
49515	Repair inguinal hernia	−23
49520	Repair inguinal hernia	−29
49525	Repair inguinal hernia	−27
49530	Repair incarcerated hernia	−28
49535	Repair strangulated hernia	−21
49540	Repair lumbar hernia	−23
49550	Repair femoral hernia	−28
49552	Repair femoral hernia	−20
49555	Repair femoral hernia	−23
49560	Repair abdominal hernia	−29
49565	Repair abdominal hernia	−29
49570	Repair epigastric hernia	−22
49575	Repair epigastric hernia	−20
49580	Repair umbilical hernia	−22
49581	Repair umbilical hernia	−29
49590	Repair abdominal hernia	−24
50590	Fragmenting of kidney stone	−16
52500	Revision of bladder neck	−16
52601	Prostatectomy (TUR)	−17
52630	Remove prostate regrowth	−16
52640	Relieve bladder constructure	−18
52650	Prostatectomy	−25
58150	Total hysterectomy	−21
58152	Total hysterectomy	−21

LIST OF OVERPRICED PROCEDURES:—Continued

Code	Description	Percent difference
58200	Extensive hysterectomy	−20
58210	Extensive hysterectomy	−17
58260	Vaginal hysterectomy	−23
58265	Hysterectomy and vagina repair	−21
58267	Hysterectomy and vagina repair	−24
58270	Hysterectomy and vagina repair	−21
58280	Hysterectomy, revise vagina	−18
58285	Extensive hysterectomy	−20
63001	Removal of spinal lamina	−15
63005	Removal of spinal lamina	−16
63010	Removal of spinal lamina	−20
63015	Removal of spinal lamina	−17
63016	Removal of spinal lamina	−16
63017	Removal of spinal lamina	−15
64716	Revision of cranial nerve	−30
64718	Revise ulnar nerve at elbow	−27
64719	Revise ulnar nerve at wrist	−27
64721	Revise median nerve at wrist	−28
65850	Incision of eye	−24
65855	Laser surgery of eye	−24
66840	Removal of lens material	−15
66920	Extraction of lens	−18
66983	Remove cataract, insert lens	−19
66984	Remove cataract, insert lens	−19
66985	Insert lens prosthesis	−16
67107	Repair detached retina	−17
67108	Repair detached retina	−17
67208	Treatment retinal lesion	−21
67210	Treatment retinal lesion	−23
67218	Treatment retinal lesion	−16
67227	Treatment retinal lesion	−20
67228	Treatment retinal lesion	−22
92265	Eye muscle evaluation	−32
92270	Electro—oculography	−33
92275	Electroretinography	−35
92280	Special eye evaluation	−35
92283	Color vision examination	−31
92284	Dark adaption eye exam	−35
92285	Eye photography	−34
92286	Internal eye photography	−33
92287	Internal eye photography	−38
93000	Electrocardiogram, complete	−27
93005	Electrocardiogram, tracing	−24
93010	Electrocardiogram report	−27
93012	Transmission of ECG	−27
93014	Report of transmitted ECG	−22
93015	Cardiovascular stress test	−27
93017	Cardiovascular stress test	−23
93018	Cardiovascular stress test	−29
93024	Cardiac drug stress test	−19
93040	Rythym ECG with report	−21
93041	Rythym ECG, tracing	−18
93045	Special ECG	−26
93501	Right heart catheterization	−31
93503	Right heart catheterization	−31
93505	Biopsy of heart lining	−26
93510	Left heart catheterization	−33
93511	Left heart catheterization	−27
93524	Left heart catheterization	−21
93526	Right and left heart catheterization	−26
93527	Right and left heart catheterization	−26

LIST OF OVERPRICED PROCEDURES:—Continued

Code	Description	Percent difference
93528	Right and left heart catheterization	−29

Number of codes: 174.

LIST OF GEOGRAPHIC PRACTICE COSTS ADJUSTMENT FACTORS

Carrier-locality code	Name	Overhead only
51005	Birmingham, AL	0.903
51004	Mobile, AL	0.900
51002	North Central AL	0.862
51001	Northwest AL	0.864
51006	Rural AL	0.848
51003	Southeast AL	0.862
102001	Alaska	1.229
103005	Flagstaff (city), AZ	0.953
103001	Phoenix (city), AZ	1.045
103007	Prescott (city), AZ	0.953
103099	Rural Arizona	0.981
103002	Tuscon (city), AZ	1.022
103008	Yuma (city), AZ	0.953
52013	Arkansas	0.789
205026	Anaheim-Santa Ana, CA	1.234
54214	Bakersfield, CA	1.089
54211	Fresno/Madera, CA	1.054
54213	Kings/Tulare, CA	1.046
205018	Los Angeles, CA (1st of 8)	1.218
205019	Los Angeles, CA (2nd of 8)	1.218
205020	Los Angeles, CA (3rd of 8)	1.218
205021	Los Angeles, CA (4th of 8)	1.218
205022	Los Angeles, CA (5th of 8)	1.218
205023	Los Angeles, CA (6th of 8)	1.218
205024	Los Angeles, CA (7th of 8)	1.218
205025	Los Angeles, CA (8th of 8)	1.218
54203	Marin/Napa/Solano, CA	1.21[illegible]
54210	Merced/surrounding counties, CA	1.05[illegible]
54212	Monterey/Santa Cruz, CA	1.14[illegible]
54201	N. Coastal counties, CA	1.10[illegible]
54202	NE rural CA	1.03[illegible]
54207	Oakland-Berkeley, CA	1.27[illegible]
54227	Riverside, CA	1.116
54204	Sacramento/surrounding counties, CA	1.14[illegible]
54215	San Bernadino/E. Central CA	1.1[illegible]
205028	San Diego/Imperial, CA	1.12[illegible]
54205	San Francisco, CA	1.311
54206	San Mateo, CA	1.311
205016	Santa Barbara, CA	1.110
54209	Santa Clara, CA	1.294
54208	Stockton/surrounding counties, CA	1.070
205017	Ventura, CA	1.161
55001	Colorado	0.951
307004	Eastern Connecticut	1.054
307001	NW and N. Central Connecticut	1.066
307003	South Central Connecticut	1.113
307002	SW Connecticut	1.151
57001	Delaware	0.975
58001	DC plus MD/VA suburbs	1.138
59003	Fort Lauderdale, FL	1.030
59004	Miami, FL	1.100
59002	N/NC Florida cities	0.954

LIST OF GEOGRAPHIC PRACTICE COSTS ADJUSTMENT FACTORS—Continued

Carrier-locality code	Name	Overhead only
59001	Rural Florida	0.900
1311001	Atlanta, GA	0.990
1311004	Rural Georgia	0.830
1311002	Small GA cities 02	0.878
1311003	Small GA cities 03	0.851
112001	Hawaii	1.086
513000	Idaho Statewide	0.927
513012	North Idaho	0.913
513011	South Idaho	0.940
62110	Champagne-Urbana, IL	0.947
62116	Chicago, IL	1.195
62103	De Kalb, IL	0.951
62111	Decatur, IL	0.953
62112	East St. Louis, IL	1.008
62106	Kankakee, IL	0.951
62108	Normal, IL	0.989
62101	Northwest, IL	0.926
62105	Peoria, IL	1.044
62107	Quincy, IL	0.926
62104	Rock Island, IL	0.943
62102	Rockford, IL	1.060
62113	Southeast IL	0.926
62114	Southern IL	0.926
62109	Springfield, IL	0.987
62115	Suburban Chicago, IL	1.132
63001	Metropolitan Indiana	0.913
63003	Rural Indiana	0.851
63002	Urban Indiana	0.859
64005	Des Moines (Polk/Warren), IA	0.929
64008	Iowa City (city limits), IA	0.930
64003	Northcentral Iowa	0.886
64002	Northeast Iowa	0.887
64006	Northwest Iowa	0.862
64004	S. Central IA (excluding Des Moine)	0.855
64001	SE Iowa (excluding Iowa City)	0.897
64007	Southwest Iowa	0.865
74005	Kansas City, KA	0.990
65001	Rural Kansas	0.879
74004	Suburban Kansas City, KA	0.990
66001	Lexington and Louisville, KY	0.886
66003	Rural Kentucky	0.851
66002	Sm Cities (city limits) KY	0.875
52807	Alexandria, LA	0.879
52803	Baton Rouge, LA	0.947
52806	Lafayette, LA	0.913
52804	Lake Charles, LA	0.895
52805	Monroe, LA	0.871
52801	New Orleans, LA	1.025
52850	Rural Louisiana	0.877
52802	Shreveport, LA	0.924
2120002	Central Maine	0.880
2120001	Northern Maine	0.889
2120003	Southern Maine	0.948
69001	Baltimore/surrounding counties, MD	1.032
69003	South plus Eastern Shore, MD	0.990
69002	Western Maryland	0.996
70002	Massachusetts suburbs/rural (cities)	1.046
70001	Massachusetts urban	1.098
71001	Detroit, MI	1.170
71002	Michigan, not Detroit	1.006
72000	Minnesota carrierwide	0.920
72002	Northern Minnesota	0.898

LIST OF GEOGRAPHIC PRACTICE COSTS ADJUSTMENT FACTORS—Continued

Carrier-locality code	Name	Overhead only
72004	Southern Minnesota	0.883
1024001	St. Paul Minneapolis, MN	0.990
1025001	Rural Mississippi	0.814
1025002	Urban MS (city limits)	0.871
74003	KC (Jackson County), MO	0.990
74002	NKC (Clay/Platte), MO	0.990
1126003	Rural (excluding rural NW), MO	0.889
74006	Rural NW counties, MO	0.904
1126002	SW. E. cities plus Jefferson County), MO	0.955
74001	St. Joseph, MO	0.906
1126001	St. Louis/large eastern cities, MO	1.015
75101	Montana	0.901
64500	Nebraska	0.801
64501	Omaha plus Lincoln, NE	0.869
64504	Rural Nebraska	0.800
64503	Urban (county population 25,000), NE	0.813
129003	Elko and Ely (cities), NV	1.041
129001	Las Vegas, et al. (cities), NV	1.090
129002	Reno et al. (cities), NV	1.142
129099	Rural Nevada	1.087
78040	New Hampshire	0.961
1331002	Middle New Jersey	1.098
1331001	Northern New Jersey	1.134
1331003	Southern New Jersey	1.084
532001	New Mexico	0.906
80101	Buffalo/surrounding counties, NY	0.945
80301	Manhattan, NY	1.330
80103	N. Central cities, NY	0.953
80302	NYC suburbs/Long Island, NY	1.318
80303	Poughkipsie/N. NYC suburbs	1.043
1433004	Queens, NY	1.330
80102	Rochester/surrounding counties, NY	1.011
80104	Rural New York	0.939
1334095	Rural North Carolina	0.821
1334094	Urban (city limits) NC	0.859
1334000	North Carolina carrierwide	0.827
82001	North Dakota	0.870
1636001	Akron, OH	0.941
1636002	Cincinnati, OH	0.952
1636003	Cleveland, OH	0.953
1636004	Columbus, OH	0.952
1636005	Dayton, OH	0.934
1636009	E. Central (Steubenville), OH	0.914
1636007	Mansfield, OH	0.908
1636013	Marion plus surrounding counties, OH	0.913
1636006	Northwest (Lima) OH	0.920
1636014	Scioto Valley, OH	0.934
1636015	Southeast (Ohio Valley) OH	0.902
1636008	Springfield, OH	0.938
1636012	W. Central (Lake Plains), OH	0.408
1636011	Youngstown, OH	0.935
137001	OK City, et al. (cities), OK	0.907
137099	Rural Oklahoma	0.833
137004	Small cities (Northern), OK	0.830
137003	Small cities (Southern), OK	0.823
137002	Tulsa, et al. (cities), OK	0.900
138002	Eugene, et al. (cities), OR	1.002
138001	Portland, et al. (cities), OR	1.023
138099	Rural Oregon	0.991
138003	Salem, et al. (cities), OR	0.986
138012	SW OR. cities (city limits)	0.983
86502	Large Pennsylvania cities	1.045

LIST OF GEOGRAPHIC PRACTICE COSTS ADJUSTMENT FACTORS—Continued

Carrier-locality code	Name	Overhead only
86501	Philly/Pittsburgh Medical Schools/Hospitals	1.070
86504	Rural Pennsylvania	0.934
86503	Small Pennsylvania cities	0.942
87001	Rhode Island	0.966
88001	South Carolina	0.822
82002	South Dakota	0.836
544035	Tennessee	0.836
90029	Abilene, TX	0.833
90026	Amarillo, TX	0.852
90031	Austin, TX	0.911
90020	Beaumont, TX	0.900
90009	Brazoria, TX	0.900
90010	Brownsville, TX	0.842
90024	Corpus Christi, TX	0.891
90011	Dallas, TX	0.914
90012	Denton, TX	0.914
90014	El Paso, TX	0.847
90028	Fort Worth, TX	0.883
90015	Galveston, TX	0.912
90016	Grayson, TX	0.854
90018	Houston, TX	0.942
90033	Laredo, TX	0.813
90017	Longview, TX	0.878
90021	Lubbock, TX	0.835
90019	McAllen, TX	0.828
90023	Midland, TX	0.938
90002	Northeast Rural Texas	0.833
90013	Odessa, TX	0.914
90025	Orange, TX	0.900
90030	San Angelo,TX	0.854
90007	San Antonio, TX	0.817
90003	Southeast rural Texas	0.845
90006	Temple, TX	0.840
90008	Texarkana, TX	0.837
90027	Tyler, TX	0.879
90032	Victoria, TX	0.916
90022	Waco, TX	0.826
90004	Western Rural Texas	0.803
90034	Wichita Falls, TX	0.849
91001	Utah	0.926
78050	Vermont	0.891
1049001	Richmond plus Charlottesville, VA	0.893
1049004	Rural Virginia	0.843
1049003	Small town/industrial VA	0.849
1049002	Tidewater plus N. VA counties	0.959
93004	E. Central plus (excluding Spokane)	0.989
93002	Seattle (King County), WA	1.051
93003	Spokane plus Richland (cities), WA	1.006
93001	W plus SEWA (excluding Seattle)	1.001
1651016	Charlestown, WV	0.929
1651018	Eastern Valley, WV	0.961
1651019	Ohio River Valley, WV	0.858
1651020	Southern Valley, WV	0.853
1651017	Wheeling, WV	0.880
95113	Central Wisconsin	0.857
95140	Green Bay, WI (Northeast)	0.879
95154	Janesville, WI (S-Central)	0.872
95119	Lacrosse, WI (W-Central)	0.889
95115	Madison, WI (Dane County)	0.937
95146	Milwaukee suburbs, WI (SE)	0.962
95104	Milwaukee, WI	0.964
95112	Northwest Wisconsin	0.868

LIST OF GEOGRAPHIC PRACTICE COSTS ADJUSTMENT FACTORS—Continued

Carrier-locality code	Name	Overhead only
95160	Oshkosk, WI (E-Central)	0.878
95114	Southwest Wisconsin	0.857
95136	Wausau, WI (N-Central)	0.866
553002	Wyoming	0.902

Part F—Revisions to the Medicare Catastrophic Coverage Act of 1988

Current

(a) The Medicare Supplemental Premium—The supplemental Medicare premium generally is payable in a year by any individual who is eligible for Part A of Medicare for at least 6 months during the year (except for those who pay the Part A premium) and who has Federal adjusted income tax liability for the year of at least $150. Subject to a limit on the amount of supplemental premium payable by an individual, the annual premium is determined by multiplying (1) the supplemental premium rate by (2) the amount determined by dividing the individual's adjusted income tax liability by $150.

The supplemental premium rate, which is the sum of the castrophic coverage and prescription drug premium rates, is $22.50 in 1989, $37.50 in 1990, $39.00 in 1991, $40.50 in 1992, and $42.00 in 1993. The maximum annual supplemental premium per Part A eligible individual shall not exceed $800 in 1989, $850 in 1990, $900 in 1991, $950, in 1992, and $1,050 in 1993. After 1993, the supplemental premium rate and annual maximum are determined by a formula that is intended to maintain reserves for the financing of the program and is intended for the supplemental premium to provide 63 percent of program financing (with the remaining 37 percent coming from the flat premium).

Married individuals who both are eligible for Part A benefits are treated as a single individual for purposes of the supplemental premium, except that the maximum limit on the supplemental premium is doubled (e.g., $1,600 for 1989). If only one spouse is Medicare-eligible, income tax liability is determined as one-half of the tax liability of the joint return. In the case of married individuals filing separate returns, the individual is treated as Medicare-eligible for purposes of the supplemental premium if either the individual or the individual's spouse is so eligible. In addition, the maximum supplemental premium is twice the supplemental premium if, without regard to the rule in the preceding sentence, both spouses are Medicare-eligible.

(b) Enrollment for Part B and Catastrophic Part B and Prescription Drug Benefits—The supplemental medical insurance benefits (Part B) program is voluntary for eligible individuals who elect to enroll or are automatically enrolled in the program. Persons entitled to hospital insurance benefits (Part A) are automatically enrolled and covered by supplementary medical insurance benefits,

unless they indicate they do not want to be enrolled for such coverage.

In the case of the relatively small number of people who are not automatically enrolled, the eligible individual must file a written request for enrollment, signed by the individual or on the individual's behalf, during an open enrollment period.

Individuals enrolled in Medicare Part B are liable for the flat catastrophic monthly premium in addition to the basic Part B premium. Low income beneficiaries are protected against the full effect of premium payments because under current law, States are required to phase in buy-in coverage of Medicare premiums and cost-sharing charges for poor Medicare beneficiaries with incomes below the poverty line.

(c) Information to Beneficiaries Regarding Voluntary Option—No provision.

(d) Penalties for Delayed Enrollment—Individuals who do not enroll in the supplementary medical insurance program within a year of the close of their initial enrollment period are required to pay an increased premium. Individuals who drop out of the program and re-enroll later are, in most cases, required to pay an increased premium. For such individuals, the monthly premium otherwise applicable is increased by ten percent for each full twelve-month period in which the individual could have been, but was not enrolled.

(e) Individuals Covered under An Employer Group Health Plan—Individuals with primary health coverage under an employer group health plan are not required to enroll during the same enrollment period applicable to others in order to avoid payment for duplicative benefits. For these individuals and their spouses, the special enrollment period begins with the first day of the first month in which the individual is no longer enrolled in an employer group health plan and ends seven months later.

(f) Adjustments in Basic Part B Premium—Part B is a voluntary program financed by premiums paid by aged, disabled and chronic renal disease enrollees, and by general revenues of the Federal government. The basic premuim rate is derived annually based partly upon the projected cost of the program for the coming year. Under prior law, the premium rate was changed on July 1 of each year. The Social Security Admendments of 1983 moved the premium increase to January 1 of each year to coincide with the changed date for the annual Social Security cash benefit cost-of-living adjustment (COLA).

Under current law, the Part B program (with the exception of catastrophic benefits) is financed jointly through beneficiary premiums and general revenues. Generally, the annual percentage increase in the Part B premium cannot exceed the percentage by which cash benefits were increased under the COLA provisions of the Social Security program. For the period 1984–1989, the Congress approved a series of amendments which set the premium equal to twenty-five percent of basic Part B program costs for the aged. Section 10161 of this bill extends this provision through 1990.

Low-income beneficiaries are protected against the full effect of premium increases by two provisions. First, premium increases are constrained by the hold harmless provision that prevents Social Se-

curity benefits, from which the premiums are deducted, from declining in absolute amount. Second, the Medicare Catastrophic Coverage Act requires States to phase-in coverage of Medicare premiums and cost-sharing charges for Medicare beneficiaries living below the Federal poverty line.

(g) Increase in Medicare Flat Monthly Premium—Under the Medicare Catastrophic Coverage Act, an additional flat monthly Part B premium finances approximately thirty-seven percent of catastrophic benefits. The calculation of this premium is completely separate from the calculation of the basic Part B premium. The addition to the basic premium was set in statute through 1993: $4.00 in 1989; $4.90 in 1990; $7.40 in 1991; $9.20 in 1992, and $10.20 in 1993.

(h) Monthly Premiums for Residents of U.S. Commonwealths and Territories—For months in 1989, the catastrophic coverage monthly premium is $1.30 for a resident of Puerto Rico and $2.10 for a resident of another U.S. commonwealth or territory. For months in 1990, the catastrophic coverage monthly premium is $3.56 for a resident of Puerto Rico and $5.78 for a resident of another U.S. commonwealth or territory.

For months in 1990, the prescription drug premium is $0.14 for a resident of Puerto Rico and $0.22 for a resident of another U.S. commonwealth or territory. For months in 1991, the prescription drug monthly premium is $1.21 for a resident of Puerto Rico and $1.93 for a resident of another U.S. commonwealth or territory.

(i) Increase in Catastrophic Drug Deductible Amount—Payments under the new catastrophic prescription drug program will be made after the beneficiary has incurred expenses for covered outpatient drugs in a year equal to a pre-determined drug deductible. The deductible is set at $550 in 1990, $600 in 1991 and $652 in 1992. In future years, the Secretary is required to set the deductible amount so that approximately 16.8 percent of beneficiaries will reach the deductible in any given year.

(j) Temporary Delay in Medicare Payments—No provision.

(k) Federal Hospital Insurance Catastrophic Coverage Reserve Fund—Specified amounts received by the general fund of the Treasury that are attributable to the new supplemental catastrophic coverage premiums are appropriated to the Federal Hospital Insurance Catastrophic Coverage Reserve Fund. The appropriation is equal to 100 percent of the HI outlays attributable to the new catastrophic benefits.

No expenditures from the Reserve Fund are permitted. Monies equal to 100 percent of HI outlays attributable to the new benefits are held in the Fund. However, actual payments for the benefits are made from the HI Fund.

(l) Premiums Deposited in Federal Supplementary Medical Insurance Trust Fund (SMI)—Receipts attributable to the supplemental catastrophic coverage premium, which are not otherwise appropriated to the Reserve Fund, are appropriated to SMI. The catastrophic coverage monthly premium is transferred to the SMI Trust Fund.

(m) Transfer of Premiums to Federal Catastrophic Drug Insurance Trust Fund—Receipts attributable to the supplemental prescription drug premium rate and the prescription drug monthly

premium are appropriated to the CDI trust fund. The Secretary of HHS shall transfer premiums attributable to the prescription drug monthly premium directly to the CDI trust fund rather than through the SMI trust fund.

(n) The Medicare Catastrophic Coverage Account—The Medicare Catastrophic Coverage Account was established on the books of the Treasury of the United States. The primary purpose of the accounts was to assure that revenues from premiums are at least as large as the outlays from the Part A and B trust funds attributable to new catastrophic coverage benefits.

No funds are transferred into or out of this Account.

(o) Conforming amendments—No provision.

Proposal

(a) The Supplemental Medicare Premium—The supplemental premium rate per $150 of adjusted Federal income tax liability would be reduced to $11.25 in taxable years beginning in 1989, $18.75 in 1990, $19.50 in 1991, $20.25 in 1992 and $21.00 in 1993 and years thereafter.

The supplemental medicare premium would apply to an individual for a taxable year if the individual is Medicare-covered for more than 6 full months beginning in the taxable year and the individual's adjusted income tax liability is at least $150 in such year.

In general, an individual would be Medicare-covered for any month if the individual would be entitled to Medicare Part B benefits for that month. For purposes of the supplemental premium, an individual who had been entitled to Medicare Part B benefits for some month after December 1989 and who elects to disenroll for reasons other than coverage under certain employer group health plans would still be considered a Medicare-covered individual.

A transition rule would provide that any individual who disenrolled from Part B during the one-time disenrollment option period or before January 1990 would not be considered a Medicare-covered individual. Thus, such an individual would not be liable for the supplemental premium for taxable years beginning in 1989. If such individual later re-enrolls in Part B, the individual would become Medicare-covered at the time of re-enrollment and therefore may be subject to the supplemental premium, possibly at the higher penalty rate for delayed enrollment.

(b) Enrollment for Part B and Catastrophic Part B and Prescription Drug Benefits—Coverage under the Medicare catastrophic coverage program would be voluntary. Physician and outpatient services currently covered by Part B, and the Part B catastrophic and prescription drug catastrophic coverage would be optional as a package. Thus, beneficiaries who choose to decline catastrophic coverage would also decline basic Part B protection.

In general, beneficiaries would be enrolled in current Part B coverage and Part B and prescription drug catastrophic coverage unless they specifically decline coverage.

Beneficiaries would have a one-time only option of declining participation in Medicare Part B coverage and Part B and prescription drug catastrophic coverage. Beneficiaries could choose to re-enroll for Medicare Part B and Part B and prescription drug catastrophic

coverage subsequent to the disenrollment period, however, significant penalties would be imposed.

Current enrollees would be given the option to disenroll during the period beginning October 1, 1989 and ending December 31, 1989. New beneficiaries would choose whether or not to decline enrollment for Part B and the catastrophic coverage benefits at the time of their initial enrollment period. All beneficiaries would be provided an opportunity to decline coverage during a designated period.

Individuals eligible for Part A but not enrolled in Part B as of October 1, 1989 would be given the opportunity to enroll for Medicare Part B and catastrophic coverage benefits during the period beginning October 1, 1989 and ending December 31, 1989. If these individuals decline enrollment during this period and subsequently elect to enroll in Medicare Part B and catastrophic coverage benefits, they would be subject to a penalty in addition to the supplemental premium.

Part A catastrophic benefits, as added by P.L. 100-360, would become part of the basic Part A program. Individuals who elect to disenroll from Medicare Part B and catastrophic coverage would, if otherwise eligible, remain entitled to hospital insurance benefits (Part A).

(c) Information to Beneficiaries Regarding Voluntary Option—The Health Care Financing Administration (HCFA) would provide all beneficiaries information on the option to decline coverage. The package of information would include the following:

(1) A general description of the Medicare program and catastrophic coverage benefits;

(2) The subsidy value of optional benefits (current year and multi-year subsidy values);

(3) An analysis of alternative private insurance coverage costs;

(4) An explanation of payment penalties for individuals who choose to disenroll and subsequently buy back into Part B and catastrophic coverage benefits, and

(5) a request form for a disenrollment application.

HCFA would provide disenrollment applications to beneficiaries upon request. The disenrollment application would include: an explanation of one-year and multi-year subsidies; the cost of alternative private insurance coverage; an explanation of payment penalties; a disenrollment form that requires the beneficiary's signature.

In the case of married beneficiaries, each would be required to make his or her own decision regarding disenrollment. Each individual who wishes to disenroll must sign a separate form. For couples in which one spouse declines coverage, appropriate adjustments would be made in the supplemental premium rates for those filing joint returns.

HCFA would provide a hotline to respond to questions from Medicare beneficiaries.

(d) Penalties for Delayed Enrollment—The current penalty for delayed enrollment in the supplemental medical insurance benefits (Part B) program would be retained and would apply to the entire Part B premium.

In addition, the supplemental premium rate and annual maximum amount would be increased fifteen percent for those individuals who disenroll during the designated disenrollment period or who waive enrollment during an initial enrollment period and subsequently enroll for Medicare Part B benefits. An exception from this rule is provided for those individuals whose disenrollment or waiver from enrollment was by reason of coverage under certain employer group health plans. For joint and married filing separate returns, the supplemental premium rate and annual maximum amount are increased appropriately to reflect the delayed enrollment of one or both of the married individuals.

(e) Individuals Covered Under An Employer Group Health Plan—Individuals entitled to Medicare part B who are currently employed and covered under a group health plan could apply on a year-to-year basis to be exempt from Part B and catastrophic coverage benefits and premiums. These beneficiaries and their spouses would have the option to decline enrollment in Part B and catastrophic Part B and prescription drug coverage after termination of employment providing primary health coverage during a special enrollment period. If they do not exercise their option to enroll during this period and subsequently enroll for Part B and catastrophic Part B and prescription drug coverage, they would be subject to the supplemental premium and penalty.

(f) Adjustments in Part B Premium—The basic Part B premium would be set at twenty-five percent of the costs of the basic Part B program for calendar years 1991 through 1993. The amount of increase attributable to the twenty-five rule that exceeds the amount of increase otherwise allowed under current law would not be matched by general revenues.

The hold harmless and buy-in provisions would be retained.

(g) Increase in Medicare Flat Monthly Premium—The flat monthly Part B premium would be increased for calendar years 1990 through 1993. The premium would be increased by $3.50 in 1990, $4.00 in 1991, $4.10 in 1992 and $4.10 in 1993. This portion of the Part B premium as well as the previously enacted catastrophic coverage monthly premium would become a part of the basic part B premium and would increase at the rate of the COLA for 1994 and subsequent years.

(h) Monthly Premiums for Residents of U.S. Commonwealths and Territories—In the case of an individual who is a resident of Puerto Rico, the increase in the flat monthly premium would be $1.30 for months in 1989, $3.26 in 1990, $6.13 in 1991, $7.42 in 1992 and $7.98 in 1993. In subsequent years, the additional amount would increase at the rate of the COLA.

In the case of an individual who is a resident of a U.S. commonwealth or territory (other than Puerto Rico), the monthly premium would be increased by $2.10 for months in 1989, $5.26 for months in 1990, $9.90 in 1991, $11.99 for months in 1992 and $12.90 in 1993. In subsequent years, the amount would be increased by the rate of the COLA.

(i) Increase in Catastrophic Drug Deductible Amount—The prescription drug deductible would be increased from $600 to $800 in 1991 and from $652 to $950 in 1992. The prescription drug deducti-

ble would, as provided by current law, be set by the Secretary to cover 16.8 percent of beneficiaries in 1993 and in subsequent years.

The General Accounting Office (GAO) would report each year by July 1 on the accuracy of the Secretary's calculation of the proposed deductible.

(j) Temporary Delay in Medicare Payments—Payments of Medicare claims to all providers would be delayed by five days at the end of fiscal year 1990, six days at the end of fiscal year 1991, three days at the end of fiscal year 1992 and one day at the end of fiscal year 1993.

The delayed payments would be made on October 1 of the following fiscal year.

(k) Federal Hospital Insurance Catastrophic Coverage Reserve Fund—The Federal Hospital Insurance Catastrophic Coverage Reserve Fund would be eliminated.

(l) Premiums Deposited in Federal Supplemental Medical Insurance Trust Fund—Revenues from the Medicare catastrophic monthly premium, the ad hoc monthly premium, the increase in basic part B premium for 1991, 1992 and 1993 and the supplemental premium would be deposited in the SMI trust fund. Any funds in the Reserve Fund before the date of its repeal would be transferred to the SMI trust fund.

(m) Transfer of Premiums to Federal Catastrophic Drug Insurance Trust Fund—The Managing Trustee would transfer funds from the SMI to the CDI trust fund sufficient to cover prescription drug expenditures for calendar years 1990 through 1993. The Managing Trustee would transfer an amount sufficient to assure end year balances of 150 percent of expenditures in 1990, 100 percent of expenditures in 1991, 70 percent of expenditures in 1992 and 50 percent at the end of calendar year 1993.

Beginning in 1994, the Managing Trustee would transfer to the CDI trust fund amounts from the supplemental and catastrophic coverage monthly premiums according to the following formula. The amount of funds attributable to the monthly premium transferred from the SMI trust fund to the CDI trust fund in 1994 would be the product of (i) 1993 prescription drug expenditures, multiplied by (ii) the proportion of total 1993 collectable revenues (supplemental premium and catastrophic coverage monthly premium) attributable to the catastrophic coverage monthly premium, increased by the Secretary's estimate of the percentage by which outlays in years subsequent to 1993 for prescription drugs exceed outlays for prescription drugs in 1993.

The amount of funds attributable to the supplemental premium appropriated to the CDI trust fund in 1994 would be the product of (i) 1993 prescription drug expenditures, multiplied by (ii) the proportion of total 1993 collectable revenues (supplemental premium and catastrophic coverage monthly premium) attributable to the supplemental premium, increased by the Secretary's estimate of the percentage by which aggregate supplemental Medicare premiums for taxable years subsequent to 1993 exceed premiums imposed for 1993.

(n) The Medicare Catastrophic Coverage Account—The Secretary would report each year through 1993 on the balance between the revenues and receipts and the costs of benefits. This report would

be submitted with the Trustees Report on the Part B trust fund and would be due on April 1 of each year.

The Account would be credited for receipts of SMI attributable to the supplemental premium, the catastrophic coverage monthly premium including the ad hoc premium and the amount of increase from the basic part B premium attributable to the 25 percent rule for 1991, 1992 and 1993. The Account would be debited for funds transferred from the SMI trust fund to the CDI trust fund and for catastrophic coverage outlays other than outlays for catastrophic prescription drugs and related administrative costs.

The GAO would review the Secretary's Report and comment within sixty days.

(o) Conforming Amendments—Additional necessary conforming revisions would be made to the provisions of the Medicare Catastrophic Coverage Act.

Effective Date

All paragraphs are effective upon enactment.

Subtitle C. Human Resources Amendments

I. CHILDREN'S INITIATIVE

A. Social Services

1. Increase Funding for the Title XX Social Services Block Grant (section 10201)

Current Law

Under Title XX of the Social Security Act States are entitled to receive social services block grant funds. These funds must be used to provide services directed at achieving five national goals: preventing or reducing dependency; achieving self-sufficiency; preventing or remedying neglect, abuse or exploitation of children and adults; preventing or reducing inappropriate institutional care; and providing services or referrals to individuals in institutions.

Title XX is a capped entitlement; funds are currently limited to $2.7 billion annually.

Proposal

To provide additional resources for social services, the entitlement ceiling for the Title XX social services block grant would be increased by $200 million in fiscal year 1991, $400 million in fiscal year 1992, and $600 million in fiscal year 1993 and thereafter. No part of these funds would be earmarked.

Effective Date

On enactment.

B. Foster Care and Child Welfare Amendments

1. Increase in Child Welfare Authorization (section 10211)

Current Law

Title IV-B of the Social Security Act authorizes the appropriation of Federal funds for child welfare services. These funds can be used for preventing or remedying neglect and abuse, preventing the separation of children from their families, reunifying families, placing children for adoption, and assuring adequate care for children in out-of-home placements. The authorization level for the Title IV-B child welfare services program is $266 million per fiscal year.

Under the Title IV-B program, if total Federal appropriations exceed $141 million in any fiscal year, a State may receive its portion of the funds in excess of $141 million only if it has met the requirements for foster care protections outlined in section 427(a). In addition, if appropriations equal or exceed $266 million for 2 consecutive years, a State may receive its share of appropriations in excess of the 1979 funding level ($56.5 million) only if it has met the requirements for foster care protections outlined in section 427(b).

Proposal

Permanently increase the authorization level of the Title IV-B child welfare services program from $266 million to $400 million. Increase the Title IV-B appropriations level at which, if equaled or exceeded for two consecutive years, a State must meet the requirements of section 427(b) in order to receive its share of the Federal appropriation for Title IV-B in excess of the 1979 funding level.

Effective Date

October 1, 1989.

2. Extension of Authority to Transfer Foster Care Funds (section 10212)

Current Law

Mandatory State-by-State ceilings are placed on foster care funds if the Federal appropriation for child welfare services reaches a specified trigger level, currently $266 million. In the absence of a mandatory foster care ceiling, States may elect to operate under a voluntary ceiling. A State may use one of several methods to calculate the most favorable ceiling.

The ceiling is intended to create financial incentives for States to reduce unnecessary placement or extended placement in foster care. Whenever a mandatory ceiling is in effect, a State may, having met certain requirements intended to protect children in foster care, transfer all of its unused foster care funds to its child welfare services program. (Any funds within the ceiling amount not expended by the State for foster care are considered unused foster care funds.) Under a voluntary ceiling, a State may transfer a portion of its unused foster care funds. However, the amount transferred, together with the State's IV-B allocation, may not

exceed what the State would have received if the child welfare services appropriation had triggered the ceiling (i.e., currently $266 million).

The foster care ceilings and the authority to transfer foster care funds to child welfare services expire September 30, 1989.

Proposal

Extend the foster care ceilings and the authority to transfer foster care funds to child welfare services for three years, through September 30, 1992.

Permanently increase the Title IV-B child welfare services appropriations level at which a mandatory foster care ceiling is triggered from $266 million to $400 million.

Effective Date

October 1, 1989.

3. Requirement for State Report to Courts on Preventive Services (section 10213)

Current Law

Public Law 96-272, the Adoption Assistance and Child Welfare Amendments of 1980, contained several court-related provisions requiring that, as a precondition for State receipt of certain Federal funds, courts take specific steps in legal proceedings involving children.

Among other court-related provisions, States may not make foster care maintenance payments with respect to a child, except in the case of a voluntary arrangement, unless there is a judicial determination that continuation in the home would be detrimental to the welfare of the child, and that reasonable efforts have been made to prevent or eliminate the need for removal of the child from his or her home.

In the case of any child removed pursuant to a voluntary agreement, Federal payments may not be made for a period in excess of 180 days, unless there has been a judicial determination that the placement is in the best interests of the child. The status of every Title IV-E foster child must be reviewed at least every six months by either a court or by administrative review to determine the continuing appropriateness of the placement and the extent of progress made toward alleviating or mitigating the causes necessitating placement in foster care.

Additionally, in order to certify compliance with the requirements of section 427, a State must, among other requirements, review the status of every foster child under the care of the State at least every six months by either court or administrative review and, no later than eighteen months after the original placement, and periodically thereafter, each child must be assured a dispositional hearing in a court of competent jurisdiction or by an administrative body appointed by the court to determine the future status of the child and whether certain procedural safeguards should be applied.

Currently, State child welfare agencies are not required to provide information to the courts, in order to assist them in carrying

out their child welfare services functions (in particular, determining whether reasonable efforts have been made to prevent or eliminate the need for removal of a child from the home), on preventive placement and other services available in the State designed to prevent or eliminate the need for removal of a child from the home, or, subsequent to removal, alleviate or mitigate the causes necessitating placement in foster care.

Proposal

Effective beginning fiscal year 1990, require that the State child welfare agency compile on an annual basis a detailed report which specifies which preplacement preventive and reunification programs and services are operating and available to children and families in need in the State.

The report would include the following information: the name of the program and the administering agency or organization, the monthly number of persons the program is capable of serving, a description of program services, a description of eligibility for the services, and the location of services, as of August of the fiscal year.

The information in the report would be arranged geographically to correspond with the relevant court jurisdictions. Require that by October 1 of the following fiscal year, a copy of the report must be provided to all judges and other judicial administrators, and all State agencies, involved in child protective services, and to the HHS Secretary. Require that the HHS Secretary publish an annual summary of the State reports by January 1.

Effective Date

October 1, 1989.

4. Increase Federal Reimbursement for Foster and Adoptive Parent Training (section 10214)

Current Law

Federal matching funds for administrative expenditures for foster care and adoption assistance under Title IV–E are available at the rate of 50 percent. Current HHS regulations specify that foster and adoptive parents and staff of licensed or approved child care institutions providing foster care under Title IV–E are eligible for short-term training at the initiation of or during their provision of care, and that certain of the costs associated with such training (travel and per diem) may be reimbursed as administrative costs under Title IV-E.

Proposal

Effective beginning fiscal year 1990, allow Federal reimbursement for foster and adoptive parent training under Title IV-E at the rate of 75 percent. In addition to travel and per diem, reimbursable activities would include the short-term training of current and prospective foster and adoptive parents and the staff of licensed or approved child care institutions providing Title IV-E foster care, in ways that increase their ability to provide support and assistance to Title IV-E foster and adopted children.

Effective Date

October 1, 1989.

5. Require Health and Education Records in the Child's Case Plan (section 10215)

Current Law

Under present law, for each child receiving foster care maintenance payments under the responsibility of the State, a written case plan must be developed which includes a description of the home or institution in which the child is to be placed, a discussion of the appropriateness of the placement and a plan for assuring that the child receives proper care and that services are provided.

These case plans must be reviewed every six months by either a court or by administrative review to determine the continuing appropriateness of the placement, the extent of compliance with the case plan, and the extent of progress made toward alleviating or mitigating the causes necessitating placement in foster care.

Additionally, in order to certify compliance with the requirements of section 427, a State must, in addition to other requirements, for each child receiving foster care under the responsibility of the State, have a written case plan and provide a case review system.

Proposal

Effective beginning fiscal year 1990, require that a foster child's case plan include a record of his educational and health status. The record must indicate the following information, to the extent the information exists and is accessible:

—The names and addresses of the child's health and educational providers,
—The child's grade level performance,
—The child's school record,
—Assurances that the child's placement in foster care takes into account proximity to the school in which the child is enrolled at the time of placement,
—A record of the child's immunizations,
—The child's known medical problems,
—The child's medications,
— In the case of a Medicaid-eligible foster child, an indication that the child has received, within 60 days of placement in foster care and periodically thereafter, comprehensive health examinations that are identical to the assessments which the State is currently required to provide under the Early and Periodic Screening Diagnosis and Treatment (EPSDT) program under Medicaid, as well as the results of the examinations and any follow-up treatment provided, and
—Any other relevant health and education information concerning the child determined to be appropriate by the State agency.

The health and education record must be reviewed and updated at the time of each placement of a foster child in foster care.

The health and education record must be supplied to the foster parent or foster care provider with which the child is placed.

Effective Date

October 1, 1989.

6. Address the Special Problems of Adolescents (section 10216)

Current Law

The Budget Reconciliation Act of 1985 established the independent living initiatives program, a State entitlement program under Title IV-E, to help States provide services in fiscal years 1987 and 1988 to facilitate the transition of Title IV-E foster children ages 16 and over to independent living. The Technical and Miscellaneous Revenue Act of 1988 extended the independent living program through fiscal year 1989, and expanded it to apply, at State option, to all children ages 16 and over in foster care, including those who are not receiving AFDC foster care payments. It was also expanded to apply for up to 6 months after foster care payments or foster care ends for children whose care or payments ended on or after they became age 16.

Independent living program services may include those that enable participants to seek a high school diploma or take part in vocational training; provide training in daily living skills, budgeting, locating housing and career planning; provide for counseling; coordinate services; establish outreach programs; and provide an independent living plan in the participant's case plan.

Proposal

Expand the purpose of the independent living program. The expanded program, called the Foster Care Adolescent Services Block-Grant, would be authorized for three years beginning in fiscal year 1990. The program would provide special services to adolescents in foster care, including the independent living services currently authorized. States could expend unobligated prior year funds in any of the three fiscal years for which the program is authorized. The entitlement level of the program would be increased to $100 million annually.

In addition, at State option, eligibility for the program would be extended to youths in foster care who are the age of 10 or older. However, of the funds authorized for the Foster Care Adolescent Services Block Grant, each State would be required to expend at least 70 percent for independent living services for foster children ages 16 and older.

Payments under the program could be used to establish, extend and/or strengthen services and programs which focus on the increasingly complex needs of adolescents in foster care. In addition to independent living activities, such services and programs could include those which encourage and support school attendance, prevent alcohol and other drug abuse, increase access to mental health services and alcohol and drug abuse treatment, as well as other adolescent services determined to be appropriate by the State.

Effective Date

October 1, 1989.

7. Improve Data Collection (section 10217)

Current Law

At the present time, HHS is not required to develop an annual report on Federal expenditures, services and participation under the various Title IV-E and Title IV-B child welfare, foster care and adoption programs. In addition, HHS does not collect and report comprehensive State-by-State data on the numbers, characteristics and status of children and families receiving Title IV-B and Title IV-E child welfare, foster care and adoption services and benefits, and of other children placed in foster care and adoption under the responsibility of the State child welfare agency.

In 1982, the Federal government provided funding, under a grant from the Office of Human Development Services, to the American Public Welfare Association (APWA) to administer a voluntary, annual reporting system for foster care and adoption. This reporting system is called the Voluntary Cooperative Information System (VCIS). According to a report by the Advisory Committee on Adoption and Foster Care Information (this Committee is described below):

> While the VCIS deserves considerable credit for providing the most useful nationwide data on children in substitute care, the system is still subject to criticism. Not all States have provided reports over the years, reporting periods differ, common definitions and methodologies are lacking, and the nature of aggregate data limits the analyses that can be carried out.

The 1986 Budget Reconciliation Act included an amendment mandating certain studies and reports to Congress related to the feasibility of establishing a system for the collection of certain foster care and adoption data. The amendment, section 479 of the Social Security Act, required the Secretary of HHS to establish an Advisory Committee on Adoption and Foster Care Information. On October 1, 1987, the Advisory Committee submitted to the Congress the results of a study which identified the types of data necessary to assess on a continuing basis the incidence, characteristics and status of adoption and foster care.

On May 26, 1989, the Secretary of HHS submitted to Congress a report, due on July 1, 1988, proposing a method of establishing, administering and financing a system for the collection of data relating to adoption and foster care in the United States. HHS is next required to promulgate final regulations providing for the implementation of the information system, with the full implementation of the system no later than October 1, 1991.

Proposal

(a) *New data requirements.*—Amend section 479 to require the collection of additional information on foster care and adoption, including:

> Separately for the Title IV-B child welfare services program, the Title IV-E foster care program, the Title IV-E adoption assistance program, and the Title IV-E Foster Care Adolescent Services Block Grant:

By State, a breakdown of total expenditures for the reporting period according to Federal dollars and State and local dollars;

By State, a breakdown of total Federal expenditures for the reporting period according to service categories developed by the Secretary (who must consider the categories used in the VCIS data collection system, the categories used under Title XX, and the ability of the States to collect and report data by service category); and

By State, the number of persons during the reporting period (or average monthly number of persons, where appropriate) who received services, total and according to the service categories established by the Secretary;

A State breakdown for the reporting period on transfers from the Title IV-E foster care program to the Title IV-B child welfare services program;

Foster care ceilings (allotments) by State under the Title IV-E foster care program;

The average monthly rate of payment, by State, for foster care maintenance, including information on special rates of payment and information, by State, on the cost of providing foster care incurred by foster care providers with whom the State contracts to provide such care;

Information by State regarding compliance with section 427 child welfare protections as of September 30 of the reporting period;

Information on the date and result of all title IV-E and title IV-B HHS compliance reviews and fiscal reviews, and any other such reviews undertaken;

Information for the reporting period regarding disallowances resulting from compliance and fiscal reviews, and any other such reviews undertaken; and

Any other data the Secretary deems necessary to monitor the operations of the child welfare programs under titles IV-B and IV-E.

(b) *Promulgation of Regulations.*—Require that no later than four months after the enactment of this legislation, the Secretary of HHS shall publish a notice of proposed rulemaking for the implementation of the data collection system required pursuant to section 479 of the Social Security Act, as amended, based on: the recommendations of the Advisory Committee on Adoption and Foster Care Information, the May 26, 1989 report of the Secretary to Congress required pursuant to section 479, and the Voluntary Cooperative Information System. The public must have 60 days to comment on the proposed regulations. No later than four months after the close of the comment period, the HHS Secretary shall publish final regulations. The regulations must provide for the full implementation of the system no later than October 1, 1991.

(c) *Timing of the Report.*—Require that the Secretary report, on an annual basis by the last day of the calendar year, the foster care and adoption information collected pursuant to section 479, as amended by this legislation. The data in the report would be based on the preceding Federal fiscal year. To the extent prior year data are available, require that it be included in the report. The annual

report must include any explanatory text and notes necessary to interpret and evaluate the data included in the report. The first report would be due December 31, 1992.

(d) *Interim Reports.*—Require that the Secretary prepare interim reports due December 31, 1990 and December 31, 1991. These reports would include any data required by section 479, as amended by this legislation, that the Secretary can reasonably and uniformly collect from the States.

(e) *Child Abuse Data Collection.*—Require that the Secretary, through the National Center on Child Abuse and Neglect, collect and analyze aggregate and case-specific data on child abuse and neglect until the Secretary implements a new system for identifying and reporting on child abuse and neglect. At a minimum, the child abuse and neglect information must include the aggregate and case-specific data that have been voluntarily reported by the States and presented by the American Humane Association under contract with HHS. The child abuse and neglect reports must be issued at least biennially. The first report, containing 1987 and 1988 data, would be due no later than the end of calendar year 1990.

The Secretary of Health and Human Services should include in any report on the new system for child abuse and neglect data collection a plan for a mandatory, uniform, nationwide system for collection of State-by-State data on abuse and neglect among children in foster care and all other children.

This plan might include the following: the total number of abuse and neglect reports made to the States; the type and source of the report; the population characteristics of child protective services cases; the number of reports that were assigned for investigation and their final status; the caseload levels of employees by areas of specialization (i.e., telephone intake, investigations, in-home services, substitute care, and family services); and the recidivism of child abuse and neglect cases in foster care placements, nonplacements, and family reunifications.

Effective Date

On enactment.

8. Improve Oversight and Accountability (section 10218)

Current Law

Public Law 96–272, the Adoption Assistance and Child Welfare Amendments of 1980, provided financial incentives to States to implement and operate a set of services and procedures designed to prevent the unnecessary removal of children from their home, prevent extended stays in foster care and ensure that efforts are made to reunify children with their families or place them for adoption. The services and procedures are outlined in section 427 of the Social Security Act.

In fiscal year 1981, HHS requested that States "self-certify" their compliance with the section 427 protections "on the basis of their understanding of the statutory requirements and an analysis of the related State child welfare programs, systems and policies implemented and in operation during the year for which they certified

(HHS Section 427 Review Handbook, August 1988, p. 1)." States which self-certified were to be reviewed later by the Department to ensure that they had actually implemented the section 427 protections.

According to the HHS Section 427 Review Handbook, to verify compliance with section 427 requirements, HHS conducts a two-stage review. The first stage is an administrative review which determines whether States have developed policy and procedures to implement the section 427 requirements for all children in foster care under the responsibility of the State. The second stage of the review is the case record survey which confirms that the policies are being implemented throughout the State.

An *initial* review is conducted for the fiscal year in which the State first certifies its eligibility. If a State meets the initial review, a *subsequent* review is conducted for the following fiscal year. States that meet the requirements of this subsequent review will be reviewed for the third fiscal year following the fiscal year for which the subsequent review was conducted. This is known as the *triennial* review. The case record survey must confirm the section 427 foster care protections are provided for at least 66 percent of the children in the initial review; 80 percent in the subsequent review; and 90 percent in the triennial review. If a State does not meet the established standards for the year under review, the review is conducted each succeeding year until eligibility is established.

Final regulations implementing section 427 became effective on June 22, 1983, three years after the passage of Public Law 96-272. According to an August 10, 1984 GAO report on implementation of the 1980 Act:

> The final regulations largely restate the statute with little amplification to help states understand the inventory, statewide information system, or selected case review system requirements. (p. iii)
>
> By not being precise in its regulations, states can make and have made varying interpretations of the act's requirements that are inconsistent with its legislative history. . . . The confusion . . . is likely to continue in the absence of explicit HHS regulations for the states to follow on how to meet each of the act's requirements. (p. 21)

Proposal

(a) *Development of New Review System.*—By March 1, 1990, the Secretary shall publish final rules which provide the specific, comprehensive set of standard criteria against which State programs will be uniformly measured for compliance with the section 427 protections.

Effective for any section 427 compliance review initiated for fiscal year 1991 or subsequent fiscal years, all HHS section 427 compliance review guidelines and all other materials used in the compliance review process, including instruments, methodology and forms, must conform to the revised regulations. In addition, no compliance review for fiscal year 1991 or later may be conducted using any guidelines and review materials that were revised less

than six months prior to the beginning of the fiscal year under review.

(b) *Review Timetable.*—No later than the beginning of fiscal year 1993, the Secretary shall have conducted a review of the State programs under the new review system and shall have determined, based on the published standards, whether the actual operation of the program in each State during the fiscal year reviewed conforms to the applicable section 427 requirements. Not less often than every three years (or not less often than annually in the case of any State which has been found in the most recent review to have been out of compliance) the Secretary shall conduct a complete review of the program in each State and determine, based on the published standards, whether the actual operation of the program during the fiscal year reviewed conforms to applicable section 427 requirements.

Any State which is found to be out of compliance with the requirements of section 427 under the new system must receive final notification of any finding of noncompliance within forty-five working days of the review. Such notification must include the basis for the finding of noncompliance.

A State which is found through a review under the new system not to be in full compliance with the requirements shall be determined to be in substantial compliance only if the Secretary determines that any noncompliance with the requirements is of a technical nature which does not adversely affect program performance. These terms must be defined in the regulations.

(c) *Corrective Action Requirements.*—Any payments reduced or withheld as a result of a finding of noncompliance shall be suspended for any fiscal year, beginning with fiscal year 1991, if the State (1) submits a corrective action plan, within a period prescribed by the Secretary. which contains steps necessary to achieve substantial compliance within a time period prescribed by the Secretary, (2) the plan is approved by the Secretary, and (3) the Secretary finds that the corrective action plan is being fully implemented by the State and that the State is progressing in accordance with the timetable contained in the plan to achieve substantial compliance.

Under the new system, a suspension of the penalty shall continue until the Secretary determines that the State has achieved substantial compliance (in which case the penalty is not applied), the State is no longer implementing the corrective action plan (in which case the penalty is applied), or the State has implemented its plan but failed to achieve substantial compliance within the specified time period (in which case the penalty is applied).

(d) *Treatment of Triennial Reviews Under Current Regulations.*—Effective June 9, 1989, the Secretary of HHS would be permanently precluded from reducing any payments to, seeking repayment from or withholding any payments from any State under Titles IV–B or IV–E of the Social Security Act, as a result of a disallowance determination made in connection with a triennial review (as established by and described in the HHS Section 427 Review Handbook) of State compliance with the foster care protections outlined in section 427 of the Social Security Act for any federal fiscal year preceding fiscal year 1991.

Effective Date

On enactment.

C. SSI Disabled Children Amendments

1. Outreach Program for Disabled and Blind Children (section 10221)

Current Law

Current law has no specific provision dealing with outreach programs. However, the Social Security Administration (SSA) conducts national, regional, and local outreach and public information campaigns to reach individuals who may be eligible for SSI. SSA is continuing to establish liaisons with national, State, and local legal and welfare agencies and advocacy groups to inform them about the SSI program and to enlist their assistance in finding potentially eligible persons.

Proposal

Establish a permanent SSI outreach program for disabled and blind children. Require the Secretary of Health and Human Services (HHS) to report annually on the effectiveness of this program. Require the Secretary to aim outreach efforts at populations for whom it would be most effective. Such efforts should include not only ongoing efforts to notify social security beneficiaries of possible eligibility for SSI, but other efforts aimed at those not receiving social security.

Effective Date

Date of enactment.

2. Individual Functional Assessments of Children (section 10222)

Current Law

A medically determinable physical or mental impairment of comparable severity to that which would be considered disabling for an adult is required for children under 18 years old to be determined disabled. A child must have an impairment that meets or equals in severity an impairment in the Listing of Impairments in the regulations. This listing consists of Parts A and B. Part B contains impairments of children under 18. These criteria are applied first. If these are not met, then Part A criteria are applied.

Under Part A, an adult must be unable to engage in substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to last at least 12 months. If the severity of an adult's impairment does not meet or equal the severity of an impairment in the Listings, he can still be found disabled if his impairment prevents him from doing any substantial gainful work that exists in the national economy, considering his vocational factors (age, education and work experience). This vocational test is not applied to children because they have no significant work histories.

Proposal

Require the Secretary of HHS, in determining SSI eligibility for the blind or disabled, to assess individually each child's functional limits that interfere with the activities of daily living appropriate to the age of the child.

Effective Date

October 1, 1989.

3. Presumptive Disability Based on Genetic or Congenital Impairments for Children under 4 Years Old (section 10223)

Current Law

Children born with genetic or congenital impairments must have impairments that meet or equal the severity of the impairments in the Listing of Impairments in regulations. Valid tests to determine this often are not available until the child reaches a certain age.

Proposal

Require the Secretary of HHS to presume disability for SSI of children under 4 years old who were born with genetic or congenital impairments that are likely to test positively for a disability later when medical professionals can administer a valid test at an older age. This presumption may be rebutted. Such impairments should include but not be limited to cystic fibrosis, Down's syndrome, junctional epidermolysis bullosa, Hirschprung's syndrome, Tourette syndrome, Prader Willi syndrome, and spina bifida.

Effective Date

October 1, 1989.

4. Revised Listings of Impairments for Children

a. *Secretary Required to Publish Notice of Proposed Rulemaking on Revised Childhood Listings of Mental Impairments* (section 10224).

Current Law

At the request of SSA, a work group of psychiatrists and other specialists in children's disabilities developed revised standards for determining SSI eligibility for children with mental impairments. The work group reported on April 1, 1986. Regulations implementing the standards have not been issued.

The revised standards developed by the work group include age-appropriate criteria for five age groups under age 18 in 11 categories of mental disorders. In each category, both "clinical signs and symptoms" and functional restrictions must be measured. The revisions reflect "the current state of the art and science where childhood mental impairments are concerned," according to the Mental Impairments Listing Workgroup.

Proposal

Require the Secretary of HHS to publish a notice of proposed rulemaking on the "Revised Childhood Listings of Mental Impairments" within 60 days after the date of enactment with final regu-

lations issued nine months after enactment. The listings should be based on those submitted by the Mental Impairments Listing Workgroup of the Associate Commissioner for Disability on April 1, 1986.

Effective Date

Date of enactment.

b. *Require Revised Listings of Impairments for Children* (section 10225).

Current Law

Current "Listings of Impairments for Children" were published in 1977 in response to congressional pressure to develop appropriate standards for evaluating impairments of children. Except for minor changes, the regulations have not been revised since 1977. The Listings exclude some childhood impairments, do not reflect current medical knowledge, do not describe associated functional limitations, and are not age-appropriate.

Proposal

Require the Secretary to solicit advice from childhood disability experts on changes that should be made to the children's "Listings of Impairments" so that they account for medical and functional rules that are appropriate to the age of the child. Require publication of proposed revisions for public comment within 18 months from the date of enactment. Regulations must be final 24 months after the date of enactment.

Effective Date

Date of enactment.

5. *Eligibility for Recipients with Weekly or Biweekly Income* (section 10226)

Current Law

An individual's eligibility for SSI in a month is determined on the basis of the individual's income, resources and other relevant factors in such month. The income is determined based on a projection of income for that month. The projected income is reconciled in later months with actual income as it is reported.

The amount of the SSI benefit in a month is determined on the basis of income and other factors in the first, or if the Secretary determines, second month preceding such month. Generally, the Secretary uses income and other factors in the second preceding month to determine the SSI benefit amount.

Individuals who earn biweekly or weekly income will occasionally receive 3 or 5 paychecks in a month instead of the usual 2 or 4 paychecks. The extra income in these months can make such individuals ineligible for SSI and Medicaid in these months. Such individuals are placed in a suspension status for that month and usually resume receiving benefits in the next month. When SSI benefits are suspended, Medicaid is terminated.

Proposal

Require the Secretary to deem certain individuals eligible for SSI benefits for the purpose of retaining Medicaid eligibility as long as they would be eligible for SSI benefits otherwise. An individual must meet three conditions: (1) the individual receives earned income on a regular weekly or biweekly basis; (2) the individual is determined to be ineligible for SSI for the month because of an extra weekly or biweekly paycheck; and (3) The individual would be eligible for SSI if the amount of his earned income in such month were equal to his average monthly rate of pay.

Effective Date

October 1, 1989.

6. SSI Benefits for Disabled Children of Parents Who Work Overseas (section 10227)

Current Law

SSI benefits are paid only to disabled children who live in the United States.

Proposal

Pay SSI benefits to disabled children who reside with parents working overseas. The child must be a U.S. citizen.

Effective Date

October 1, 1989.

7. Waiver of SSI Income and Resource Deeming Rules for Certain Severely Disabled Children (section 10228)

Current Law

Under the SSI program, the income and resources of a disabled child's parents are "deemed" to the child if the child is living at home. These deeming rules do not apply if the child is hospitalized.

The Social Security Act authorizes States to offer programs so that disabled children can be cared for at home while retaining Medicaid eligibility. Under these programs, for purposes of Medicaid eligibility, the income and resource deeming rules do not apply. There are five waivers under title XIX under which States may offer home care options for disabled children: Home and Community-Based Waivers ("section 2176 waivers"); Model Home and Community-Based Waivers; "Katie Beckett Waivers; State Plan Options; and State Plan Services.

Proposal

Require the Secretary to ignore the SSI income and resource deeming rules in the case of severely disabled children who were eligible for SSI benefits while in a medical institution, who are beneficiaries of any State home care plan authorized under title XIX, and who are ineligible for SSI benefits because of the application of the income and resource deeming rules. For purposes of the SSI monthly benefit, such children would receive the same personal needs allowance as if they were hospitalized. Thus, these dis-

abled children who are beneficiaries under a State home care plan would be entitled to Medicaid benefits (as under present law) and the SSI personal needs allowance.

Effective Date

January 1, 1990.

8. Intergenerational Demonstration Project for Disabled Children (section 10229)

Current Law

No provision.

Proposal

Authorize the Secretary of Health and Human Services to conduct demonstration projects in 10 communities. The demonstrations would test the use of volunteer senior aides to provide basic medical assistance and support to families with moderately or severely disabled or chronically ill children. The demonstration would determine the contribution of such voluntary assistance to the reduction of the costs of care for these children.

Effective Date

October 1, 1989

9. Exclusion of the Value of Income-Producing Property from Equity Value of Property (section 10230)

Current Law

Excludes from countable resources income producing property which is so essential to the means of self-support of the individual as to warrant its exclusion.

The exclusion (known as the $6,000/6 percent rule) is limited by regulation to $6,000 of an individual's equity in income-producing property and applies only if such property produces a net annual income to the individual of at least 6 percent of the excluded equity.

In cases where income produced by property essential to self-support meets the regular definition of earned income, it is counted as earned income. In all other cases it is counted as unearned income.

Proposal

Require that the value of property which is used in the person's trade or business, or in the employment of a family member, be excluded from the equity value of the person's property. Income generated from the property would be counted in determining eligibility and benefits.

Effective Date

October 1, 1989.

D. Child Support Enforcement Amendments

1. Extension of IRS Intercept for Non-AFDC Families (sections 10231 and 10232)

Current Law

States can collect child support arrearages of at least $500 owed to non-AFDC families through the Federal income tax refund offset mechanism. The arrearages must be owed to a "minor child." A similar mechanism is authorized for AFDC families, but the limit on arrearages is set at $150 by regulations.

Proposal

Extend for five years present law that allows States to request that the Internal Revenue Service (IRS) collect child support arrearages of at least $500 out of income tax refunds due to non-custodial parents. Since the current provision expires at the end of calendar year 1990, it would be extended through calendar year 1995.

Eliminate the minor child restriction on court-ordered arrearages in non-AFDC child support cases under the income tax refund offset for adults with a current support order who are disabled, as defined under OASDI or SSI.

Effective Date

Date of enactment for extension with expiration on January 10, 1996; January 1, 1990 for minor child provision.

2. Medicaid Transition in Child Support Cases (section 10233)

Current Law

Medicaid benefits continue for 4 months after a family loses AFDC eligibility as a result of collection of child support payments under Title IV–D of the Social Security Act. (Title IV–D authorizes the Child Support Enforcement (CSE) program.) This provision expires on October 1, 1989.

Proposal

Make permanent the requirement that Medicaid benefits continue after a family loses AFDC eligibility as a result of collection of child support payments under the IV–D program. This requirement would be conformed to the Family Support Act by extending these benefits for 12 months after a family leaves AFDC due to collection of child support.

Effective Date

October 1, 1989.

II. INITIATIVE FOR THE POOR ELDERLY

A. SSI Benefit Increase (section 10241)

Current Law

The 1989 Federal SSI benefit standard for an individual and a couple is $368 and $553 per month, respectively.

Proposal

Increase SSI benefits by $2 per month for individuals and $3 per month for couples.

Effective Date

January 1, 1990.

B. Improve Program Participation (section 10242)

Current Law

Current law has no specific provision dealing with outreach programs. However, the Social Security Administration (SSA) conducts national, regional, and local outreach and public information campaigns to reach individuals who may be eligible for SSI. SSA is continuing to establish liaisons with national, State, and local legal and welfare agencies and advocacy groups to inform them about the SSI program and to enlist their assistance in finding potentially eligible persons.

Proposal

Establish a permanent SSI outreach program for adults. Require the Secretary of Health and Human Services (HHS) to report annually on the effectiveness of this program. Require the Secretary to aim outreach efforts at populations for whom it would be most effective. Such efforts should include not only ongoing efforts to notify social security beneficiaries of possible eligibility for SSI, but other efforts aimed at those not receiving social security.

Effective Date

Date of enactment

C. Representative Payee Reform (section 10243)

Current Law

When the Secretary of HHS determines it is in the best interests of the beneficiary, the Secretary may appoint a relative or some other person (known as a"representative payee") to receive the SSI payments on behalf of the beneficiary. The Secretary must investigate each individual applying to be a representative payee either before or within 45 days after the Secretary certifies payment of the benefit to that individual.

The Secretary must have a system to maintain accountability under which each representative payee is required to report not less than annually regarding the use of the payment. The Secretary is required to review the reports and identify instances where payments are not being used properly.

Anyone convicted of a felony under Section 1632(b) of the Social Security Act, which deals with fraud, may not be certified as a representative payee.

Proposal

1. Provide that persons who have been convicted of violations of certain provisions in the Social Security Act and the U.S. Code or who have been dismissed for misuse of payments could not be certi-

fied as representative payees. The Secretary could establish certain exceptions by regulation. In certifying representative payees, the Secretary would be required to: (a) document proof of identity; (b) verify social security numbers; (c) determine whether they have been convicted of a violation of certain provisions in the Social Security Act and the U.S. Code; and (d) determine whether they have ever been dismissed as a representative payee for misuse of payments.

2. Require the Secretary to maintain a centralized, current file readily retrievable by all Social Security Administration offices containing: (a) the address and social security number of all representative payees and associated beneficiaries; and (b) the name, address, and social security number of each person who has been convicted of the violation of certain provisions of the Social Security Act and the U.S. Code.

3. Require the Secretary to study and make recommendations regarding high-risk representative payees (see discussion under social security amendments).

4. Require the Secretary to maintain a list in each Social Security Administration office of all agencies and organizations providing representative payee services.

5. Allow community-based nonprofit social services agencies to receive a fee from beneficiaries, as determined by the Secretary, for providing representative payee services.

6. Authorize 2 demonstration projects (see discussion under social security amendments).

Effective Date

July 1, 1990.

D. Treatment of Income in Shared Living Arrangements (section 10244)

Current Law

An individual living in another's household and receiving in-kind support and maintenance from the person in whose house he resides has his eligibility and benefits under SSI determined using a benefit rate that is reduced from the full Federal benefit rate by one-third. This is in lieu of including the actual value of the support and maintenance in his income.

Under regulations, the one-third reduction applies whenever an individual lives in the household of another unless: (1) all others in the household receive public assistance benefits; (2) the individual does not receive both food and shelter from within the household; or (3) the individual pays a pro rata share of the household's operating expenses.

If an individual is living with others and is not subject to the one-third reduction or is the owner of the house, regulations provide for determining whether the individual is receiving in-kind assistance from someone in the household. If he is receiving assistance, it is presumed to have a value of one-third of the Federal benefit rate plus $20 (the unearned income disregard) unless he shows SSA that the value of what he receives is less. The effect of

the presumed maximum value is to reduce the benefit of the recipient by an amount equal to the one-third reduction.

Proposal

Count the lesser of the actual value of in-kind assistance received by individuals or the current law one-third of the SSI benefit against the SSI benefit. Require the Secretary to study the effect this provision has on SSI beneficiaries and the administration of the program and to report to Congress not later than 2 years after the date of enactment.

Effective Date

January 1, 1990.

E. Exclusion From Income of Domestic Commercial Transportation Tickets Received As Gifts (section 10245)

Current Law

Domestic commercial transportation tickets received as gifts by SSI recipients are treated as unearned income and valued at their current market value unless the ticket is not convertible to cash (e.g., charged on the donor's credit card), in which case it is not counted as income.

Proposal

Gifts of domestic commercial transportation tickets given to an individual or eligible spouse, which are used by that individual or spouse and not converted to cash, would be disregarded in determining their income.

Effective Date

October 1, 1989.

F. Reduction in Time During Which Income and Resources of Separated Couples Must Be Treated As Jointly Available (section 10246)

Current Law

A husband and wife who are aged, blind, or disabled, and who have not been living apart from each other for more than 6 months are considered to be an eligible couple under SSI. If the couple separates, the spouses are considered to be a couple for SSI purposes until they have lived apart for more than 6 months.

Proposal

A married couple would be treated as separate individuals for the purposes of determining eligibility and benefit amounts under SSI beginning after the first full month of their living apart. The Secretary could waive the one month period in an emergency.

Effective Date

October 1, 1989.

G. Exclusion of Interest and Accruals on Burial Spaces From Resource Limits (section 10247)

Current Law

Burial funds within established limits of $1,500 and burial spaces belonging to individuals and their immediate family are excluded from an individual's resources. Interest and other accruals on the $1,500 burial fund are excluded as a resource for all purposes, but are not excluded for burial spaces.

Proposal

Treat burial spaces and burial funds the same way by excluding interest and other accruals on burial spaces from the resource limits.

Effective Date

October 1, 1989.

H. Work Incentives for Social Security Disability Insurance (SSDI) Recipients Who Become Ineligible for SSDI Because of Earnings (section 10248)

Current Law

Social security disability insurance (SSDI) recipients become ineligible for SSDI as a result of earning more than $300 per month following a 9-month trial work period and a 3-month grace period. These individuals generally cannot qualify for SSI and its work incentive provisions under section 1619 because they cannot meet the test of disability that is applied at application (i.e. their earnings demonstrate substantial gainful activity in excess of what is allowed to meet the test of disability).

Proposal

Allow SSDI recipients who lose their SSDI benefits because of earnings to participate in the SSI work incentives program under section 1619 without first being required to receive at least one month of SSI benefits. For those otherwise eligible for SSI who do not meet the SSI resource limits ($2,000 for individuals and $3,000 for couples), a 33-month period would be allowed in which they could reduce their assets below the SSI limits so that they too could be eligible.

Effective Date

July 1, 1990.

I. Exclusion of Victims' Compensation Payments From SSI Income and Assets Determinations (section 10249)

Current Law

Under current law, amounts received from victim assistance funds are included as income or assets for purposes of determining eligibility and benefits for SSI.

Proposal

Any payment, or portion thereof, received from a State-administered victim assistance fund, that the beneficiary could demonstrate was compensation for expenses incurred or losses suffered as a result of the crime, would not be included as income or assets for purposes of determining SSI eligibility and benefits.

Any portion of a victim assistance payment which does not compensate for expenses incurred or losses suffered as a result of the crime, would not be counted as income for the month in which it is received. However, such portion, to the extent it is not expended during the nine-month period beginning after the month in which it was received, would be counted as a resource in the tenth month following the month in which it was received.

No person awarded victims' compensation, who was otherwise eligible for SSI and who refused to accept such compensation, would be considered ineligible for SSI as a result of such refusal.

Effective Date

October 1, 1989.

J. Improve Social Security Administration Services and Beneficiary Protections (sections 10251 through 10257)

(See Social Security Subcommittee recommendations for provisions affecting both Title II and Title XVI of the Social Security Act.)

Current Law

When the Secretary finds that an individual has been paid more than the correct amount of title XVI benefits, he must attempt to recover the overpayment. However, the requirement to repay an overpayment is waived in cases where the individual is without fault and recovery would either be against equity or good conscience, or defeat the purpose of title XVI. In addition, failure or delay by an individual in furnishing information relevant for eligibility determination may result in a benefit reduction, except where the individual is without fault. SSA regulations require that in determining whether an individual is without fault, consideration be given to his age, intelligence, education and physical and mental capabilities.

A beneficiary receiving benefits based on a disability whom the Secretary determines is no longer disabled has the option of having his or her benefits continued through a hearing before an Administrative Law Judge (ALJ). Benefits paid during this period are considered overpayments if the individual loses the appeal and are subject to recovery by the Secretary. However, if the individual acted in good faith in pursuing the appeal, repayment of the benefits can be waived. SSA regulations establish a presumption that appeals are made in good faith unless the individual fails to cooperate with the agency during the appeal.

Proposal

Require SSA to take into account any physical, mental, educational, or linguistic limitation of an individual (including lack of fa-

cility with English) in determining whether the individual acted in good faith or was at fault, and in determining fraud, deception, or intent.

Effective Date

January 1, 1990.

III. MISCELLANEOUS AMENDMENTS

1. Optional Benefits for Non-Professional School Employees (section 10261)

Current Law

States are required to deny eligibility for Unemployment Compensation to nonprofessional employees of educational institutions between academic years or terms. Before the Social Security Amendments of 1983, States had the option to provide such benefits.

Proposal

Allow States the option of paying unemployment compensation to nonprofessional employees of educational institutions between academic terms or years.

Effective Date

Date of enactment.

2. Prohibition on Collateral Estoppel (section 10262)

Current Law

Currently, 14 States prohibit courts from using quasi-judicial decisions reached in Unemployment Compensation hearings to stop law suits on related employment issues, such as wrongful discharge from a job. This judicial doctrine is called, "collateral estoppel." Federal law has no provision.

Proposal

Require State Unemployment Compensation laws to prohibit courts from stopping law suits on related employment issues based on a decision made in an unemployment compensation hearing.

Effective Date

Generally, October 1, 1989.

3. Continued Moratorium on AFDC and Emergency Assistance Regulations (section 10263)

Current Law

The Stewart B. McKinney Homeless Assistance Amendments Act of 1988 prohibits the Secretary of Health and Human Services, prior to September 30, 1989, from taking any action that would have the effect of implementing, in whole or in part, the proposed regulations published in the *Federal Register* on December 14, 1987. These regulations would have restricted the use of AFDC emergency assistance funds for homeless families and would have

limited States' authority to use AFDC funds for shelter in temporary quarters, whether as a basic or special need.

Proposal

Extend for one year, through September 30, 1990, the moratorium barring the Secretary of Health and Human Services from taking any action that would have the effect of implementing, in whole or in part, the proposed regulations published in the *Federal Register on* December 14, 1987.

Effective Date

October 1, 1989.

4. Administrative Expenses in Self-Employment Demonstration Projects (section 10264)

Current Law

The Omnibus Reconciliation Act of 1987 authorized a demonstration project under which States would continue paying unemployment benefits to unemployed persons who attempt to set up their own businesses. In order to participate in a self-employment project, States would have to guarantee that no net additional costs in any fiscal year would accrue to the unemployment program as a result of the projects. (State general revenues would have to be used to meet administrative costs and to make up any losses to the unemployment compensation program.)

Proposal

Authorizes appropriations totaling $1 million to cover State administrative expenses for operating self-employment demonstration projects authorized by the Omnibus ReconciliationAct of 1987.

Effective Date

Upon enactment.

5. Minnesota Family Investment Plan (MFIP) Demonstration Project (section 10265)

Current Law

The State of Minnesota has passed legislation to conduct field trials of the Minnesota Family Investment plan (MFIP) as an alternative to the present Aid to Families with Dependent Children (AFDC) program. The legislation authorizes the Minnesota Commissioner of Human Services to enter into an agreement with the Federal government consistent with the goals of the MFIP. The field trials cannot proceed without Federal authorizing legislation.

Proposal

Permit the State of Minnesota to conduct a demonstration, through field trials involving up to 6,000 families, of its proposed MFIP, subject to the approval of the Secretary. The demonstration would simplify the welfare system and increase recipient work incentives. It would be conducted in at least two field trials. One of the field trials would be conducted for an urban area and would

include random assignment of families to treatment and control groups.

Families in the project would be entitled to fair hearing and dispute resolution procedures guaranteed under current AFDC law. At least the education, employment and training services available under the State's Title IV–F plan would be available to families who have a contract under the project. The State would ensure that families participating in the project receive no less in assistance than they would have received under the AFDC and food stamp programs. The State would not require participation in project activities of any individual exempt under current AFDC law.

The demonstration would begin on the date the first person received assistance under the project enrolled in the program and would end five years later. The demonstration could be terminated on six months' notice by the State or 180 days after the Secretary, after 30 days written notice and the opportunity for a hearing, finds that the State has failed to comply with this section. An evaluation plan would be developed and implemented by the State. The State would issue an interim and final report of the evaluation.

Effective Date

Upon enactment.

6. Family Support Act (section 10266)

The Office of Legislative Counsel has identified several technical errors (i.e., incorrect cross references and citations as well as text that was inadvertently dropped) in the Family Support Act of 1988. Legislation to correct these technical errors is included.

IV. AFDC QUALITY CONTROL

A. Resolve The Backlog of Disallowances Through FY90 (section 10271)

Current Law

States are required to pay back estimated misspent Federal funds, or so-called disallowances, under the AFDC quality control (QC) program. States with error rates above 3 percent are subject to repaying the Federal matching funds on the erroneous payments exceeding 3 percent. States may appeal disallowances to the Secretary of HHS, to a Departmental Appeals Board, and ultimately, to the courts.

All States but one, Nevada, are subject to disallowances. Currently, the States have been informed that they owe a total of about $1.2 billion to the Federal government for misspent Federal funds from fiscal years 1981 through 1986. A moratorium on collecting these disallowances expired on July 1, 1989.

Proposal

To resolve the backlog of pending disallowances, defined as all disallowances from fiscal years 1981 through 1990, the following statutory changes would be made:

1. For fiscal years 1983 through 1990, States would be subject to potential disallowances if their official error rates are above the lowest national annual average achieved since 1980. In the case of fiscal years 1981 and 1982, this threshold would be the higher of (a) the lowest national annual average achieved since 1980, or (b) the target error rate in effect for fiscal years 1981 and 1982 for the respective States. The lowest national average achieved from 1981 through 1987 was 6.0 percent in 1984. Consequently, the 6.0 percent figure would apply for 1981 through 1987. If a lower national average than 6.0 percent is achieved in 1988, 1989, or 1990, it would be used to establish the threshold for those years. Otherwise, 6.0 percent would apply to these years also.

2. State official error rates would be recalculated excluding so-called "technical errors." Technical errors are errors which, if corrected, would not result in a change in benefit amount, including failure to secure or apply for a Social Security number, failure to register for a work program, failure to assign child support rights, failure to assign rights to third party payments, and failure to obtain monthly reports from cases for which they are required. Excluding technical errors for purposes of calculating official error rates however, does not obviate the need to meet the requirements of the Social Security Act in these areas. For example, States must continue to obtain social security numbers.

3. All States subject to potential disallowances would have one of two options:

(a) pay 75 percent of the potential disallowance in lieu of any further appeal; or

(b) appeal directly to the Departmental Appeals Board. There would be no appeal to the Secretary for a waiver of the disallowance. States would have 6 months from the later of the date of enactment or the official announcement of the disallowance in which to file an appeal. The Board must rule on the appeal within 12 months from the date on which the appeal is filed. Interest would accrue on disallowances beginning after the Departmental Appeals Board decision and would be collected after appeals are exhausted. Interest is paid only on the final disallowance amount. The Board's decision would be subject to judicial review.

4. In deciding how much, if any, sanction would be imposed on the States, the Board must consider the following illustrative, but not all inclusive list of factors:

Whether the State's error rate is sufficiently statistically reliable to support a conclusion that the State exceeded the tolerance level;

Whether the errors for which the State was cited in fact represented misspending of funds;

Whether the errors for which the State was cited could have been avoided by the State agency by cost-efficient means that would not have interfered with program purposes;

Whether the State's error rate in a year diverges from its historical trend enough to demonstrate a significant problem in need of correction;

Whether the error rate was affected by factors beyond the State's control, such as caseload growth, caseload composition, program changes, strikes, or natural disasters;

Whether the State's record with respect to corrective action demonstrates a concerted effort to reduce errors;

Whether measurement of errors was against State practice as outlined in State regulations and policy clarifications; and

Any other factors the Board determines to be relevant.

Effective Date

July 1, 1989, applying to potential disallowances for fiscal years 1981 through 1990.

B. Permanently Modify the Quality Control System After FY90
(section 10281)

Current Law

States are required to pay back estimated misspent Federal funds, or so-called disallowances, under the AFDC quality control (QC) program. States with error rates above 3 percent are subject to repaying the Federal matching funds on the erroneous payments exceeding 3 percent. States may appeal disallowances to the Secretary of HHS, to a Departmental Appeals Board, and ultimately, to the courts.

Proposal

The following modifications would be made in the existing AFDC quality control system, beginning with fiscal year 1991:

1. Technical errors (as defined in the previous section) would be determined but excluded from all error rates for purposes of estimating disallowances. Failure to register for a work program would not be a technical error under the new system because the new JOBS program does not require registration. Recouped overpayments from child support collections or to her efforts would also be excluded before determining potential disallowances. As in resolving the backlog of disallowances, excluding technical errors in calculating State error rates would not obviate the need to meet the requirements of the Social Security Act in these areas. For example, States still must obtain social security numbers.

2. The official estimate of the error rate for the State would be the midpoint of the confidence interval around each State estimate. Confidence intervals would be set at the 95 percent level. Standard errors and confidence intervals must be published.

3. Thresholds for State error rates would be:

Below incentives threshold: Incentives paid.

Between incentives and disallowance thresholds: Corrective actions required.

Above disallowance threshold: Potential disallowance imposed and corrective actions required.

The incentives threshold would be one-half of the lowest sum of the national average overpayment and underpayment error rates ever achieved in prior years beginning with fiscal year 1981. Technical errors would be excluded from the overpayment error rates.

The disallowance threshold, would be one percentage point plus the lowest sum of the national average overpayment and underpayment error rates ever achieved in prior years beginning with fiscal year 1981. Technical errors would be excluded from the overpayment error rates.

Incentive payments would equal half the difference between the incentive threshold and the State's error rate times the Federal share of the State's total payments.

Disallowances are the Federal share of erroneous payments in excess of the disallowance threshold.

4. As in the resolution of the backlog of disallowances, States would have one of two options:

(a) pay 75 percent of the potential disallowance in lieu of and further appeal; or

(b) appeal the sanction directly to the Departmental Appeals Board within 45 days. The Department of Health and Human Services waiver process would be eliminated. The Board would follow the same procedure as outlined under the backlog proposals. In addition, the Board must consider whether the State's error rate is based on errors that are reflected in other welfare programs and whether offsetting savings in other programs might have resulted from misspending on the AFDC program. The Board's decisions would be subject to judicial review.

5. Interest would accrue on disallowances beginning after the Departmental Appeals Board decision and would be collected after appeals are exhausted to dissuade States from simply delaying the collection by appealing. Interest would be paid on only the final disallowance amount.

6. Require States to collect and report data on underpayments and negative case actions as part of the basic quality control sample. Negative case actions include improper denials and terminations. The Secretary would be required to study negative case actions and make recommendations to Congress on how to incorporate them into State error rates and the Federal incentive and disallowance formulas. States must begin reporting all data by no later than October 1, 1990. The Secretary must report to Congress no later than October 1, 1992.

Effective Date

Date of enactment.

Subtitle D. Trade Agency Authorizations, Customs User Fees, and Other Customs Provisions

PART 1—TRADE AGENCY AUTHORIZATIONS FOR FISCAL YEAR 1990

Sec. 10301. United States International Trade Commission

Current Law

There was no authorization of appropriations for the U.S. International Trade Commission (USITC) for FY 1989. P.L. 100-459 appropriated $35,958,000 for the USITC for FY 1989.

CONTENTS

(TITLE XI—REVENUE RECONCILIATION PROVISIONS)

for the period beginning with the determination date and ending on the date on which the employee attains normal retirement age, at the interest rate used under the plan in calculating the present value of accrued benefits (sec. 417(e)(3)). The conversion of the employee's contributions (plus interest) to an annuity is calculated using the interest rate used under the plan in determining the present value of accrued benefits (sec. 417(e)(3)).

The bill also eliminates the present-law limitation on the accrued benefit derived from employee contributions.

Some employers may have already amended their plans to conform to the interest rate rule of the Pension Protection Act, or may have adopted a new plan that conforms to such rule. If such plans are amended to conform to the bill, in some cases this might be considered a prohibited reduction in accrued benefits (sec. 411(d)(6)). Accordingly, the bill provides a transition rule that permits such plans to be amended to conform to the new rules without violating the reduction in accrued benefit rules.

Amendments Related to other Pension Provisions (secs. 11891–11894 of the bill)

The provision makes clerical and conforming changes relating to the Single Employer Pension Plan Amendments Act and the Employee Retirement Income Security Act of 1974.

Subtitle I. Child Care and Earned Income Credit Provisions

A. Child Care Provisions

1. Expansion of the Title XX social services block grant for child care services (sec. 11901 of the bill)

Present Law

Child care spending under the Title XX Social Services Block Grant is estimated to be the second largest Federal source of funding for general child care services (the dependent care tax credit is the largest). Under Title XX of the Social Security Act, States are entitled to receive social services block grant funds. These funds must be used to provide services directed at achieving five national goals: preventing or reducing dependency; achieving self-sufficiency; preventing or remedying neglect, abuse or exploitation of children and adults; preventing or reducing inappropriate institutional care; and providing services or referrals to individuals in institutions.

Title XX is a capped entitlement; funds are currently limited to $2.7 billion annually. (Note: As part of its reconciliation bill, the Committee has approved a separate increase in the ceiling; under the Committee's plan, by 1993 the basic entitlement ceiling will reach $3.3 billion.) Nearly all States use a portion of their Title XX funds to provide child care assistance to needy families.

Explanation of Provision

The bill permanently increases funds for Title XX of the Social Security Act by $200 million for fiscal year 1990; $350 million for

fiscal year 1991 and $400 million for fiscal year 1992 and each subsequent year. These additional funds will be earmarked for child care, are in addition to the basic increases approved by the Committee in a separate section of the budget reconciliation legislation, and cannot be used to supplant Federal and State funds currently used for child care. States will have two fiscal years to expend a given fiscal year allocation. States will be required to use 80 percent of the monies for child care services; the remaining 20 percent will be used for child care-related administration and training as well as enforcement of child care standards.

Child care expenses will be reimbursed at market rates, with higher reimbursements for infants and toddlers, children with disabilities, and comprehensive child care programs for children of adolescent parents. States will be required to establish a sliding fee schedule for the delivery of child care services and must assure that such services are provided at no cost to families with incomes below the poverty level. The State agency with primary responsibility for child care will administer these funds.

Before expending the allocation, the State will report to the Secretary on the intended uses of the payment, and the amount of any payment which the State does not intend to expend. Unexpended funds will be reallocated to other States. Annually, beginning for FY 1992, each State must report to the Secretary on the child care activities actually carried out with Title XX funds. The report must provide certain specific information, including the number of children receiving services, grouped by family income as a percent of the poverty line; the average cost and market rate of child care services; out-of-pocket costs for services by family income level as a percent of the poverty line; the criteria applied in determining eligibility for services; the methods of service provision; child care standards; licensing and regulatory requirements; and enforcement policies and practices.

A State that receives funds earmarked for child care under Title XX must, beginning three years after enactment, have in effect State child care standards that address all of the matters specified below (see paragraph which describes the required categories for State standards). The standards must apply to all Title XX-funded child care and to any child care services delivered by providers that receive public funds for child care services. Each provider who receives funds earmarked for child care under Title XX must also comply with all applicable State and local licensing or regulatory requirements (including registration requirements). The Committee does not consider child care to include camping.

A State will be ineligible for the additional Title XX funds beginning three years after enactment unless it demonstrates that all Title XX-funded child care providers and all other providers that receive public funds for child care services are: (1) licensed or regulated as required by State and local law; (2) satisfy any applicable State standards; and (3) are subject to certain enforcement provisions (see below).

There will exist no requirement, or mandate on the States to require, the training or licensing of individuals who provide child care to members of their families.

The required categories for State child care standards will be the following:

a. Center-based child care services

—group size limits in terms of the number of caregivers and numbers and ages of children;

—maximum appropriate child-staff ratios;

—qualifications and background of child care personnel;

—requirements for inservice training;

—health and safety requirements, including requirements for the prevention and control of infectious diseases (including immunization and washing procedures), injury prevention and treatment, building and physical premises safety, general health and nutrition, children with special needs, and prevention of child abuse; and

—requirements for parental involvement in licensed and regulated child care services.

b. Family child care services

—maximum number of children and maximum number of infants for whom child care services should be provided;

—minimum age of caregivers;

—requirements for inservice training or participation in a provider organization that addresses child development and management issues; and

—health and safety requirements (including those described above for center-based child care services, as are appropriate for family child care services).

c. Group home child care services

—maximum appropriate child staff ratios;

—maximum number of children and maximum number of infants for whom child care services should be provided;

—minimum age of caregivers;

—requirements for inservice training or participation in a provider organization that addresses child development and management issues; and

—health and safety requirements (including those described above for center-based child care services, as are appropriate for group home child care services).

Beginning two years after enactment, any State that receives the earmarked Title XX funds must require that all Title XX child care providers and any other child care providers that receive public funds for child care services, and the caregivers employed by such providers, complete an average of 15 hours of training annually. Such training must be tailored to the needs of the State and the providers.

The State may not reduce the categories of child care providers licensed or regulated by the State on the date of enactment, or reduce the level of standards applicable to child care services provided in the State, unless the State demonstrates, to the satisfaction of the Secretary of Health and Human Resources, that the reduction is: (1) based on positive developmental practice; or (2) necessary to increase access to and availability of child care providers and will not jeopardize the health and safety of children.

Not later than three years after enactment, the State must have in effect enforcement policies and practices that apply to all child

care funded under Title XX and all child care services delivered by providers who receive public funds for child care services, including certain specific policies and practices (e.g., every State must make one unannounced inspection of each center-based provider in the State annually, and make unannounced inspections annually of not less than 25 percent of licensed and regulated family child care providers).

Effective Date

The provision is effective beginning fiscal year 1990.

2. Child care standards improvement incentive grant and demonstration project (sec. 11902 of the bill)

Present Law

No provision.

Explanation of Provision

The bill authorizes a Child Care Standards Improvement Incentive Grant Program to assist States in improving child care standards. Grants would be for a 2-year period with no State receiving more than three consecutive grants.

Also, beginning in fiscal year 1990, the Secretary of Health and Human Resources is authorized to make grants for a Child Development Systems Demonstration Program. Under the program, grants are to be made annually to not more than 10 eligible public or private entities, in urban and rural areas, to administer child development systems in which high quality child development centers become a mentor for a network of smaller community centers and family day care providers for the purpose of improving the quality of child care and assuring greater continuity and parental involvement.

Expenditures of $75 million annually are authorized for the Child Care Standards Improvement Incentive Grant Program of which 2 percent is earmarked for the Child Development Systems Demonstration Program. The authorization extends through fiscal year 1998. The Federal matching rate will be 80 percent.

Effective Date

The provision is effective beginning in fiscal year 1990.

B. Expansion of Earned Income Tax Credit (sec. 11903 of the bill and secs. 32 and 3507 of the Code)

Present Law

An eligible individual who maintains a home for one or more children is allowed an advance refundable tax credit based on the taxpayer's earned income (sec. 32). In 1989, the earned income tax credit (EITC) is equal to 14 percent of the first $6,500 of earned income. The credit is phased out at a rate of 10 percent of the amount of adjusted gross income (or, if greater, the earned income) that, in 1989, exceeds $10,240. The $6,500 and $10,240 amounts are

adjusted annually for inflation, so that the maximum amount of credit and the maximum amount of income eligible for the credit increase with inflation.

The credit is available to married individuals filing a joint return who are entitled to a dependency exemption for a child, a head of household, and a surviving spouse. In order to be eligible to claim a dependency exemption, the taxpayer, in general, must provide over half of the support for the child. For this purpose, benefits under the Aid to Families with Dependent Children (AFDC) program are not considered support provided by the taxpayer. Thus, if more than half of the taxpayer's income is from AFDC or sources other than the taxpayer's own income, the earned income tax credit generally is not available.

Reasons for Change

The earned income tax credit is intended to provide tax relief to low-income working individuals with children and to provide incentives for work. The committee believes that additional financial support should be provided to low-income working families with children and that an increase in the size of the earned income credit is appropriate.

The committee recognizes that the obligation of caring for more than one young child place additional financial burdens on low-income working families. Thus, the earned income credit is adjusted for family size so that a larger amount of credit is available to families with young children and to those families with a larger number of children.

The committee understands the importance of administrative simplicity for assuring the widest possible utilization of the credit by low-income working families. The committee believes the provisions balance the need for simplicity with the goal of providing greater financial support for larger families and families with young children.

Explanation of Provisions

Increase in earned income credit and adjustment for family size

The bill increases the amount of the earned income tax credit and adjusts the credit for family size. Using the present-law income breakpoints, the credit and phaseout percentages are increased according to the number of qualifying children of the eligible individual as follows:

Number of children	Credit percentage	Phaseout percentage	Projected maximum credit amount
1	17	12	$1,217
2	21	15	$1,504
3 or more	25	18	$1,790

Note: The maximum credit amounts are projections for 1991, the first year in which the increased credit is available. The maximum credit amount for 1991 under present law is projected to be $1,002. The actual maximum amounts will depend on future inflation adjustments.

A qualifying child is generally a child for whom the eligible individual is entitled to a dependency exemption (except that certain

children in custodial arrangements will still be treated as a qualifying child to the custodial parent) and who has the same principal place of abode as the eligible individual for at least half the year. Solely for purposes of determining eligibility for the EITC, Federal means-tested transfer payments shall be treating as support provided by the individual in meeting the dependency requirement for the determination of a qualifying child. Under the bill, for example, AFDC payments received by a parent are counted as support provided by the parent and may make the parent eligible for the EITC even though a personal exemption for a dependent may not be claimed for the child. Thus, the taxpayer could be eligible for the EITC even though the taxpayer is an unmarried individual other than a surviving spouse or a head of household. Of course, the provision is not intended to alter the present law treatment of means-tested payments for the definition of earned income.

Supplemental young child credit

If any of the taxpayer's qualifying children are under the age of 6, the bill provides a further credit amount. The supplemental young child credit amount is available in addition to the amount determined by family size. Using present-law breakpoints, the supplemental young child credit provides an additional credit percentage of 6 percent and an increased phaseout percentage of 4.25 percent. Thus, the maximum supplemental young child credit is projected to be $430 in 1991; the actual maximum will depend on future inflation adjustments.

Other modifications

In order to increase utilization of the advance payment system, the provision requires employers to obtain from all new employees a certificate indicating their eligibility for advance payments of the earned income credit and, if the employees are eligible, their choice on whether to receive advance payments. The certificate and election will remain in effect until changed, except that an employer must obtain, on an annual basis, updated certifications of advance payment eligibility and election to receive advance payment from those employees already receiving advance EITC payments.

The provision provides that the amount of the earned income tax credit is not treated as income for purposes of determining eligibility for Federal means-tested programs or for State and local means-tested programs financed in whole or in part with Federal funds.

Recognizing the importance of administrative simplicity for the efficient operation of the EITC with respect to both employers and individual taxpayers, the committee intends that the Secretary shall prescribe the simplest tables and forms necessary to implement the intention of the provision.

Effective Date

The provision is effective for taxable years beginning after December 31, 1990.

IV. BUDGET EFFECTS OF THE BILL

A. Committee Estimates

In compliance with clause 7(a) of Rule XIII of the Rules of the House of Representatives, the following statement is made:

The Committee agrees with the estimates in the second table using the directed baseline prepared by the Congressional Budget Office (CBO) which is included below. The estimates of the Mediare Catastrophic program were changed significantly since the February baseline. Consequently, the Committee based its policy decisions for this program on the revised July estimates and these are shown in the Committee tables below. Examining the Committee's decisions using the February estimates presents a misleading impression of the Committee's decisions.

Table 1 below summarizes the budget effect (both outlays and revenues) by major provision. These estimates are identical to those made by the Congressional Budget Office (CBO) and the Joint Committee on Taxation. Only provisions which have a direct impact upon budget outlays or revenues are shown in these tables.

The reconciliation target (both outlays and revenues) was $8 billion for both fiscal years 1990 and 1991. The Committee recommendations have achieved total deficit reduction of $9.5 billion in fiscal year 1990 and $10.6 billion for fiscal year 1991. These numbers include $568 million and $31 million of scoring credit for fiscal years 1990 and 1991 respectively for actions the Committee took with respect to the Financial Institutions Reform, Recovery, and Enforcement Act of 1989 (H.R. 1278).

Table 2 and Table 3 present the outlay and revenue impact for each provision in Title X and Title XI, respectively.

TABLE 1.—TOTAL BUDGET IMPACT OF COMMITTEE ON WAYS AND MEANS RECONCILIATION RECOMMENDATIONS BY MAJOR CATEGORY

[By fiscal year, dollars in millions]

	1990	1991	1992	1993	1994
RECONCILIATION INSTRUCTION					
Outlays	2,300	2,300	0	0	0
Revenues	5,300	5,300	0	0	0
Either outlays or revenues	400	400	0	0	0
Total	8,000	8,000	0	0	0
RECONCILIATION PROVISIONS					
A. Social Security initiatives:					
Include deferred compensation in indexing of wage base	400	1,095	1,087	1,083	1,069
Miscellaneous amendments	−8	−24	−95	−160	−267
B. Trade initiatives:					
Custom service user fees	−154	773	−8	−12	−4
Caribbean Basin Iniative (CBI)	−31	−35	−39	−12	−2

TABLE 1.—TOTAL BUDGET IMPACT OF COMMITTEE ON WAYS AND MEANS RECONCILIATION RECOMMENDATIONS BY MAJOR CATEGORY—Continued

[By fiscal year, dollars in millions]

	1990	1991	1992	1993	1994
Miscellaneous tariff measures	−122	−151	−177	−58	−13
C. Human Resource initiatives:					
Children's initiative	−132	−424	−655	−823	−838
Elderly poor initiative	−179	−268	−281	−333	−296
Miscellaneous amendments	−5	0	0	0	0
Quality control amendments	0	−314	−515	−167	−161
Total	−316	−1,006	−1,451	−1,323	−1,295
D. Medicare initiatives:					
Part A	772	203	104	119	144
Part B	1,112	1,355	1,484	1,659	1,864
Parts A and B	831	895	816	576	300
Beneficiaries	325	455	485	515	545
Total	3,040	2,908	2,889	2,869	2,853
E. Amendments to Medicare Catastrophic Program:					
Reduce supplemental premium	−2,475	−2,456	−2,375	−2,679	−3,029
Increase part B premium [1]	975	1,960	2,750	3,810	4,240
Increase drug deductible	0	340	950	610	0
Make program voluntary	−90	−360	−160	−180	−180
Delay payments	2,000	700	−1,200	−940	−560
Total	410	184	−35	621	471
F. Child care initiative:					
Earned income tax credit	0	−415	−4,072	−4,366	−4,673
Title XX	−120	−266	−362	−394	−400
Total	−120	−681	−4,434	−4,760	−5,073
G. FSLIC scoring credit (H.R. 1278)	568	31	351	310	213
H. Revenue initiatives:					
Capital gains reduction	2,871	3,813	2,697	−5,723	−5,177
Permanent extension and speedup of telephone excise tax	102	1,615	2,737	2,936	3,149
Employee stock ownership plan proposals	1,392	1,828	2,298	2,743	3,184
Suspend airport and airway trust fund trigger for 1 years [2]	907	242	2	2	2
Administration "loophole closers"	413	655	822	966	1,042
Corporate mergers and acquisitions	462	778	832	847	798
Tax on ozone-depleting chemicals	384	560	753	1,171	1,442
Repeal bank foreign tax credit special rule	168	229	150	81	22
Permit limited use of excess pension funds for current retiree health benefits	286	465	176	0	0
Repeal balance of completed contract method of accounting	171	390	262	116	28
Impose income tax withholding on wages of certain agricultural workers	270	68	21	22	23
Payroll tax speedup for large companies (effective 1994)	0	0	0	0	1,775
Other revenue proposals	532	440	314	250	207
Expiring provisions	−1,605	−2,757	−2,967	−3,201	−3,744
Repeal section 89	−106	−78	−85	−93	−101
Corporate alternative minimum tax	−422	−676	−698	−684	−729
Tax penalty reform	0	−51	−82	−58	−25
Total	5,825	7,521	7,232	−625	1,896
Grand total—deficit reduction	9,492	10,615	5,320	−2,067	−152

[1] Includes both the ad hoc pat B premium increases of $3.50 per month in calendar year 1990, $4 in 1991, and $4.10 in 1992 and 1993, and extension of the 25 percent rule through 1993.

[2] Also includes modification in collection period of airline ticket tax.

Note: Since for reconciliation scoring, only direct spending and revenue provisions count, authorizations are not shown. Deficit reduction is net revenues plus net outlays savings.

Minus indicates a decrease in revenues or an increase in outlays.

Source: Congressional Budget Office and the Joint Committee on Taxation.

TABLE 2.—COMMITTEE ON WAYS AND MEANS RECONCILIATION PROVISIONS—TITLE X

[CBO and JCT estimates, in millions of dollars]

	1990	1991	1992	1993	1994
SUBCOMMITTEE ON SOCIAL SECURITY					
1. Independent agency (auth.)	(1)	−1	−1	−1	−1
2. Beneficiary services	−10	−7	−4	−5	−6
Authorization	−22	−34	−32	−32	−32
3. Representative payee (auth.)	−12	−3	−3	−3	−3
4, 7, and 10. Minor and technical	(1)	(1)	(1)	−1	−2
5. Adopted child benefits	−5	−12	−16	−21	−22
6. Religious exemptions (rev.)	−1	−1	−1	−1	—
8. DI work incentives	(1)	−1	−1	−3	−4
9. DI benefits during appeal	−8	−36	−48	−55	−65
11. Preeffectuation review	4	6	8	9	11
Authorization	4	5	5	6	6
12. Recoup benefits through IRS offset	20	125	90	60	0
Authorization	−5	−10	−5	−5	0
13. SSN for legalized aliens	(1)	(1)	(1)	(1)	(1)
14. Increase in retirement test—age 65–69	−60	−120	−140	−150	−170
15. Increase in special minimum benefit	−100	−140	−145	−155	−160
16. Repeal of retroactive benefits	150	160	160	160	150
17. Railroad life insurance (rev.)	(1)	(1)	(1)	(1)	(1)
18. Railroad 401(k) (rev.)	2	2	2	2	2
19. Codification of Rowan (rev.)	0	0	0	0	0
20. Include Deferred Compensation in Calculation of Indexing FICA Base Revenue	400	1,100	1,100	1,100	1,100
Outlay		−5	−13	−17	−31
Total direct spending	−9	−30	−109	−178	−299
Total authorizations	−35	−43	−36	−35	−30
Total revenues	402	1,101	1,101	1,101	1,101
SUBCOMMITTEE ON HUMAN RESOURCES					
Children's initiative:					
A. Social Services Block Grant:					
1. Title XX SSBG increase	0	−190	−390	−590	−600
B. Foster Care and child welfare amendments:					
1. Increase child welfare authorization	−98	−132	−134	−134	−134
2. Extend ceilings and transfer authority	−5	−7	−7	−2	0
3. Prevention report	(*)	(*)	(*)	(*)	(*)
4. Foster parent training	−1	−1	−1	−1	−1
5. Health/Education case plans	−2	−2	−2	−2	−2
ESPDT services for foster care	−10	−10	−10	−15	−15
6. Adolescent's block grant	−75	−100	−100	−25	0
7. Improve data collection	0	−2	−1	−1	−1
8. Improve accountability	(*)	(*)	(*)	(*)	(*)
C. SSI disabled children amendments:					
1. Individual assessment	−18	−50	−75	−105	−130
Authorization	−2	−2	−2	−2	−2
2. Presumptive eligibility	−4	−7	−7	−7	−7
3. Revise listings	(*)	−18	−23	−30	−35
4. Children's outreach	−3	−5	−7	−8	−10
Authorization	−1	(*)	(*)	(*)	(*)
5. Income averaging	−1	−1	−1	−1	−1
6. U.S. children abroad	−1	−2	−2	−2	−2
7. Intergenerational demo project (auth.)	−1	−1	−2	−2	−2
Donnelly amendment	−2	−2	−2	−2	−2
D. Child Support Enforcement amendments:					
1. Extend/modify IRS intercept	0	−2	−2	−2	−2
2. Make permanent and expand Medicaid transition in CSE cases	−10	−25	−25	−30	−30
Total, children direct spending	−132	−424	−655	−823	−838

TABLE 2.—COMMITTEE ON WAYS AND MEANS RECONCILIATION PROVISIONS—TITLE X—Continued

[CBO and JCT estimates, in millions of dollars]

	1990	1991	1992	1993	1994
Initiative for the poor elderly:					
1. SSI benefit increase ($2/mo.)	−60	−90	−95	−145	−105
2. SSI Outreach	−70	−110	−110	−105	−105
Authorization	−20	−5	−5	−5	−5
3. Representative payee reform (auth.)	−5	−1	−1	−2	−2
4. Modify ⅓ reduction	−45	−60	−65	−70	−70
Authorization	−5	−3	−3	−3	−3
5. Transportation gifts	(*)	(*)	(*)	(*)	(*)
6. Separated couples	−2	−2	−2	−2	−2
7. Burial spaces	(*)	(*)	(*)	(*)	(*)
8. Work incentives for SSDI recipients	−2	−6	−9	−11	−14
Total, elderly direct spending	−179	−268	−281	−333	−296
Miscellaneous amendments:					
A. Unemployment Compensation:					
1. Option for school employees	−5	0	0	0	0
2. Collateral estoppel	0	0	0	0	0
B. Family Support Act	0	0	0	0	0
AFDC/quality control amendments:					
1. Resolve backlog of disallowances	0	−314	−515	−167	−161
2. Permanently modify QC system	0	0	0	0	0
Total, Human Resources direct spending	−316	−1,006	−1,415	−1,323	−1,295
Total, Human Resources authorizations	−132	−144	−147	−148	−148
SUBCOMMITTEE ON HEALTH					
Part A:					
1. Capital at −15 percent in 1990	675	100	0	0	0
2. Hospital payments:					
a. Reduce payment by 1.35 percent/ProPAC differential	530	660	730	800	870
c. Increase update for rural	−140	−160	−180	−200	−220
d. Rural referral centers	−15	−25	−30	−15	0
e. Newly designated sole community hos	−20	−40	−40	−45	−50
h. EACH demonstration projects	0	−10	−20	−30	−30
Transition grants (auth.)	−25	−40	−40	0	0
k. Increase disproportionate share	−230	−285	−315	−345	−375
3. Rebase long-term and cancer hospitals	−8	−12	−12	−12	−12
4. Hospice payments	−20	−25	−30	−35	−40
5. Miscellaneous Part A provisions:					
g. Extend F.L.A.H.C.	0	(1)	1	1	1
Total, part A direct spending	772	203	104	119	144
Part B:					
6. Reduce overpriced procedures:					
a. Up to 15 percent using RB RVS eff. 4/1/90	210	285	325	370	415
b. By 8 percent for radiology services	110	140	160	180	200
c. Round anesthesiology to actual time	40	45	55	60	65
7. Reduce update for physician services	515	415	465	525	590
8. Three part physician payment package	0	0	130	145	165
9. Other physician provisions:					
a. New physician customaries	25	150	0	0	0
b. Desigflated specialties	30	35	40	45	50
10. Hosp. out-patient capital at −15 percent in 90	25	20	0	0	0
11. Durable medical equipment—total	200	420	475	535	600
12. Clinical Labs	90	145	180	205	240
13. Mental health services:					
a. Pay psychologists	−15	−25	−30	−40	−40
b. Eliminate $1,100 limit	−20	−55	−75	−90	−115
14. Miscellaneous Part B					
a. Payments to Nurses	−71	−186	−206	−231	−256

TABLE 2.—COMMITTEE ON WAYS AND MEANS RECONCILIATION PROVISIONS—TITLE X—Continued

[CBO and JCT estimates, in millions of dollars]

	1990	1991	1992	1993	1994
b. Revise payments to comm. health ctrs.	−13	−30	−35	−45	−50
c. Small blood labs	−14	−4	0	0	0
e. Diabetic shoe inserts	(1)	(1)	(1)	0	0
Total, part B	1,112	1,355	1,484	1,659	1,864
Parts A and B:					
15. Delay payments 2 days	470	70	80	80	90
16. Secondary payer info from IRS	325	780	680	420	110
Authorization	−25	−30	−30	−20	−10
17. Cap ESRD method II payments	75	110	135	165	200
18. Medical effectiveness/outcomes research (auth.)	−72	−110	−170	−225	−270
19. Hospital patient protection amendments	0	0	0	0	0
20. HMO physician incentive plans	0	0	0	0	0
21. Physician ownership/referral	0	0	0	0	0
22. Miscellaneous Parts A and B:					
a. Coverage for religious orders	−12	−15	−20	−0	−25
b. Long-term care study (auth.)	−5	−3	0	0	0
c. Medicare buy-in for SSDI benef.	(1)	−3	−7	−12	−18
d. Hospital based nursing schools	−25	−45	−50	−55	−55
Authorization	(1)	−1	−1	−1	−1
e. GAO review of LTC insur. standards	0	0	0	0	0
f. Cancer Protocol Demo	−2	−2	2	−2	−2
Total, parts A and B direct spending	831	895	816	576	300
Beneficiaries:					
23. Extend 25 percent Part B premium rule for one year	325	455	485	515	545
Other:					
24. Extend COBRA coverage from 18 to 29 for SSI disabled	(1)	(1)	(1)	(1)	(1)
Total, Health direct spending	3,040	2,908	2,889	2,869	2,853
AMENDMENTS TO MEDICARE CATASTROPHIC PROGRAM					
1. Reduce supplemental premium	−2,475	−2,456	−2,375	−2,679	−3,029
2. Ad Hoc increase Part B premium	975	1,460	1,550	1,585	1,660
3. Extend Part B premium 25 percent rule	0	500	1,200	2,225	2,580
4. Increase drug deductible	0	340	950	610	0
5. Make Program voluntary	−90	−360	−160	−180	−180
6. Delay payments	2,000	700	−1,200	−940	−560
Total	410	184	−35	621	471
SUBCOMMITTEE ON TRADE					
1. H.R. 2443 Trade Agency authorizations	0	0	0	0	0
2. Customs user fees	−154	773	−8	−12	−4
3. Eliminate Superfund differential	0	0	0	0	0
4. Caribbean Basin Initiative (CBI)	−31	−35	−39	−12	−2
5. Miscellaneous tariff measures	−122	−151	−177	−58	−13
Total	−307	587	−224	−82	−19
Grand Total, deficit reduction	3,219	3,744	2,171	3,008	2,812

[1] Less than $500,000.

Note.—Unless otherwise indicated, each provision represents a change in direct spending. For purposes of reconciliation scoring, authorizations do not count, because they require further action by the Appropriations Committee.

Minus indicates a decrease in revenues or an increase in outlays.

TABLE 3.—ESTIMATES OF REVENUE EFFECTS OF ITEMS REPORTED PURSUANT TO BUDGET RECONCILIATION INSTRUCTIONS—TITLE XI: FISCAL YEARS 1990–94

[In millions of dollars]

Item	1990	1991	1992	1993	1994	1990–94
I. ADMINISTRATION PROPOSALS*						
A. Suspend airport and airway trust fund tax reduction trigger until expiration of present taxes (effective Jan. 1, 1990) [1]	851	269				1,120
B. Loophole closers:						
1. Characterize certain high-yield original issue discount (OID) obligations as preferred stock	25	51	94	131	160	461
2. Require consolidated computation of earnings and profits for corporations filing consolidated returns	27	69	123	170	224	613
3. Like-kind exchanges:						
a. Limit like-kind exchanges to similar use property	143	222	273	325	378	1,341
b. Restrict basis shifting techniques between related parties	100	120	130	140	151	641
c. Amend holding period requirements	(2)	(2)	(2)	(2)	(2)	(2)
4. Limit section 104 exclusion from income to amount received for personal injury	4	8	8	10	12	42
5. Tax pre-contribution gain on certain in-kind partnership distributions	9	20	26	31	36	122
6. Limit nonrecognition treatment when securities are received in certain section 351 transactions	105	165	168	159	81	678
Subtotal	1,264	924	822	966	1,042	5,018
II. MODIFIED ADMINISTRATION PROPOSALS*						
A. Impose oilspill liability trust fund petroleum tax (effective Oct. 1, 1989, through Dec. 31, 1991) at $0.03 per barrel (cap at $300 million), without waiting for authorizing legislation	69	122	41			232
B. Telephone excise tax:						
1. Permanent extension		1,717	2,737	2,936	3,149	10,539
2. Modify collection period of tax (100 percent speedup, effective for taxes billed by service producers after June 30, 1990)	102	−102				
Subtotal	171	1,737	2,778	2,936	3,149	10,771
III. OTHER PROVISIONS*						
A. Employee stock ownership plans (ESOP's):						
1. Repeal partial exclusion for interest paid on ESOP loans (section 133) (generally effective June 7, 1989)	1,008	1,258	1,663	2,036	2,369	8,334
2. Repeal the deduction for dividends paid on employer securities obtained by an ESOP (section 404(k))	307	404	536	657	765	2,669
3. Impose 3-year holding period on seller to be eligible for tax-free rollover (section 1042)	(2)	(2)	(2)	(2)	(2)	(2)
4. Repeal sections 2057, 2210, 415(c)(6), and 382(1)(3)(C)	77	166	99	50	50	442
B. Repeal transition rule for certain high withholding tax interest (effective Jan. 1, 1990)	168	229	150	81	22	650
C. Repeal remaining portion of completed contract method of accounting	171	390	262	116	28	967
D. Corporate mergers and acquisitions:						
1. Certain transactions involving foreign and other tax-exempt investors:						
a. Limit interest deductions for earnings-stripping payments to related parties	28	38	44	47	49	206
b. Tax stock gains of certain foreign investors	2	5	6	35	50	98
2. Clarify Treasury regulation authority relating to bifurcation of an instrument into debt and equity portions (section 385)	(2)	(2)	(2)	(2)	(2)	(2)
3. Require reporting to IRS of acquisitions and recapitalizations (effective on date of enactment)	(2)	(2)	(2)	(2)	(2)	(2)

TABLE 3.—ESTIMATES OF REVENUE EFFECTS OF ITEMS REPORTED PURSUANT TO BUDGET RECONCILIATION INSTRUCTIONS—TITLE XI: FISCAL YEARS 1990–94—Continued

[In millions of dollars]

Item	1990	1991	1992	1993	1994	1990–94
4. Require Treasury study of "debt versus equity" and integration issues						
E. Permit limited use of excess pension funds to pay current retiree health benefits (effective Jan. 1, 1990)	286	465	176	(3)	(3)	927
F. Impose gasoline excise tax when gasoline is received at terminal (effective Oct. 1, 1989)	117	60	60	60	60	357
G. Require corporate estimated tax payments on tax liability for certain subchapter S income (effective Jan. 1, 1990)	25	(2)	(2)	(2)	(2)	25
H. Impose income tax withholding on the wages of certain agricultural workers (effective Jan. 1, 1990)	270	68	21	22	23	404
I. Require regulated investment companies (mutual funds) to distribute 98 percent of ordinary income to their shareholders (effective for taxable years ending after July 10, 1989	50	5	5	5	5	70
J. Adjust basis for mutual fund load charge only if shareholder holds shares for 30 days	14	28	13	5	3	63
K. Reduce built-in gain or loss threshold of sections 382 and 384 to lesser of 15 percent or $10 million	25	42	44	46	49	206
L. Increase enforceability of section 482 with respect to U.S. subsidiaries and branches of foreign corporations through improved reporting	60	80	85	90	95	410
M. Modify excess loss account recapture rules to prevent shifting of basis to debt	54	69	61	52	42	278
N. Require basis reduction for nontaxed portion of dividends on self-liquidating ("wasting") stock	6	10	11	12	13	52
O. Modify treatment of costs of acquiring franchises, trademarks, and trade names	75	135	173	203	225	811
P. Conform tax years of controlled foreign corporations and foreign personal holding companies to the tax years of their U.S. shareholders	48	71	71	71	36	297
Q. Change the sourcing of foreign income of certain commonly controlled nonconsolidated corporations	20	37	41	45	49	192
R. Limit nonrecognition treatment when securities are received by corporate transferors in certain section 351 transactions (effective July 11, 1989)	52	83	84	80	40	339
S. Deny expensing for certain R&D not performed in the United States (effective for taxable years beginning after Dec. 31, 1989)	43	81	68	57	47	296
T. Include dividends in income of RIC's (regulated investment companies) on ex-dividend date (effective for ex-dividend dates after date of enactment)	110	20	20	20	20	190
U. Deny retroactive certification of WIN credit	38	28	12			78
V. Deny amortization of life estate in related-party joint purchases		7	7	8	8	30
W. Treat cellular telephones and other similar telecommunications equipment as "listed property"	2	10	14	18	24	68
X. Require reporting of mortgage points by lender	2	5	5	5	5	22
Subtotal	3,058	3,794	3,731	3,821	4,077	18,481
IV. CHILD CARE PROVISIONS						
A. Expanded earned income tax credit (effective Jan. 1, 1991):						
1. Adjustment for family size (3+): phasein 17 percent, 21 percent, 25 percent; phaseout 12 percent, 15 percent, 18 percent		−296	−2,878	−3,092	−3,315	−9,581
2. Supplemental for children under 6 years old: phasein 6 percent; phaseout 4.25 percent		−119	−1,194	−1,274	−1,358	−3,945
B. Expansion of title XX block grant for child care services (4)	−120	−266	−362	−394	−400	−1,542
Subtotal	−120	−681	−4,434	−4,760	−5,073	−15,068

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

ROBERT D. REISCHAUER,
Director.

TABLE 1.—TITLE X: BUDGET RECONCILIATION PROVISIONS OF THE COMMITTEE ON WAYS AND MEANS

[Outlays by fiscal year, in millions of dollars]

	1990	1991	1992	1993	1994	Total 1990–94
TITLE X: GRAND TOTAL						
Direct spending:						
Directed baseline	−5,626	−5,675	−3,531	−4,811	−5,235	−24,875
Current law	−5,626	−5,675	−3,531	−5,836	−6,905	−27,570
Revenues	−1,932	−1,560	−1,874	−2,058	−2,390	−9,811
Net deficit effect:						
Directed baseline	−3,694	−4,115	−1,657	−2,753	−2,845	−15,064
Current law	−3,694	−4,115	−1,675	−3,778	−4,515	−17,759
Spending subject to appropriation	1,326	508	494	440	463	3,230
Total effect assuming appropriations:						
Directed baseline	−2,368	−3,607	−1,163	−2,313	−2,382	−11,835
Current law	−2,368	−3,607	−1,163	−3,338	−4,052	−14,530
February baseline:						
Direct spending:						
Directed baseline [1]	−3,065	−3,030	−2,210	−3,455	−3,980	−15,740
Current law	−3,065	−3,030	−2,210	−3,120	−3,545	−14,970
Revenues	−2,182	−2,475	−2,758	−3,089	−3,475	−13,979
Net deficit effect:						
Directed baseline [1]	−883	−555	−548	−366	−505	−1,761
Current law	−883	−555	−548	−31	−70	−991
July baseline:						
Direct spending:						
Directed baseline [1]	−3,055	−3,180	−2,720	−3,720	−3,970	−16,645
Current law	−3,055	−3,180	−2,720	−3,385	−3,535	−15,875
Revenues	−2,645	−2,996	−2,755	−3,099	−3,499	−14,995
Net deficit effect:						
Directed baseline [1]	−410	−184	35	−621	−471	−1,651
Current law	−410	−184	35	−286	−36	−881
SUBTITLE A—SOCIAL SECURITY ADMINISTRATION, OLD-AGE, SURVIVORS AND DISABILITY INSURANCE, AND RAILROAD RETIREMENT						
Chapter 1: Administrative changes						
Subchapter A: Establishment of the Social Security Administration as an independent agency:						
Secs. 10001–10014. Establish Social Security Administration as independent agency (subject to appropriation)	(2)	1	1	1	1	4
Subchapter B: Improvements in Social Security services:						
Sec. 10021. Standards governing collection of overpayments	10	7	3	3	3	26
Sec. 10022: Demonstration projects relating to telephone service centers (subject to appropriation)	1	3	1	(2)	(2)	4
Sec. 10023. Standards applicable in certain determinations of good cause, fault, and good faith (subject to appropriation)	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 10024. Assistance to the homeless (subject to appropriation)	20	30	30	30	30	140
Sec. 10025. Notice requirements (subject to appropriation)	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 10026. Representation of claimants (subject to appropriation)	(2)	(2)	(2)	1	1	2
Sec. 10027. Applicability of administrative res adjudicata	(2)	(2)	(2)	(2)	(2)	(2)

TABLE 1.—TITLE X: BUDGET RECONCILIATION PROVISIONS OF THE COMMITTEE ON WAYS AND MEANS—Continued

[Outlays by fiscal year, in millions of dollars]

	1990	1991	1992	1993	1994	Total 1990–94
Sec. 10028. Authority for Secretary to take into account misinform. Provided to applicants in determining date of application for benefits	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 10029. Same-day personal interviews where time is of the essence (subject to appropriation)	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 10030. Authority to amend wage records after time limitation expires	(2)	(2)	1	2	3	7
(Subject to appropriation)	1	1	1	1	1	4
Subchapter C: Representative payee reforms:						
Sec. 10031. Improvements in the Representative payee selection and recruitment (subject to appropriation)	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 10032. Improvements in recordkeeping and auditing requirements, (subject to appropriation)	12	3	3	3	3	24
Sec. 10033. Report to the Congress (subject to appropriation)	(2)	(2)	(2)	(2)	(2)	(2)
Subtotal: Chapter 1:						
Subject to appropriation	34	38	36	36	36	178
Direct spending	10	7	4	5	6	33
Total spending assuming appropriations	44	45	40	41	42	211
Chapter 2: Provisions affecting Coverage						
Sec. 10051. Elimination of the dependency test for certain adopted children	5	12	16	21	22	76
Sec. 10052. Clarification of rules governing taxation of individuals of certain religious faiths (Revenue Effect)	−1	−1	−1	−1	−1	−5
Sec. 10053. Prohibition of termination of coverage of U.S. citizens and residents abroad by foreign Affiliates of American Employers	(2)	(2)	(2)	(2)	(2)	(2)
Subtotal: Chapter 2:						
Direct spending	5	12	16	21	22	76
Revenues	−1	−1	−1	−1	−1	−5
Total deficit effect	6	13	17	22	23	81
Chapter 3: Provisions affecting entitlement to benefits						
Subchapter A: Work incentives for certain adult disabled children:						
Secs. 10061–10064. Continuation of entitlement to certain child's insurance benefits based on disability:						
Social Security	(2)	1	1	2	3	7
SSI	(2)	(2)	(2)	(2)	(2)	−1
Medicare	(2)	(2)	(2)	1	1	3
Subtotal	(2)	1	1	3	4	9
Subchapter B: Other Provisions:						
Sec. 10071. Continuation of disability benefits upon appeal:						
Social Security	6	27	37	43	51	164
Medicare	2	9	11	12	14	48
Subtotal	8	36	48	55	65	212
Sec. 10072. Elimination of any carryover reduction in retirement of disability benefits due to receipt of widow's or widower's benefits before attaining age 62	(2)	(2)	(2)	1	2	3
Sec. 10073. Modification of preeffectuation review requirement applicable to disability insurance cases	−4	−6	−8	−9	−11	−38
(Subject to appropriation)	−4	−5	−5	−6	−6	−26
Sec. 10074. Recovery of OASDI overpayments by means of reduction in tax refunds	−20	−125	−90	−60	0	−295
(Subject to appropriation)	5	10	5	5	0	25

TABLE 1.—TITLE X: BUDGET RECONCILIATION PROVISIONS OF THE COMMITTEE ON WAYS AND MEANS—Continued

[Outlays by fiscal year, in millions of dollars]

	1990	1991	1992	1993	1994	Total 1990–94
Sec. 10075. Exemption for certain aliens, receiving amnesty, from liability for misreporting of earnings or misuse of Social Security account numbers or cards	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 10076. Adjustments in exempt amount for the retirement test	60	120	140	150	170	640
Sec. 10077. Increase in the minimum primary insurance amount	100	140	145	155	160	700
Sec. 10078. Elimination of eligibility for retroactive benefits for certain individuals	−150	−160	−160	−160	−150	780
Sec. 10079. Inclusion of certain deferred compensation in determination of wage-based adjustments:						
Outlays	0	5	13	17	31	66
Revenues	400	1,100	1,100	1,100	1,100	4,800
Subtotal: Chapter 3:						
Social Security—Subject to Appropriations	1	5	0	−1	−6	−1
Social Security—Direct Spending	−8	2	78	139	256	467
SSI	(2)	(2)	(2)	(2)	(2)	−1
Medicare	2	9	11	13	15	51
Revenues	400	1,100	1,100	1,100	1,100	4,800
Subtotal: Chapter 3:						
Direct spending	−6	11	89	152	271	517
Revenues	400	1,100	1,100	1,100	1,100	4,800
Net deficit effect	−406	−1,089	−1.011	−948	−829	−4,283
Spending subject to appropriation	1	5	0	−1	−6	−1
Total effect assuming appropriations	−405	−1084	−1011	−949	−835	−4284
Chapter 4: Railroad Retirement						
Sec. 10081. Treatment of group-term life insurance under railroad retirement taxes: revenue	(2)	(2)	(2)	(2)	(2)	2
Sec. 10082: Treatment of certain deferred compensation and salary reduction arrangements under railroad retirement taxes	2	2	2	2	012	11
Subtotal: Chapter 4 Revenues	2	2	2	2	2	13
Subtitle A: Total:						
Direct spending	9	30	109	178	299	626
Revenues	401	1,101	1,101	1,101	1,101	4,808
Net deficit effect	−392	−1,071	−992	−923	−802	−4,182
Spending subject to appropriation	35	43	36	35	30	177
Total effect assuming appropriations	−357	−1,028	−956	−888	−772	−4,005
Subtitle B—Medicare						
Part A: Part A provisions of Medicare						
Subpart 1: Payment for inpatient hospital services:						
10101 Reduction in payments for capital	−675	−100	0	0	0	−775
10102 Prospective payment hospitals						
a. Reduction in hospital update factors	−530	−660	−730	−800	−870	−3,590
c. Disproportionate share adjustments	220	285	315	345	375	1,550
d. Update factor for rural hospitals	140	160	180	200	220	900
e. Extend regional referral center classification	15	25	30	15	0	85
f. Sole community hospitals	20	40	40	45	50	195
h. Essential access community hospital demonstration						
1. Demonstration grants subject to appropriation	25	40	40	0	0	105
2. Medicare reimbursement to: E.A.C.H. and rural primary care hospitals	0	10	20	30	30	90

TABLE 1.—TITLE X: BUDGET RECONCILIATION PROVISIONS OF THE COMMITTEE ON WAYS AND MEANS—Continued

[Outlays by fiscal year, in millions of dollars]

	1990	1991	1992	1993	1994	Total 1990–94
10103 PPS-exempt hospitals:						
a. Exempt cancer hospitals	3	2	2	2	112	
b. Rebase cancer hospitals to 1987 costs	5	10	10	10	10	45
Subpart 2: Other provisions:						
10111 Payments for hospice care	20	25	30	35	40	150
10112 Miscellaneous part A provisions:						
b. Buy-in for disabled individuals	(2)	3	7	12	18	40
g. Waiver extensions for Finger Lakes area hospital's corporation	0	(2)	−1	−1	−1	−3
Subtotal Part A Savings:						
Direct spending	−772	−220	−97	−107	−126	−1,302
Amounts subject to appropriations	25	40	40	0	0	105
Part B: Part B provisions of Medicare						
Subpart 1: Payment physicians' services:						
10121 Reduce certain procedures:						
a. Reduce overpriced procedures	−210	−285	−325	−370	−415	−1,605
b. Reduce radiology services	−110	−140	−160	−180	−200	−790
c. Round anesthesiology payments to actual time	−40	−45	−55	−60	−65	−265
10122 Reduce MEI update:						
a. Delay update of all fees	−260	0	0	0	0	−260
b. Reduce update from 5.3 percent to 2 percent	−255	−415	−465	−525	−590	−2,250
10123 Physician payment reform implement RB RVS on Jan. 1, 1991: [1]						
Directed baseline	0	0	−130	−145	−165	−440
Current law	0	0	−130	−1,505	−2,270	−3,905
10124 Miscellaneous provisions relating to payment for physician services:						
a. New physician customary charges	−25	−150	0	0	0	−175
b. Designated specialties	−30	−35	−40	−45	−50	−200
Subpart 2: Payment for other services:						
10131 Reduce out-patient hospital capital	−25	−20	0	0	0	−45
10132 Durable medical equipment	−200	−420	−475	−535	−600	−2,230
10133 Clincial lab tests	−90	−145	−180	−205	−240	−860
Mileage fee small blood labs	14	4	0	0	0	18
10134 Mental health services:						
a. pay psychologists	15	25	30	40	40	150
b. Eliminate $1,100 limit (incl. interaction with a.)	20	55	75	90	115	355
10135 Payments to nurses:						
Increase level of CRNA payments $14/21 Proposal	70	185	205	230	255	945
First assistants at surgery	1	1	1	1	1	5
10136 Federally qualified health center services	13	30	35	45	50	173
10137 Miscellaneous part B provisions: Diabetic shoe inserts	(2)	(2)	(2)	0	0	(2)
Subtotal for Part B:						
Direct spending:						
Directed baseline	−1,112	−1,355	−1,484	−1,659	−1,864	−7,474
Current law	−1,112	−1,355	−1,484	−3,019	−3,969	−10,939
Part C: Part A and B Medicare provisions						
10151 Delay in payments in FY 1990	−470	−70	−80	−80	−90	−790
10152 Medicare as secondary payor:						
Direct spending	−325	−780	−680	−420	−110	−2,315
Subject to appropriation	25	30	30	20	10	115
Coverage rule for religious order	12	15	20	20	25	92
10153 ESRD services	−75	−110	−135	−165	−200	−685
10154 Outcomes Effectiveness Research Subject to Appropriation	72	110	170	225	270	847

TABLE 1.—TITLE X: BUDGET RECONCILIATION PROVISIONS OF THE COMMITTEE ON WAYS AND MEANS—Continued

[Outlays by fiscal year, in millions of dollars]

	1990	1991	1992	1993	1994	Total 1990–94
10158 Miscellaneous part A and B provisions:						
e. Rural health medical education demonstration	(2)	(2)	(2)	(2)	(2)	(2)
f. Cancer treatment protocol demonstration	2	2	2	2	2	10
i. Recognize hospital-based nursing costs	25	25	50	55	55	230
j. Inner city hospital triage demonstration	(2)	(2)	(2)	(2)	(2)	(2)
Subtotal Part A and B Savings:						
Direct spending	−831	−898	−823	−588	−318	−3,458
Amounts subject to appropriations	97	140	200	245	280	962
Part D: Part B Premium						
10161 Basic part B premium: 25 percent CY 90 (includes interaction with other part B savings)	−325	−455	−485	−515	−545	−2,325
Part E: Extension of Cobra Continuation coverage for disabled employees						
10171 Extension from 18 to 29 months	(2)	(2)	(2)	(2)	(2)	(2)
Part F: Revisions to Medicare Catastrophic Coverage Act [3]						
Subpart 1: Medicare part A and supplemental Medicare premium:						
10181 Supplemental Medicare premium:						
a. Reduction in supplemental premium rate:[4] Revenue	−2,082	−2,035	−2,278	−2,559	−2,895	−11,849
b. Supplemental based on part B enrollment: Revenue	−100	−440	−480	−530	−580	−2,130
10182 Abolition of Federal hospital insurance catastrophic coverage reserve fund	0	0	0	0	0	0
Subpart 2: Medicare part B provisions:						
10191 Catastrophic linked to election of part B [5]	−90	−190	−230	−260	−300	−1,070
10192 Adjustments in part B premium						
a. Part B premium adjustments:						
Directed baseline	0	−500	−1,200	−2,225	−2,580	−6,505
Current law	0	−500	−1,200	−1,890	−2,145	−5,735
b. Ad hoc premium increase [6]						
Directed baseline	−975	−1,460	−1,550	−1,585	−1,660	7,230
Current law	−975	−1,460	−1,550	−1,585	−1,660	−7,230
10193 Increase in catastrophic drug deductible	0	−180	−430	−325	0	−935
10194 Temporary delay in Medicare payments	−2,000	−700	−1,200	−940	−560	0
Subtotal for part F: Revenue	−2,182	−2,475	−2,758	−3,089	−3,475	−13,979
Direct spending:						
Directed baseline	−3,065	−3,030	−2,210	−3,455	−3,980	−15,740
Current law	−3,065	−3,030	−2,210	−3,120	−3,545	−14,970
Grand total Medicare: Revenue	−2,182	−2,475	−2,758	−3,089	−3,475	−13,979
Direct spending:						
Directed baseline	−6,105	−5,938	−5,099	−6,324	−6,833	−30,299
Current law	−6,105	−5,938	−5,099	−7,349	−8,503	−32,994
Net deficit effect:						
Directed baseline	−3,923	−3,463	−2,341	−3,235	−3,358	−16,320
Current law	−3,923	−3,463	−2,341	−4,260	−5,028	−19,015
Amounts subject to appropriation	122	180	240	245	280	1,067
Total deficit effect assuming full appropriation:						
Directed baseline	−3,801	−3,283	−2,101	−2,990	−3,078	−15,253
Current law	−3,801	−3,283	−2,101	−4,015	−4,748	−17,948

TABLE 1.—TITLE X: BUDGET RECONCILIATION PROVISIONS OF THE COMMITTEE ON WAYS AND MEANS—Continued

[Outlays by fiscal year, in millions of dollars]

	1990	1991	1992	1993	1994	Total 1990–94
SUBTITLE C—HUMAN RESOURCE AMENDMENTS						
Part 1: Children's initiative						
Subpart A: Social services: Sec. 10201. Increase Title XX block grant	0	190	390	590	600	1,770
Subpart B: Foster care and child welfare amendments:						
Sec. 10211. Increase child welfare authorization (subject to appropriation)	98	132	134	134	134	632
Sec. 10212. Extend ceilings and transfer authority	5	7	7	2	0	21
Sec. 10213. Prevention report	(2)	(2)	(2)	(2)	(2)	1
Sec. 10214. Increase foster parent training reimbursement	1	1	1	1	1	5
Sec. 10215. Require health and education plans and require comprehensive health exams:						
Foster care medicaid	2	2	2	2	2	10
Medicaid	10	10	10	15	15	60
Total	12	12	12	17	17	70
Sec. 10216. Foster care adolescent services block grant	75	100	100	25	0	300
Sec. 10217. Improve data collection	(2)	2	1	1	1	5
Sec. 10218. Improve accountability	(2)	(2)	(2)	(2)	(2)	(2)
Subpart C: SSI disabled children amendments:						
Sec. 10221. Conduct Children's outreach:						
SSI—Subject to appropriation	1	(2)	(2)	(2)	(2)	1
SSI—Direct spending	2	4	5	6	7	24
Total	4	5	7	8	10	34
Medicaid	1	2	3	3	4	13
Food stamps	0	−1	−1	−1	−1	−4
Subject to appropriation	1	(2)	(2)	(2)	(2)	1
Direct spending	3	5	7	8	10	33
Total	4	5	7	8	10	34
Sec. 10222. Individual functional assessment for children:						
SSI—Subject to appropriation	2	2	2	2	2	10
SSI—Direct spending	15	40	60	80	95	290
Medicaid	5	15	25	35	45	125
Food stamps	−2	−5	−10	−10	−10	−37
Subject to appropriation	2	2	2	2	2	10
Direct spending	18	50	75	105	130	378
Total	20	52	77	107	132	388
Sec. 10223. Presumptive disability for certain children under age of 4:						
SSI	3	5	5	5	5	23
Medicaid	1	2	2	2	2	9
Total	4	7	7	7	7	32
Sec. 10224. Publish childhood mental impairment listing:						
SSI	(2)	15	20	25	30	90
Medicaid	(2)	5	5	10	10	30
Food stamps	(2)	−2	−2	−5	−5	−14
Total	(2)	18	23	30	35	106

TABLE 1.—TITLE X: BUDGET RECONCILIATION PROVISIONS OF THE COMMITTEE ON WAYS AND MEANS—Continued

[Outlays by fiscal year, in millions of dollars]

	1990	1991	1992	1993	1994	Total 1990–94
Sec. 10225. Revise listings of impairments for childhood disabilities	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 10226. Provide medicaid eligibility in months when ineligible because weekly or biweekly checks	1	1	1	1	1	5
Sec. 10227. Make U.S. children abroad eligible for SSI	1	2	2	2	2	9
Sec. 10228. Change deeming rules for children in State home care plans	2	2	2	2	2	10
Sec. 10229. Demo intergenerational project for disabled children (subject to appropriation)	1	1	2	2	2	8
Sec. 10230. Exclude from resources work: related equipment	(2)	(2)	(2)	(2)	(2)	(2)
Subpart D: Child support enforcement amendments:						
Sec. 10231. Extend IRS intercept	0	2	2	2	2	8
Sec. 10232. Allow IRS intercept for non-minor disabled children	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 10233. Provide 12 months of medicaid eligibility for families leaving AFDC because of child support medicaid	10	25	25	30	30	120
Subtotal: Part 1:						
TITLE XX	0	190	390	590	600	1,770
Child care—Subject to Appropriation	98	132	134	134	134	632
Foster care—Direct spending	83	112	111	31	4	342
SSI—Subject to Appropriation	4	3	4	4	4	19
SSI—Direct spending	23	68	94	120	141	446
Child support enforcement	0	2	2	2	2	8
Medicaid	28	60	71	96	107	362
Food stamps	−2	−8	−13	−16	−16	−55
Total: Part 1:						
Subject to appropriation	102	135	138	138	138	651
Direct spending	132	424	655	823	838	2,873
Total spending	234	559	793	961	976	3,524
Part 2: SSI service improvements						
Subpart A: Initiative for the Poor Elderly:						
Sec. 10241. SSI Benefit Increase:						
SSI	70	100	105	160	115	550
Medicaid	(*)	5	5	5	5	20
Food stamps	−10	−15	−15	−20	−15	−75
Total	60	90	95	145	105	495
Sec. 10242. Establish SSI outreach—Adults:						
SSI—Subject to appropriation	20	5	5	5	5	40
SSI—Direct spending	35	55	55	50	50	245
Medicaid	40	60	60	60	60	280
Food stamps	−5	−5	−5	−5	−5	−25
Subject to appropriation	20	5	5	5	5	40
Direct spending	70	110	110	105	105	500
Total	90	115	115	110	110	540
Sec. 10243. Reform representative payee procedures and tracking (subject to appropriation)	5	1	1	2	2	11
Sec. 10244. Modify one-third reduction rule:						
SSI—Subject to appropriation	5	3	3	3	3	17
SSI—Direct spending	45	60	65	70	70	310
Total	50	63	68	73	73	327

TABLE 1.—TITLE X: BUDGET RECONCILIATION PROVISIONS OF THE COMMITTEE ON WAYS AND MEANS—Continued

[Outlays by fiscal year, in millions of dollars]

	1990	1991	1992	1993	1994	Total 1990–94
Sec. 10245, Exclude domestic travel tickets from SSI income	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 10246. Reduction in time when separated couples income treated jointly	2	2	2	2	2	10
Sec. 10247. Exclude interest income on burial spaces	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 10248. Deem certain recipients of title II disability insurance to have received SSI:						
SSI	2	2	3	4	5	16
Medicaid	(2)	4	6	7	9	26
Total	2	6	9	11	14	42
Sec. 10249. Exclude Victims Compensation Payments	(2)	(2)	(2)	(2)	(2)	(2)
Subpart B: Other service improvements:						
Sec. 10251. Determination of good faith	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 10252. Assist homeless	(8)	(8)	(8)	(8)	(8)	(8)
Sec. 10253. Notice requirements	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 10254. Representation of claimants	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 10255. Application of administrative res judicata	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 10256. Misinformation for beneficiaries	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 10257. Same day personnel interview	(2)	(2)	(2)	(2)	(2)	(2)
Subtotal: Part 2:						
SSI—Subject to appropriation	30	9	9	10	10	68
SSI—Direct spending	154	219	230	286	242	1,131
Medicaid	40	69	71	72	74	326
Food stamps	−15	−20	−20	−25	−20	−100
Subtotal: Part 2:						
Subject to appropriation	30	9	9	10	10	68
Direct spending	179	268	281	333	296	1,357
Total spending	209	277	290	343	306	1,425
Part 3: Miscellaneous amendments						
Sec. 10261. Option for school employees	5	0	0	0	0	5
Sec. 10263. Extend moratorium on implementation of regulation on homeless AFDC families [9]	0	0	0	0	0	0
Sec. 10264. Authorize self-employment demonstration program subject to appropriation	(2)	(2)	(2)	0	0	1
Sec. 10265. Minnesota AFDC demonstration	(2)	(2)	(2)	(2)	(2)	1
Subtotal: Part 3:						
Direct spending	5	0	0	0	0	6
Total spending	5	0	0	0	0	6
Part 4: AFDC quality control amendments						
Subpart A: Resolution of disallowance backlog through fiscal year 1990: Sec. 10271. Modify treatment of quality control sanctions backlog	0	314	515	167	161	1,157
Subpart B: Permanent modification of quality control system after fiscal year 1990: Sec. 10281. Modify quality control system [10]	0	0	0	0	0	0
Subtotal: Part 4:						
Direct spending	0	314	515	167	161	1,157
Total spending	0	314	515	167	161	1,157
Subtitle C: Total						
Subject to appropriation	132	144	147	148	148	719

TABLE 1.—TITLE X: BUDGET RECONCILIATION PROVISIONS OF THE COMMITTEE ON WAYS AND MEANS—Continued

[Outlays by fiscal year, in millions of dollars]

	1990	1991	1992	1993	1994	Total 1990–94
Direct spending	316	1,006	1,451	1,323	1,295	5,393
Total effect assuming appropriations	448	1,150	1,598	1,471	1,443	6,112
SUBTITLE D—TRADE AMENDMENTS						
Part 1—Trade Agency authorizations for fiscal year 1990						
Sec. 10301. United States International Trade Commission (subject to appropriation)	34	3	1	1	(2)	40
Sec. 10302. United States Customs Service (subject to appropriation)	984	134	70	11	5	1,203
Sec. 10303. United States Trade Representative (subject to appropriation)	18	3	(2)	(2)	(2)	21
Subtotal: Part 1—Subject to appropriation	1,036	140	71	12	5	1,264
Part 2—Customs user fees						
Sec. 10311–10316. Customs user fees	154	−773	8	12	4	−595
Subtotal: Part 2—Offsetting receipts	154	−773	8	12	4	−595
Subtitle D—Total:						
Subject to appropriation	1,036	140	71	12	5	1,264
Direct spending (offsetting receipts)	154	−773	8	12	4	−595
Total effect assuming appropriations	1,190	−663	79	24	9	669
SUBTITLE E—CARIBBEAN BASIN ECONOMIC RECOVERY						
Part 2—Amendments to the Caribbean Basin Economic Recovery Act and related provisions						
Subpart A—Amendments to the Caribbean Basin Economic Recovery Act: Sec. 10412. Exceptions to general duty-free treatment revenue	−29	−32	−37	−10	0	−108
Subpart B—Amendments to the harmonized tariff schedule and other provisions affecting CBI beneficiary countries: Sec. 10423. Duty-free treatment of articles assembled from U.S. components revenue	−1	−2	−2	−2	−2	−9
Subtotal: Part 2 revenue	−30	−34	−39	−12	−2	−117
Part 3—Scholarship assistance and tourism promotion						
Sec. 10433. Pilot preclearance program (subject to appropriation)	1	1	0	0	0	2
Subtotal: Part 3 subject to appropriation	1	1	0	0	0	2
Subtitle E—Total:						
Revenues	−30	−34	−39	−12	−2	−117
Subject to appropriation	1	1	0	0	0	2
Total effect assuming appropriations	31	35	39	12	2	119
SUBTITLE F—TARIFF PROVISIONS						
Subtitle F—Total:						
Revenues	−121	−152	−178	−58	−14	−523
Subject to appropriation	(2)	(2)	(2)	(2)	(2)	1
Total effect assuming appropriations	121	152	178	58	14	523

[1] Savings associated with current law reflect no further action taken by Congress. Directed baseline savings assume no expenditure target specifications in future years as directed in the Legislative language.
[2] Less than $500,000.
[3] All estimates are based on the CBO February Baseline.
[4] Revenue estimate provided by the Joint Committee on Taxation.

[5] The estimate for the voluntary option assumes that those who do not enroll or who disenroll (except for those under the working aged/disabled provisions) will be subject to current penalties for late enrollment and the supplemental premium would be increased by 15% as a further penalty.

[6] The Ad Hoc premium increase is $3.50 in 1990, $4.00 in 1991, and $4.10 in 1992 and 1993, and would be increased by the Social Security Cost-of-Living adjustment (COLA) in 1994 and beyond.

[7] Standards are to be set by the Secretary of Health and Human Services. Because the standards are not yet known, an estimate of costs or savings cannot be done at this time.

[8] Estimated administrative costs included in Sec. 10024.

[9] The moratorium would have no cost because the regulation was never implemented and thus is not in CBO's baseline. According to the Administration, a regulation limiting assistance could save $35 to $85 million a year.

[10] Changes in the quality control system after 1990 would have no cost during the 1990–1994 period because CBO's baseline estimates include the collection of sanction only for years through 1989. There would be a cost of this provision in the years after 1994.

NOTE.—Savings associated with current law reflect no further action taken by Congress. Directed baseline savings assume no expenditure target in specifications in future years as directed in the legislative language. Estimated savings in the Medicare Catastrophic Coverage Act are based on February estimates. Estimated savings for the MCCA under July assumptions are displayed below. Details may not add to totals because of rounding. All estimates are relative to the CBO February 1989 Baseline. Certain provisions that are expected to have no cost have been omitted from the table.

TITLE XI: REVENUE PROVISIONS OF THE COMMITTEE ON WAYS AND MEANS 1990 RECONCILIATION BILL [1]

[Outlays, in millions of dollars by fiscal year]

	1990	1991	1992	1993	1994	Total 1990–94
SUBTITLE I—CHILD CARE PROVISIONS						
Sec. 11901. Grants to States for child care	120	266	362	394	400	1542
Sec. 11902. Incentive grants for improving child care standards (subject to appropriations)	17	68	75	75	75	310
Sec. 11903. Expansion of earned income tax credit: [2]						
Outlays	0	378	3,717	3,986	4,266	12,347
Revenues	0	−37	−355	−380	−407	−1,179
Subtitle I: Total:						
Direct spending	120	644	4,079	4,380	4,666	13,889
Revenues	0	−37	−355	−380	−407	−1,179
Net deficit effect	120	681	4,434	4,760	5,073	15,068
Subject to appropriations	17	68	75	75	75	310
Total effect on deficit assuming appropriations	137	749	4,509	4,835	5,148	15,378

[1] This table does not include estimates for the revenue provisions in Subtitles A–H of Title XI.
[2] Estimates provided by the Joint Committee on Taxation.

TABLE 2.—TITLE X: BUDGET RECONCILIATION PROVISIONS OF THE COMMITTEE ON WAYS AND MEANS

[Outlays by fiscal year, in millions of dollars]

	1990	1991	1992	1993	1994	Total 1990–94
Title X: Grand total:						
Direct spending:						
Directed baseline	−5,616	−5,825	−4,041	−5,076	−5,225	−25,780
Current law	−5,616	−5,825	−4,041	−6,101	−6,895	−28,475
Revenues	−2,395	−2,081	−1,871	−2,068	−2,414	−10,826
Net deficit effect:						
Directed baseline	−3,221	−3,744	−2,170	−3,008	−2,811	−14,954
Current law	−3,221	−3,744	−2,170	−4,033	−4,481	−17,649
Spending subject to appropriation	1,326	508	494	440	463	3,230
Total effect assuming appropriations						
Directed baseline	−1,895	−3,236	−1,676	−2,568	−2,348	−11,725
Current law	−1,895	−3,236	−1,676	−3,593	−4,018	−14,420
February baseline:						
Direct spending:						
Directed baseline [1]	−3,065	−3,030	−2,210	−3,455	−3,980	−15,740
Current law	−3,065	−3,030	−2,210	−3,120	−3,545	−14,970

TABLE 2.—TITLE X: BUDGET RECONCILIATION PROVISIONS OF THE COMMITTEE ON WAYS AND MEANS—Continued

[Outlays by fiscal year, in millions of dollars]

	1990	1991	1992	1993	1994	Total 1990–94
Revenues	−2,182	−2,475	−2,758	−3,089	−3,475	−13,979
Net deficit effect:						
Directed baseline [1]	−883	−555	548	−366	−505	−1,761
Current law	−883	−555	548	−31	−70	−991
July baseline:						
Direct spending:						
Directed baseline [1]	−3,055	−3,180	−2,720	−3,720	−3,970	−16,645
Current law	−3,055	−3,180	−2,720	−3,385	−3,535	−15,875
Revenues	−2,645	−2,996	−2,755	−3,099	−3,499	−14,994
Net deficit effect:						
Directed baseline [1]	−410	−184	35	−621	−471	−1,651
Current law	−410	−184	35	−286	−36	−881
SUBTITLE A—SOCIAL SECURITY ADMINISTRATION, OLD-AGE, SURVIVORS, and DISABILITY INSURANCE, and RAILROAD RETIREMENT						
Chapter 1: Administrative changes						
Subchapter A: Establishment of the Social Security Administration as an independent agency:						
Secs. 10001–10014. Establishment Social Security Administration as independent agency (subject to appropriation)	(2)	1	1	1	1	4
Suchapter B: Improvements in Social Security services:						
Sec. 10021. Standards governing collection of overpayments	10	7	3	3	3	26
Sec. 10022. Demonstration projects relating to telephone service centers (subject to appropriation)	1	3	1	(2)	(2)	4
Sec. 10023. Standards applicable in certain determinations of good cause, fault, and good faith (subject to appropriation)	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 10024. Assistance to the homeless (subject to appropriation)	20	30	30	30	30	140
Sec. 10025. Notice requirements (subject to appropriation)	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 10026. Representation of claimants (subject to appropriation)	(2)	(2)	(2)	1	1	2
Sec. 10027. Applicability of administrative res adjudicata	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 10028. Authority for Secretary to take into account misinform. provided to applicants in determining date of application for benefits	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 10029. Same-day personal interviews where time is of the essence (subject to appropriation)	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 10030. Authority to amend wage records after time limitation expires	(2)	(2)	1	2	3	7
(Subject to appropriation)	1	1	1	1	1	4
Subchapter C: Representative payee reforms:						
Sec. 10031. Improvements in the Representative payee selection and recruitment (subject to appropriation)	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 10032. Improvements in recordkeeping and auditing requirements (subject to appropriation)	12	3	3	3	3	24
Sec. 10033. Reports to the Congress (subject to appropriation)	(2)	(2)	(2)	(2)	(2)	(2)
Subtotal: Chapter 1:						
Subject to appropriation	34	38	36	36	36	178
Direct spending	10	7	4	5	6	33
Total spending assuming appropriations	44	45	40	41	42	211
Chapter 2: Provisions Affecting Coverage						
Sec. 10051. Elimination of the dependency test for certain adopted children	5	12	16	21	22	76

TABLE 2.—TITLE X: BUDGET RECONCILIATION PROVISIONS OF THE COMMITTEE ON WAYS AND MEANS—Continued

[Outlays by fiscal year, in millions of dollars]

	1990	1991	1992	1993	1994	Total 1990–94
Sec. 10052. Clarification of rules governing taxation of individuals of certain religious faiths (revenue effect)	−1	−1	−1	−1	−1	−5
Sec. 10053. Prohibition of termination of coverage of U.S. citizens and residents abroad by foreign affiliates of American employers	(2)	(2)	(2)	(2)	(2)	(2)
Subtotal: Chapter 2:						
Direct spending	5	12	16	21	22	76
Revenues	−1	−1	−1	−1	−1	−5
Total deficit effect	6	13	17	22	23	81
Chapter 3: Provisions Affecting Entitlement to Benefits						
Subchapter a: Work incentives for certain adult disabled children:						
Secs. 10061—10064. Continuation of entitlement to certain child's insurance benefits based on disability:						
Social Security	(2)	1	1	2	3	7
SSI	(2)	(2)	(2)	(2)	(2)	−1
Medicare	(2)	(2)	(2)	1	1	3
Subtotal	(2)	1	1	3	4	9
Subchapter B: Other provisions:						
Sec. 10071. Continuation of disability benefits upon appeal						
Social Security	6	27	37	43	51	164
Medicare	2	9	11	12	14	48
Subtotal	8	36	48	55	65	212
Sec. 10072. Elimination of any carryover reduction in retirement or disability benefits due to receipt of widow's or widower's benefits before attaining age 62	(2)	(2)	(2)	1	2	3
Sec. 10073. Modification of preeffectuation review requirement applicable to disability insurance cases	−4	−6	−8	−9	−11	−38
(Subject to appropriation)	−4	−5	−5	−6	−6	−26
Sec. 10074. Recovery of OASDI overpayments by means of reduction in tax refunds	−20	−125	−90	−60	0	−295
(Subject to appropriation)	5	10	5	5	0	25
Sec. 10075. Exemption for certain aliens, receiving amnesty, from liability for misreporting of earnings or misuse of Social Security account numbers or cards	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 10076. Adjustment in exempt amount for the retirement test	60	120	140	150	170	640
Sec. 10077. Increase in the minimum primary insurance amount	100	140	145	155	160	700
Sec. 10078. Elimination of eligibility for retroactive benefits for certain individuals	−150	−160	−160	−160	−150	−780
Sec. 10079. Inclusion of certain deferred compensation in determination of wage-based adjustments:						
Outlays	0	5	13	17	31	66
Revenues	400	1,100	1,100	1,100	1,100	4,800
Subtotal: Chapter 3:						
Social Security—Subject to Approp.	1	5	0	−1	−6	−1
Social Security—Direct Spending	−8	2	78	139	256	467
SSI	(2)	(2)	(2)	(2)	(2)	(2)
Medicare	2	9	11	13	15	51
Revenues	400	1,100	1,100	1,100	1,100	4,800
Subtotal: Chapter 3:						
Direct spending	−6	11	89	152	271	517
Revenues	400	1,100	1,100	1,100	1,100	4,800
Net deficit effect	−406	−1,089	−1,100	−948	−829	−4,283

TABLE 2.—TITLE X: BUDGET RECONCILIATION PROVISIONS OF THE COMMITTEE ON WAYS AND MEANS—Continued

[Outlays by fiscal year, in millions of dollars]

	1990	1991	1992	1993	1994	Total 1990–94
Spending subject to appropriation	1	5	0	−1	−6	−1
Total effect assuming appropriations	−405	−1,084	−1,100	−949	−835	−4,284
Chapter 4: Railroad Retirement						
Sec. 10081. Treatment of group-term life insurance under railroad retirement taxes revenue	(2)	(2)	(2)	(2)	(2)	2
Sec. 10082. Treatment of certain deferred compensation and salary reduction arrangements under railroad retirement taxes	2	2	2	2	2	11
Subtotal: Chapter 4 revenues	2	2	2	2	2	13
Subtitle A: Total:						
Direct spending	9	30	109	178	299	626
Revenues	401	1,101	1,101	1,101	1,101	4,808
Net deficit effect	−392	−1,071	−992	−923	−802	−4,182
Spending subject to appropriation	35	43	36	35	30	177
Total effect assuming appropriations	−357	−1,028	−956	−888	−772	−4,005
SUBTITLE B—MEDICARE						
Part A: Part A Provisions of Medicare						
Subpart 1: Payment for Inpatient Hospital Services:						
10101 Reduction in payments for capital	−675	−100	0	0	0	−775
10102 Prospective Payment Hospitals:						
a. Reduction in hospital update factors	−530	−660	−730	−800	−870	−3,590
c. Disproportionate share adjustments	230	285	315	345	375	1,550
d. Update factor for rural hospitals	140	160	180	200	220	900
e. Extend regional referral center classification	15	25	30	15	0	85
f. Sole community hospitals	20	40	40	45	50	195
h. Essential access community hospital demonstration:						
1. Demonstration grants subject to appropriation	25	40	40	0	0	105
2. Medicare reimbursement to: E.A.C.H. and rural primary care hospitals	0	10	20	30	30	90
10103 PPS-Exempt hospitals:						
a. Exempt cancer hospitals	3	2	2	2	2	11
b. Rebase cancer hospitals to 1987 costs	5	10	10	10	10	45
Subpart 2: Other provisions:						
10111 Payments for hospice care	20	25	30	35	40	150
10112 Miscellaneous part A provisions:						
b. Buy-in for disabled individuals	(2)	3	7	12	18	40
g. Waiver extension for finger lakes area hospital's corporation	0	(2)	−1	−1	−1	−3
Subtotal part A savings:						
Direct spending	−772	−200	−97	−107	−126	−1,302
Amounts subject to appropriations	25	40	40	0	0	105
Part B: Part B Provisions of Medicare						
Subpart 1: Payment physicians' services:						
10121 Reduce certain procedures:						
a. Reduce overpriced procedures	−210	−285	−325	−370	−415	−1,605
b. Reduce radiology services	−110	−140	−160	−180	−200	−790
c. Round anesthesiology payments to actual time	−40	−45	−55	−60	−65	−265
10122 Reduce MEI update:						
a. Delay update of all fees	−260	0	0	0	0	−260
b. Reduce update from 5.3 percent to 2 percent	−255	−415	−465	−525	−590	−2,250

TABLE 2.—TITLE X: BUDGET RECONCILIATION PROVISIONS OF THE COMMITTEE ON WAYS AND MEANS—Continued

[Outlays by fiscal year, in millions of dollars]

	1990	1991	1992	1993	1994	Total 1990–94
10123 Physician payment reform, Implement RB RVS on Jan. 1, 1991: [1]						
Directed baseline	0	0	−130	−145	−165	−440
Current law	0	0	−130	−1,505	−2,270	−3,905
10124 Miscellaneous provisions relating to payment for physician services:						
a. New physician customary charges	−25	−150	0	0	0	−175
b. Designated specialties	−30	−35	−40	−45	−50	−200
Subpart 2: Payment for other services:						
10131 Reduce out-patient hospital capital	−25	−20	0	0	0	−45
10132 Durable medical equipment	−200	−420	−475	−535	−600	−2,230
101133 Clinical lab tests	−90	−145	−180	−205	−240	−860
Mileage fee small blood labs	14	4	0	0	0	18
10134 Mental health services:						
a. Pay psychologies	15	25	30	40	40	150
d. Eliminate $1,100 limit (incl. interaction with a.)	20	55	75	90	115	355
10135 Payments to nurses:						
Increase level of CRNA payments $14/21 proposal	70	185	205	230	255	945
First assistants at surgery	1	1	1	1	1	5
10136 Federally qualified health center services	13	30	35	45	50	173
10137 Miscellaneous part B provisions: Diabetic shoe inserts	([2])	([2])	([2])	0	0	([2])
Subtotal for part B:						
Direct spending:						
Directed baseline	−1,112	−1,355	−1,484	−1,659	−1,864	−7,474
Current law	−1,112	−1,355	−1,484	−3,019	−3,969	−10,939
Part C: Part A and B Medicare Provisions						
10151 Delay in payments in FY 1990	−470	−70	−80	−80	−90	−790
10155 Medicare as secondary payor:						
Direct spending	−325	−780	−680	−420	−110	−2,315
Subject to appropriation	25	30	30	20	10	115
Coverage rule for religious order	12	15	20	20	25	92
10153 ESRD services	−75	−110	−135	−165	−200	−685
10154 Outcomes effectiveness research: Subject to appropriation	72	110	170	225	270	847
10158 Miscellaneous part A and B provisions:						
e. Rural health medical education demonstration	([2])	([2])	([2])	([2])	([2])	([2])
f. Cancer treatment protocol demonstration	2	2	2	2	2	10
i. Recognize hospital-based nursing costs	25	45	50	55	55	230 ([2])
j. Inner-city hospital triage demonstration	([2])	([2])	([2])	([2])	([2])	([2])
Subtotal part A and B savings:						
Direct spending	−831	−898	−823	−588	−318	−3,458
Amounts subject to appropriations	97	140	200	245	280	962
Part D: Part B Premium						
10161 Basic Part B Premium: 25 percent CY 90 (includes interaction with other Part B savings)	−325	−455	−485	−515	−545	−2,325
Part E: Extension of COBRA Continuation Coverage for Disabled Employees						
10171 Extension from 18 to 29 months	([2])	([2])	([2])	([2])	([2])	([2])
Part F: Revisions to Medicare Catastrophic Coverage Act [3]						
Subpart 1: Medicare part A and supplemental medicare premium:						
10181 Supplemental Medicare premium:						
a. Reduction in supplemental premium rate: [4] Revenue	−2,475	−2,456	−2,375	−2,679	−3,029	−13,014
b. Supplemental based on Part B Enrollment: Revenue	−170	−540	−380	−420	−470	−1,980

TABLE 2.—TITLE X: BUDGET RECONCILIATION PROVISIONS OF THE COMMITTEE ON WAYS AND MEANS—Continued

[Outlays by fiscal year, in millions of dollars]

	1990	1991	1992	1993	1994	Total 1990–94
10182 Abolition of Federal hospital insurance catastrophic coverage reserve fund	0	0	0	0	0	0
Subpart 2: Medicare part B provisions:						
10191 Catastrophic linked to election of part B [5]	−80	−180	−220	−240	−290	−1,010
10192 Adjustment in part B premium:						
a. Part B premium adjustments:						
Directed-baseline	0	−500	−1,200	−2,225	−2,580	−6,505
Current law	0	−500	−1,200	−1,890	−2,145	−5,735
b. Ad hoc premium increase: [6]						
Directed baseline	−975	−1,460	−1,550	−1,585	−1,660	−7,230
Current law	−975	−1,460	−1,550	−1,585	−1,660	−7,230
10193 increase in catastrophic drug deductible	0	−340	−950	−610	0	−1,900
10194 Temporary delay in Medicare payments	−2,000	−700	−1,200	−940	−560	0
Subtotal for part F: Revenue	−2,645	−2,996	−2,755	−3,099	−3,499	−14,994
Direct spending:						
Directed baseline	−3,055	−3,180	−2,720	−3,720	−3,970	−16,645
Current law	−3,055	−3,180	−2,720	−3,385	−3,535	−15,875
Grand total medicare: Revenue	−2,645	−2,996	−2,755	−3,099	−3,499	−14,994
Direct spending:						
Directed baseline	−6,095	−6,088	−5,609	−6,589	−6,823	−31,204
Current law	−6,095	−6,088	−5,609	−7,614	−8,493	−33,899
Net deficit effect:						
Directed baseline	−3,450	−3,092	−2,854	−3,490	−3,324	−16,210
Current law	−3,450	−3,092	−2,854	−4,515	−4,994	−18,905
Amounts subject to appropriation	122	180	240	245	280	1,067
Total deficit effect assuming full appropriation:						
Directed baseline	−3.328	−2,912	−2,614	−3,245	−3,044	−15,143
Current law	−3,328	−2,912	−2,614	−4,270	−4,714	−17,838
SUBTITLE C—HUMAN RESOURCE AMENDMENTS						
Part 1: Children's initiative						
Subpart A: Social services:						
Sec. 10201. Increase title XX block Grant	0	190	390	590	600	1,770
Subpart B: Foster care and child welfare amendments:						
Sec. 10211. Increase child welfare authorization (subject to appropriation)	98	132	134	134	134	632
Sec. 10212. Extend ceilings and transfer authority	5	7	7	2	0	21
Sec. 10213. Prevention report	([2])	([2])	([2])	([2])	([2])	1
Sec. 10214. Increase foster parent training reimbursement	1	1	1	1	1	5
Sec. 10215. Require health and education plans and require comprehensive health exams:						
Foster Care	2	2	2	2	2	10
Medicaid	10	10	10	15	15	60
Total	12	12	12	17	17	70
Sec. 10216. Foster care adolescent services block grant	75	100	100	25	0	300
Sec. 10217. Improve data collection	([2])	2	1	1	1	5
Sec. 10218. Improve accountability	([2])	([2])	([2])	([2])	([2])	([2])
Subpart C: SSI disabled children amendments:						
Sec. 10221. Conduct Children's Outreach:						
SSI—Subject to appropriation	1	([2])	([2])	([2])	([2])	1
SSI—Direct spending	2	4	5	6	7	24
Medicaid	1	2	3	3	4	13
Food Stamps	0	−1	−1	−1	−1	−4
Subject to appropriation	1	([2])	([2])	([2])	([2])	1
Direct spending	3	5	7	8	10	33
Total	4	5	7	8	10	34

TABLE 2.—TITLE X: BUDGET RECONCILIATION PROVISIONS OF THE COMMITTEE ON WAYS AND MEANS—Continued

[Outlays by fiscal year, in millions of dollars]

	1990	1991	1992	1993	1994	Total 1990–94
Sec. 10222. Individual functional assessment for children:						
SSI—Subject to appropriation	2	2	2	2	2	10
SSI—Direct spending	15	40	60	80	95	290
Medicaid	5	15	25	35	45	125
Food stamps	−2	−5	−10	−10	−10	−37
Subject to appropriation	1	2	2	2	2	10
Direct spending	18	50	75	105	130	378
Total	20	52	77	107	132	388
Sec. 10223. Presumptive disability for certain children under age of 4:						
SSI	3	5	5	5	5	23
Medicaid	1	2	2	2	2	9
Total	4	7	7	7	7	32
Sec. 10224. Publish childhood mental impairment listings:						
SSI	(2)	15	20	25	30	90
Medicaid	(2)	5	5	10	10	30
Food stamps	(2)	−2	−2	−5	−5	−14
Total	(2)	18	23	30	35	106
Sec. 10225. Revise listings of impairments for childhood disabilities	(7)	(7)	(7)	(7)	(7)	(7)
Sec. 10226. Provide medicaid eligibility in months when ineligible because weekly or biweekly checks	1	1	1	1	1	5
Sec. 10227. Make U.S. children abroad eligible for SSI	1	2	2	2	2	9
Sec. 10228. Change deeming rules for children in State home care plans	2	2	2	2	2	10
Sec. 10229. Demo intergenerational project for disabled children (subject to appropriation)	1	1	2	2	2	8
Sec. 10230. Exclude from resources work-related equipment	(2)	(2)	(2)	(2)	(2)	(2)
Subpart D: Child support enforcement amendments						
Sec. 10231. Extend IRS intercept	0	2	2	2	2	8
Sec. 10232. Allow IRS intercept for non-minor disabled children	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 10233. Provide 12 months of medicaid eligibility for families leaving AFDC because of child support medicaid	10	25	25	30	30	120
Subtotal: Part 1						
Title XX	0	190	390	590	600	1,770
Child Care—Subject to appropriation	98	132	134	134	134	632
Foster care—Direct spending	83	112	111	31	4	342
SSI—Subject to appropriation	4	3	4	4	4	19
SSI—Direct spending	23	68	94	120	141	446
Child support enforcement	0	2	2	2	2	8
Medicaid	28	60	71	96	107	362
Food stamps	−2	−8	−13	−16	−16	−55
Total: Part 1:						
Subject to appropriation	102	135	138	138	138	651
Direct spending	1322	424	655	823	838	2,873
Total spending	234	559	793	961	976	3,524
Part 2: SSI service improvements						
Subpart A: Initiative for the poor elderly:						
Sec. 10241. SSI benefit increase:						
SSI	70	100	105	160	115	550

TABLE 2.—TITLE X: BUDGET RECONCILIATION PROVISIONS OF THE COMMITTEE ON WAYS AND MEANS—Continued

[Outlays by fiscal year, in millions of dollars]

	1990	1991	1992	1993	1994	Total 1990–94
Medicaid	(2)	5	5	5	5	20
Food stamps	−10	−15	−15	−20	−15	−75
Total	60	90	95	145	105	495
Sec. 10242. Establish SSI outreach—Adults:						
SSI—Subject to appropriation	20	5	5	5	5	40
SSI—Direct spending	35	55	55	50	50	245
Medicaid	40	60	60	60	60	280
Food stamps	−5	−5	−5	−5	−5	−25
Subject to appropriation	20	5	5	5	5	40
Direct spending	70	110	110	105	105	500
Total	90	115	115	110	110	540
Sec. 10243. Reform representative payee procedures and tracking (subject to appropriation)	5	1	1	2	2	11
Sec. 10244. Modify one-third reduction rule:						
SSI—Subject to appropriation	5	3	3	3	3	17
SSI—Direct spending	45	60	65	70	70	310
Total	50	63	68	73	73	327
Sec. 10245. Exclude domestic travel tickets from SSI income	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 10246. Reduction in time when separated couples income treated jointly	2	2	2	2	2	10
Sec. 10247. Exclude interest income on burial spaces	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 10248. Deem certain recipients of Title II disability insurance to have received SSI						
SSI	2	2	3	4	5	16
Medicaid	(2)	4	6	7	9	26
Total	2	6	9	11	14	42
Sec., 10249. Exclude victims compensation payments	(2)	(2)	(2)	(2)	(2)	(2)
Subpart B: Other service improvements:						
Sec. 10251. Determination of good faith	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 1052. Assist homeless	(8)	(8)	(8)	(8)	(8)	(8)
Sec. 10253. Notice requirements	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 10254. Representation of claimants	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 10255. Application of administrative res judicata	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 10256. Misinformation for beneficiaries	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 10257. Same day personnel interview	(2)	(2)	(2)	(2)	(2)	(2)
Subtotal: Part 2:						
SSI—Subject to appropriation	30	9	9	10	10	68
SSI—Direct spending	154	219	230	286	242	1,131
Medicaid	40	69	71	72	74	326
Food stamps	−15	−20	−20	−25	−20	−100
Subtotal: Part 2:						
Subject to appropriation	30	9	9	10	10	68
Direct spending	179	268	281	333	296	1,357
Total spending	209	277	290	343	306	1,425
Part 3: Miscellaneous amendments						
Sec. 10261. Option for school employees	5	0	0	0	0	5
Sec. 10263. Extend moratorium on implementation of regulation on homeless—AFDC Families c/	0	0	0	0	0	0
Sec. 10264. Authorize self-employment demonstration program—subject to appropriation	(2)	(2)	(2)	0	0	1

TABLE 2.—TITLE X: BUDGET RECONCILIATION PROVISIONS OF THE COMMITTEE ON WAYS AND MEANS—Continued

[Outlays by fiscal year, in millions of dollars]

	1990	1991	1992	1993	1994	Total 1990–94
Sec. 10265. Minnesota AFDC demonstration	(²)	(²)	(²)	(²)	(²)	1
Subtotal: Part 3:						
Direct spending	5	0	0	0	0	6
Total spending	5	0	0	0	0	6
Part 4: AFDC quality control amendments						
Subpart A: Resolution of disallowance backlog through fiscal year 1990: Sec. 10271. Modify treatment of quality control sanctions backlog	0	314	515	167	161	1,157
Subpart B: Permanent modification of quality control system after fiscal year 1990: Sec. 10281. Modify quality control system d/	0	0	0	0	0	0
Subtotal: Part 4:						
Direct spending	0	314	515	167	161	1,157
Total spending	0	314	515	167	161	1,157
Subtitle C: Total:						
Subject to appropriation	132	144	147	148	148	719
Direct spending	316	1,006	1,451	1,323	1,295	5,393
Total effect assuming appropriations	448	1,150	1,598	1,471	1,443	6,112
SUBTITLE D—TRADE AMENDMENTS						
Part 1—Trade agency authorizations for fiscal year 1990						
Sec. 10301. United States International Trade Commission (subject to appropriation)	34	3	1	1	(*)	40
Sec. 10302. United States Customs Service (subject to appropriation)	984	134	70	11	5	1,203
Sec. 10303. United States Trade Representative (subject to appropriation)	18	3	(*)	(*)	(*)	21
Subtotal: Part 1—Subject to Appropriation	1,036	140	71	12	5	1,264
Part 2—Customs user fees						
Sec. 10311–10316 Customs User Fees	154	−773	8	12	4	−595
Subtotal: Part 2—Offsetting Receipts	154	−773	8	12	4	−595
Subtitle D: Total:						
Subject to appropriation	1,036	140	71	12	5	1,264
Direct spending (offsetting receipts)	154	−773	8	12	4	−595
Total effect assuming appropriations	1,190	−633	79	24	9	669
SUBTITLE E—CARIBBEAN BASIN ECONOMIC RECOVERY						
Part 2—Amendments to the Caribbean Basin Economic Recovery Act and related provisions						
Subpart A—Amendments to the Caribbean Basin Economic Recovery Act: Sec. 10412. Exceptions to general duty-free treatment revenue	−29	−32	−37	−10	0	−108
Subpart B—Amendments to the harmonized tariff schedule and other provisions affecting CBI beneficiary countries: Sec. 10423. Duty-free treatment of articles assembled from U.S. components revenue	−1	−2	−2	−2	−2	−9
Subtotal: Part 2 revenue	−30	−34	−39	−12	−2	−117

TABLE 2.—TITLE X: BUDGET RECONCILIATION PROVISIONS OF THE COMMITTEE ON WAYS AND MEANS—Continued

[Outlays by fiscal year, in millions of dollars]

	1990	1991	1992	1993	1994	Total 1990–94
Part 3—Scholarship assistance and tourism promotion						
Sec. 10433. Pilot preclearance program (subject to appropriation)	1	1	0	0	0	2
Subtotal: Part 3—Subject to appropriation	1	1	0	0	0	2
SUBTITLE F—TARIFF PROVISIONS						
Subtitle F: Total:						
Revenues	−121	−152	−178	−58	−14	−523
Subject to appropriation	([2])	([2])	([2])	([2])	([2])	1
Total effect assuming appropriations	121	152	178	58	14	523

[1] Savings associated with current law reflect no further action taken by Congress. Directed baseline savings assume no expenditure target specifications in future years as directed in the legislative language.

[2] Less than $500,000.

[3] Estimates of the provisions relating to the MCCA of 1988 are based on July reestimates, except for the Part B premium adjustment, which is based on the CBO February 1989 Baseline.

[4] Revenue estimate provided by the Joint Committee on Taxation.

[5] The estimate for the voluntary option assumes that those who do not enroll or who disenroll (except for those under the working aged/disabled provisions) will be subject to current penalties for late enrollment and the supplmental premium would be increased by 15% as a further penalty.

[6] The Ad Hoc premium increase is $3.50 in 1990, $4.00 in 1991, and $4.10 in 1992 and 1993, and would be increased by the Social Security Cost-of-Living adjustment (COLA) in 1994 and beyond.

[7] Standards are to be set by the Secretary of Health and Human Services. Because the standards are not yet known, an estimate of costs or savings cannot be done at this time.

[8] Estimated administrative costs included in Sec. 10024.

[9] The moratorium would have no cost because the regulation was never implemented and thus is not in CBO's baseline. According to the Administration, a regulation limiting assistance could save $35 to $85 million a year.

[10] Changes in the quality control system after 1990 would have nc cost during the 1990–1994 period because CBO's baseline estimates include the collection of sanction only for years through 1989. There would be a cost of this provision in the years after 1994.

Notes.—Savings associated with current law reflect no further action taken by Congress. Directed base savings assume no expenditure target in specifications in future years as directed in the legislative language. Estimated savings in the Medicare Catastrophic Coverge Act are based on July reestimates, except fo the part B premium adjustment, which is based on the CBO's February 1989 baseline. Estimated savings under February assumptions are displayed below. Details may not add to totals because of rounding. All estimates are relative to the CBO February 1989 Baseline. Certain provisions that are expected to have no cost have been ommitted from the table.

TITLE XI: REVENUE PROVISIONS OF THE COMMITTEE ON WAYS AND MEANS 1990 RECONCILIATION BILL[1]

[Outlays, in millions of dollars by fiscal year]

	1990	1991	1992	1993	1994	Total 1990–94
SUBTITLE I—CHILD CARE PROVISIONS						
Sec. 11901. Grants to States for child care	120	266	362	394	400	1,542
Sec. 11902. Incentive grants for improving child care standards (subject to appropriations)	17	68	75	75	75	310
Sec. 11903. Expansion of earned income tax credit: [2]						
Outlays	0	378	3,717	3,986	4,266	12,347
Revenues	0	−37	−355	−380	−407	−1,179
Subtitle I: Total:						
Direct spending	120	644	4,079	4,380	4,666	13,889
Revenues	0	−37	−355	−380	−407	−1,179
Net deficit effect	120	681	4,434	4,760	5,073	15,068
Subject to appropriations	17	68	75	75	75	310
Total effect on deficit assuming appropriations	137	749	4,509	4,835	5,148	15,378

[1] This table does not include estimates for the revenue provisions in Subtitle A–H of Title XI.

[2] Estimates provided by the Joint Committee on Taxation.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, September 19, 1989.

Hon. LEON E. PANETTA,
Chairman, Committee on the Budget,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget office has calculated the net deficit effect of Titles X and XI of the budget reconciliation provisions of the Committee on Ways and Means using CBO estimates of outlay effects and Joint Committee on Taxation estimates of revenue effects. Adding this estimate to the net deficit effect of the Financial Institutions Reform, Recovery, and Enforcement Act of 1989 (P.L. 101–73), CBO calculates the net deficit effect of the Committee on Ways and Means response to reconciliation instructions to be:

COMMITTEE ON WAYS AND MEANS RESPONSE TO RECONCILIATION INSTRUCTIONS

[By fiscal year, in billions of dollars]

	1990	1991	1992	1993	1994
Net deficit effect:					
Relative to directed baseline	−10.0	−11.0	−4.8	2.3	0.1
Relative to current law	−10.0	−11.0	−4.8	1.3	−1.6

Notes.—Minus sign indicates reduction in deficit. Savings associated with current law reflect no further action taken by the Congress. Directed baseline savings assume no expenditure target in specifications in future years as directed in the legislative language.

The provisions of Titles X and XI are estimated as ordered transmitted to the Committee on the Budget by the Committee on Ways and Means on September 14, 1989. The Medicare catastrophic coverage program provisions included here are calculated relative to the CBO February 1989 baseline. The above estimate is represented in more detail in Table 1 (enclosed).

Also enclosed, for your information, are the four tables containing the revenue and outlay estimates, by provision, on which the totals shown above and on Table 1 are based.

Sincerely,

ROBERT D. REISCHAUER, *Director.*

TABLE 1.—COMMITTEE ON WAYS AND MEANS RESPONSE TO RECONCILIATION INSTRUCTIONS

[By fiscal years, in millions of dollars]

	1990	1991	1992	1993	1994	1990–94
BUDGET RECONCILIATION PROVISIONS OF THE COMMITTEE ON WAYS AND MEANS						
Title X						
Medicare Catastrophic Program: [1]						
Outlays: [2]						
Directed baseline	−3,065	−3,030	−2,210	−3,455	−3,980	−15,740
Current law	−3,065	−3,030	−2,210	−3,120	−3,545	−14,970
Revenues	−2,182	−2,475	−2,758	−3,089	−3,475	−13,979
Net deficit effect: [2]						
Outlays: [2]						
Directed baseline	−883	−555	548	−366	−505	−1,761
Current law	−883	−555	548	−31	−70	−991

TABLE 1.—COMMITTEE ON WAYS AND MEANS RESPONSE TO RECONCILIATION INSTRUCTIONS—Continued

[By fiscal years, in millions of dollars]

	1990	1991	1992	1993	1994	1990–94
All other:						
Outlays: [2]						
Directed baseline	−2,561	−2,645	−1,321	−1,356	−1,255	−9,135
Current law	−2,561	−2,645	−1,321	−2,716	−3,360	−12,600
Revenues	250	915	884	1,031	1,085	4,168
Net deficit effect: [2]						
Outlays: [2]						
Directed baseline	−2,811	−3,560	−2,205	−2,387	−2,340	−13,303
Current law	−2.811	−3,560	−2,205	−3,747	−4,445	−16,768
Subtotal (title X):						
Outlays: [2]						
Directed baseline	−5,626	−5,675	−3,531	−4,811	−5,235	−24,875
Current law	−5,626	−5,675	−3,531	−5,836	−6,905	−27,570
Revenues	−1,932	−1,560	−1,874	−2,058	−2,390	−9,811
Net Deficit effect: [2]						
Directed baseline	−3,694	−4,115	−1,657	−2,753	−2,845	−15,064
Current law	−3,694	−4,115	−1,657	−3,778	−4,515	−17,759
Title XI						
Outlays: [2]						
Directed baseline	120	644	4,079	4,380	4,666	13,889
Current law	120	644	4,079	4,380	4,666	13,889
Revenues	5,825	7,484	6,877	−1,005	1,489	20,670
Net deficit effect: [2]						
Directed baseline	−5,705	−6,840	−2,798	5,385	3,177	−6,781
Current law	−5,705	−6,840	−2,798	5,385	3,177	−6,781
Total: Titles X and XI:						
Outlays: [2]						
Directed baseline	−5,506	−5,031	548	−431	−569	−10,986
Current law	−5,506	−5,031	548	−1,456	−2,239	−13,681
Revenues	3,893	5,924	5,003	−3,063	−901	10,859
Net deficit effect: [2]						
Directed baseline	−9,399	−10,955	−4,455	2,632	332	−21,845
Current law	−9,399	−10,955	−4,455	1,607	−1,338	−24,540
Deficit reduction achieved in prior legislation:						
Financial Institutions Reform, Recovery, and Enforcement Act of 1989: Net deficit effect	−568	−31	−351	−310	−213	−1,473
Grand total, Committee on Ways and Means response to reconciliation instructions:						
Net deficit effect:						
Directed baseline [2]	−9,967	−10,986	−4,806	2,322	119	−23,318
Current law	−9,967	−10,986	−4,806	1,297	−1,551	−26,013

[1] Based on CBO's February 1989 baseline estimates. Estimated savings for the Medicare catastrophic program under July 1989 CBO assumptions are:

	1990	1991	1992	1993	1994	1990–94
Outlays: [2]						
Directed baseline	−3,055	−3,180	−2,720	−3,720	−3,970	−16,645
Current law	−3,055	−3,180	−2,720	−3,385	−3,535	−15,875
Revenues	−2,645	−2,996	−2,755	−3,099	−3,499	−14,994
Net deficit effect: [2]						
Outlays: [2]						
Directed baseline	−410	−184	35	−621	−471	−1,651
Current law	−410	−184	35	−286	−36	−881

[2] Savings associated with current law reflect no further action taken by Congress. Directed baseline savings assume no expenditure target in specifications in future years as directed in the legislative language.

Sources: Outlay estimates by CBO. Revenue estimates by JCT.

TITLE X: BUDGET RECONCILIATION PROVISIONS OF THE COMMITTEE ON WAYS AND MEANS

[Outlays by fiscal year, in millions of dollars]

	1990	1991	1992	1993	1994	Total 1990–94
Title X: Grand total:						
Direct spending:						
Directed baseline	−5,626	−5,675	−3,531	−4,811	−5,235	−24,875
Current law	−5,626	−5,675	−3,531	−5,836	−6,905	−27,570
Revenues	−1,932	−1,560	−1,874	−2,058	−2,390	−9,811
Net deficit effect:						
Directed baseline	−3,694	−4,115	−1,657	−2,753	−2,845	−14,064
Current law	−3,694	−4,115	−1,657	−3,778	−4,515	−17,759
Spending subject to appropriation	1,326	508	494	440	463	3,230
Total effect assuming appropriations:						
Directed baseline	−2,368	−3,607	−1,163	−2,313	−2,382	−11,835
Current law	−2,368	−3,607	−1,163	−3,338	−4,052	−14,530
February baseline:						
Direct spending:						
Directed baseline [1]	−3,065	−3,030	−2,210	−3,455	−3,980	−14,740
Current law	−3,065	−3,030	−2,210	−3,120	−3,545	−14,970
Revenues	−2,182	−2,475	−2,758	−3,089	−3,475	−13,979
Net deficit effect:						
Directed baseline [1]	−883	−555	548	−366	−505	−1,761
Current law	−883	−555	548	−31	−70	−991
July baseline:						
Direct spending:						
Directed baseline [1]	−3,055	−3,180	−2,720	−3,720	−3,970	−16,645
Current law	−3,055	−3,180	−2,720	−3,385	−3,535	−15,875
Revenues	−2,645	−2,996	−2,755	−3,099	−3,499	−14,994
Net deficit effect:						
Directed baseline [1]	−410	−184	35	−621	−471	−1,651
Current law	−410	−184	35	−286	−36	−881
SUBTITLE A—SOCIAL SECURITY ADMINISTRATION, OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE, AND RAILROAD RETIREMENT						
Chapter 1: Administrative changes						
Subchapter A: Establishment of the Social Security Administration as an independent agency:						
Secs. 10001–10014. Establish Social Security Administration as independent agency (subject to appropriation)	([2])	1	1	1	1	4
Suchapter B: Improvements in Social Security Services						
Sec. 10021. Standards governing collection of overpayments	10	7	3	3	3	26
Sec. 10022. Demonstration projects relating to telephone service centers (subject to appropriation)	1	3	1	([2])	([2])	4
Sec. 10023. Standards applicable in certain determinations of good cause, fault, and good faith (subject to appropriation)	([2])	([2])	([2])	([2])	([2])	([2])
Sec. 10024. Assistance to the homeless (subject to appropriation)	20	30	30	30	30	140
Sec. 10025. Notice requirements (subject to appropriation)	([2])	([2])	([2])	([2])	([2])	([2])
Sec. 10026. Representation of claimants (subject to appropriation)	([2])	([2])	([2])	1	1	2
Sec. 10027. Applicability of administrative res adjudicata	([2])	([2])	([2])	([2])	([2])	([2])
Sec. 10028. Authority for Secretary to take into account misinform. provided to applicants in determining date of application for benefits	([2])	([2])	([2])	([2])	([2])	([2])
Sec. 10029. Same-day personal interviews where time is of the essence (subject to appropriation)	([2])	([2])	([2])	([2])	([2])	([2])

TITLE X: BUDGET RECONCILIATION PROVISIONS OF THE COMMITTEE ON WAYS AND MEANS—Continued

[Outlays by fiscal year, in millions of dollars]

	1990	1991	1992	1993	1994	Total 1990–94
Sec. 10030. Authority to amend wage records after time limitation expires	(1)	(1)	1	2	3	7
(Subject to appropriation)	1	1	1	1	1	4
Subchapter C: Representative payee reforms:						
Sec. 10031. Improvements in the representative payee selection and recruitment (subject to appropriation)	(1)	(1)	(1)	(1)	(1)	(1)
Sec. 10032. Improvements in recordkeeping and auditing requirements (subject to appropriation)	12	3	3	3	3	24
Sec. 10033. Reports to the Congress (subject to appropriation)	(1)	(1)	(1)	(1)	(1)	(1)
Subtotal: Chapter 1:						
Subject to appropriation	34	38	36	36	36	178
Direct spending	10	7	4	5	6	33
Total spending assuming appropriations	44	45	40	41	42	211
Chapter 2: Provisions affecting coverage						
Sec. 10051. Elimination of the dependency test for certain adopted children	5	12	16	21	22	76
Sec. 10052. Clarification of rules governing taxation of individuals of certain religious faiths (revenue effect)	−1	−1	−1	−1	−1	−5
Sec. 10053. Prohibition of termination of coverage of U.S. citizens and residents abroad by foreign affiliates of American employers	(1)	(1)	(1)	(1)	(1)	(1)
Subtotal: Chapter 2:						
Direct spending	5	12	16	21	22	76
Revenues	−1	−1	−1	−1	−1	−5
Total deficit effect	6	13	17	22	23	81
Chapter 3: Provisions affecting entitlement to benefits						
Subchapter A: Work incentives for certain adult disabled children:						
Secs. 10061—10064. Continuation of entitlement to certain child's insurance benefits based on disability:						
Social Security	(1)	1	1	2	3	7
SSI	(1)	(1)	(1)	(1)	(1)	−1
Medicare	(1)	(1)	(1)	1	1	3
Subtotal	(1)	1	1	3	4	9
Subchapter B: Other provisions:						
Sec. 10071. Continuation of disability benefits upon appeal:						
Social Security	6	27	37	43	51	164
Medicare	2	9	11	12	14	48
Subtotal	8	36	48	55	65	212
Sec. 10072. Elimination of any carryover reduction in retirement or disability benefits due to receipt of widow's or widower's benefits before attaining age 62	(1)	(1)	(1)	1	2	3
Sec. 10073. Modification of preeffectuation review requirement applicable to disability insurance cases	−4	−6	−8	−9	−11	−38
(Subject to appropriation)	−4	−5	−5	−6	−6	−26
Sec. 10074. Recovery of OASDI overpayments by means of reduction in tax refunds	−20	−125	−90	−60	0	−295
(Subject to appropriation)	5	10	5	5	0	25
Sec. 10075. Exemption for certain aliens, receiving amnesty, from liability for misreporting of earnings or misuse of Social Security account numbers or cards	(1)	(1)	(1)	(1)	(1)	(1)
Sec. 10076. Adjustments in exempt amount for the retirement test	60	120	140	150	170	640

TITLE X: BUDGET RECONCILIATION PROVISIONS OF THE COMMITTEE ON WAYS AND MEANS—Continued

[Outlays by fiscal year, in millions of dollars]

	1990	1991	1992	1993	1994	Total 1990–94
Sec. 10077. Increase in the minimum primary insurance amount	100	140	145	155	160	700
Sec. 10078. Elimination of eligibility for retroactive benefits for certain individuals	−150	−160	−160	−160	−150	−780
Sec. 10079. Inclusion of certain deferred compensation in determination of wage-based adjustments:						
Outlays	0	5	13	17	31	66
Revenues	400	1,100	1,100	1,100	1,100	4,800
Subtotal: Chapter 3:						
Social Security—Subject to approp.	1	5	0	−1	−6	−1
Social Security—direct spending	−8	2	78	139	256	467
SSI	(2)	(2)	(2)	(2)	(2)	−1
Medicare	2	9	11	13	15	51
Revenues	400	1,100	1,100	1,100	1,100	4,800
Subtotal: Chapter 3:						
Direct spending	−6	11	89	152	271	517
Revenues	400	1,100	1,100	1,100	1,100	4,800
Net deficit effect	−406	−1,089	−1,011	−948	−829	−4,283
Spending subject to appropriation	1	5	0	−1	−6	−1
Total effect assuming appropriations	−405	−1,084	−1,011	−949	−835	−4,284
Chapter 4: Railroad retirement						
Sec. 10081, Treatment of group-term life insurance under railroad retirement taxes revenue	(2)	(2)	(2)	(2)	(2)	2
Sec. 10082. Treatment of certain deferred compensation and salary reduction arrangements under railroad retirement taxes	2	2	2	2	2	11
Subtotal: Chapter 4 revenues	2	2	2	2	2	13
Subtitle A: Total:						
Direct spending	9	30	109	178	299	626
Revenues	401	1,101	1,101	1,101	1,101	4,808
Net deficit effect	−392	1,071	−992	−923	−802	−4,182
Spending subject to appropriation	35	43	36	35	30	177
Total effect assuming appropriations	−357	−1,028	−956	−888	−772	−4,005
Subtitle B—Medicare						
Part I: Part A Provisions of Medicare						
Subpart 1: Payment for inpatient hospital services:						
10101 Reduction in payments for capital	−675	−100	0	0	0	−775
10102 Prospective payment hospitals:						
a. Reduction in hospital update factors	−530	−660	−730	−800	−870	−3,590
c. Disproportionate share adjustments	230	285	315	345	375	1,550
d. Update factor for rural hospitals	140	160	180	200	220	900
e. Extend regional referral center classfication	15	25	30	15	0	85
f. Sole community hospitals	20	40	40	45	50	195
h. Essential access community hospital demonstration:						
1. Demonstration grants subject to appropriation	25	40	40	0	0	105
2. Medicare reimbursement to: E.A.C.H. and rural primary care hospitals	0	10	20	30	30	90
10103 PPS-Exempt hospitals:						
a. Exempt cancer hospitals	3	2	2	2	2	11
b. Rebase cancer hospitals to 1987 costs	5	10	10	10	10	45
Subpart 2: Other provisions:						
10111 Payments for hospice care	20	25	30	35	40	150

TITLE X: BUDGET RECONCILIATION PROVISIONS OF THE COMMITTEE ON WAYS AND MEANS—Continued

[Outlays by fiscal year, in millions of dollars]

	1990	1991	1992	1993	1994	Total 1990–94
10112 Miscellaneous part A provisions:						
b. Buy-In for disabled individuals	(2)	3	7	12	18	40
g. Waiver extension for Finger Lakes area hospital's corporation	0	(2)	−1	−1	−1	−3
Subtotal Part A Savings						
Direct spending amounts to appropriations	25	40	40	0	0	105
Part B: Part B Provisions of Medicare						
Subpart 1: Payment phyisicans' services:						
10121 Reduce certain procedures:						
a. Reduce overpriced procedures	−210	−285	−325	−370	−415	−1,605
b. Reduce radiology services	−110	−140	−160	−180	−200	−790
c. Round anesthesiology payments to actual time	−40	−45	−55	−60	−65	−265
10122 Reduce MEI update:						
a. Delay update of all fees	−260	0	0	0	0	−260
b. Reduce update from 5.3% to 2%	−255	−415	−465	−525	−590	−2,250
10123 Physician payment reform implement RB RVS on Jan 1, 1991: [1]						
Directed baseline	0	0	−130	−145	−165	−440
Current law	0	0	−130	−1,505	−2,270	−3,905
10124 Miscellaneous provisions relating to payment for physician services:						
a. New physician customary charges	−25	−150	0	0	0	−175
b. Designated specialties	−30	−35	−40	−45	−50	−200
Subpart 2: Payment for other services:						
10131 Reduce out-patient hospital capital	−25	−20	0	0	0	−45
10132 Durable medical equipment	−200	−420	−475	−535	−600	−2,230
10133 Clinical lab tests	−90	−145	−180	−205	−240	−860
Mileage fee small blood labs	14	4	0	0	0	18
10134 Mental health services:						
a. Pay psychologists	15	25	30	40	40	150
d. Eliminate $1,100 limit (including interaction with a.)	20	55	75	90	115	355
10135 Payments to nurses:						
Increase level of CRNA payments $14/21 proposal	70	185	205	230	255	945
First assistants at surgery	1	1	1	1	1	5
10136 Federally qualified health center services	13	30	35	45	50	173
10137 Miscellaneous part B provisions: Diabetic shoe inserts	(2)	(2)	(2)	0	0	(2)
Subtotal for Part B: Direct spending:						
Directed baseline	−1,112	−1,355	−1,484	−1,659	−1,864	−7,474
Current law	−1,112	−1,355	−1,484	−3,019	−3,969	−10,939
Part C: Part A and B Medicare Provisions						
10151 Delay in payments in FY 1990	−470	−70	−80	−80	−90	−790
10152 Medicare as secondary payor:						
Direct spending	−325	−780	−680	−420	−110	−2,315
Subject to appropriation	25	30	30	20	10	115
Coverage rule for religious order	12	15	20	20	25	92
10153 ESRD services	−75	−110	−135	−165	−200	−685
10154 Outcomes effectiveness research: Subject to appropriation	72	110	170	225	270	847
10158 Miscellaneous part A and B provisions:						
e. Rural health medical education demonstration	(2)	(2)	(2)	(2)	(2)	(2)
f. Cancer treatment protocol demonstration	2	2	2	2	2	10
i. Recognize hospital-based nursing costs	25	45	50	55	55	230
j. Inner-city hospital triage demonstration	(2)	(2)	(2)	(2)	(2)	(2)
Subtotal Part A and B Savings:						
Direct spending	−831	−898	−823	−588	−318	−3,458

TITLE X: BUDGET RECONCILIATION PROVISIONS OF THE COMMITTEE ON WAYS AND MEANS—Continued

[Outlays by fiscal year, in millions of dollars]

	1990	1991	1992	1993	1994	Total 1990–94
Amounts subject to appropriations	97	140	200	245	280	962
Part D: Part B Premium						
10161 Basic Part B Premium: 25% CY 90 (includes intersection with other Part B Savings)	−325	−455	−485	−515	−545	−2,325
Part E: Extension of Cobra Continuation Coverage for Disabled Employees						
10171 Extension from 18 to 29 months	(2)	(2)	(2)	(2)	(2)	(2)
Part F: Revisions to Medicare Catastrophic Coverage Act [3]						
Subpart 1: Medicare part A and supplemental Medicare premium:						
10181 Supplemental Medicare premium:						
a. Reduction in supplemental premium rate revenue [4]	−2,082	−2,035	−2,278	−2,559	−2,895	−11,849
b. Supplemental based on part B enrollment revenue	−100	−440	−480	−530	−580	−2,130
10182 Abolition of Federal hospital insurance catastrophic coverage reserved fund	0	0	0	0	0	0
Subpart 2: Medicare part B provisions:						
10191 Catastrophic linked to election of part B [5]	−90	−190	−230	−260	−300	−1,070
10192 Adjustment in part B premium:						
a. Part B premium adjustments:						
Directed baseline	0	−500	−1,200	−2,225	−2,580	−6,505
Current law	0	−500	−1,200	−1,890	−2,145	−5,735
b. Ad hoc premium increase [6]						
Directed baseline	−975	−1,460	−1,550	−1,585	−1,660	−7,230
Current law	−975	−1,460	−1,550	−1,585	−1,660	−7,230
10193 Increase in catastrophic drug deductible	0	−180	−430	−325	0	−935
10194 Temporary delay in Medicare payments	−2,000	−700	−1,200	940	560	0
Subtotal for part F:						
Revenue	−1,182	−2,475	−2,758	−3,089	−3,475	−13,979
Direct spending:						
Directed baseline	−3,065	−3,030	−2,210	−3,455	−3,980	−15,740
Current law	−3,065	−3,030	−2,210	−3,120	−3,545	−14,970
Grand Total Medicare:						
Revenue	−2,182	−2,475	−2,758	−3,089	−3,475	−13,979
Direct spending:						
Directed baseline	−6,105	−5,938	−5,099	−6,324	−6,833	−30,299
Current law	−6,105	−5,938	−5,099	−7,349	−8,503	−32,994
Net deficit effect:						
Directed baseline	−3,923	−3,463	−2,341	−3,325	−3,358	−16,320
Current law	−3,923	−3,463	−2,341	−4,260	−5,028	−19,015
Amounts subject to appropriation	122	180	240	245	280	1,067
Total deficit effect assuming full appropriation:						
Directed baseline	−3,801	−3,283	−2,101	−3,990	−3,078	−15,253
Current law	−3,801	−3,283	−2,101	−4,015	−4,748	−17,948
SUBTITLE C—HUMAN RESOURCE AMENDMENTS						
Part 1: Children's Initiative						
Subpart A: Social services:						
Sec. 10201. Increase title XX block grant	0	190	390	590	600	1,770
Subpart B: Foster care and child welfare amendments:						
Sec. 10211. Increase child welfare authorization (subject to appropriation)	98	132	134	134	134	632
Sec. 10212. Extend ceilings and transfer authority	5	7	7	2	0	21
Sec. 10213. Prevention report	(2)	(2)	(2)	(2)	(2)	1
Sec. 10214. Increase foster parent training reimbursement	1	1	1	1	1	5

TITLE X: BUDGET RECONCILIATION PROVISIONS OF THE COMMITTEE ON WAYS AND MEANS—Continued

[Outlays by fiscal year, in millions of dollars]

	1990	1991	1992	1993	1994	Total 1990–94
Sec. 10215. Require health and education plans and require comprehensive health exams:						
Foster Care	2	2	2	2	2	10
Medicaid	10	10	10	15	15	60
Total	12	12	12	17	17	70
Sec. 10216. Foster care adolescent services stock grant	75	100	100	25	0	300
Sec. 10217. Improve data collection	(2)	2	1	1	1	5
Sec. 10218. Improve accountability	(2)	(2)	(2)	(2)	(2)	(2)
Subpart C: SSI disabled children amendments:						
Sec. 10221. Conduct children's outreach:						
SSI—Subject to appropriation	1	(2)	(2)	(2)	(2)	1
SSI—Direct spending	2	4	5	6	7	24
Medicaid	1	2	3	3	4	13
Food stamps	0	−1	−1	−1	−1	−4
Subject to appropriation	1	(2)	(2)	(2)	(2)	1
Direct spending	3	5	7	8	10	33
Total	4	5	7	8	10	34
Sec. 10222. Individual functional assessment for children:						
SSI—Subject to appropriation	2	2	2	2	2	10
SSI—Direct spending	15	40	60	80	95	290
Medicaid	5	15	25	35	45	125
Food stamps	−2	−5	−10	−10	−10	−37
Subject to appropriation	2	2	2	2	2	10
Direct spending	18	50	75	105	130	378
Total	20	52	77	107	132	388
Sec. 10223. Presumptive disability for certain children under age of four:						
SSI	3	5	5	5	5	23
Medicaid	1	2	2	2	2	9
Total	4	7	7	7	7	32
Sec. 10224. Publish childhood mental impairment listings:						
SSI	(*)	15	20	25	30	90
Medicaid	(*)	5	5	10	10	30
Food stamps	(*)	−2	−2	−5	−5	−14
Total	(*)	18	23	30	35	106
Sec. 10225. Revise listings of impairments for childhood disabilities	(7)	(7)	(7)	(7)	(7)	(7)
Sec. 10226. Provide medicaid eligibility in months when ineligible because weekly or biweekly checks	1	1	1	1	1	5
Sec. 10227. Make U.S. children abroad eligible for SSI	1	2	2	2	2	9
Sec. 10228. Change deeming rules for children in State home care plans	2	2	2	2	2	10
Sec. 10229. Demo intergenerational project for disabled children (subject to appropriation)	1	1	2	2	2	8
Sec. 10230. Exclude from resources work-related equipment	(2)	(2)	(2)	(2)	(2)	(2)
Subpart D: Child support enforcement amendments:						
Sec. 10231. Extended IRS intercept	0	2	2	2	2	8
Sec. 10232. Allow IRS intercept for nonminor disabled children	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 10233. Provide 12 months of medicaid eligibility for families leaving AFDC because of child support medicaid	10	25	25	30	30	120

TITLE X: BUDGET RECONCILIATION PROVISIONS OF THE COMMITTEE ON WAYS AND MEANS—Continued

[Outlays by fiscal year, in millions of dollars]

	1990	1991	1992	1993	1994	Total 1990–94
Subtotal: Part 1:						
Title XX	0	190	390	590	600	1,770
Child care—Subject to appropriation	98	132	134	134	134	632
Foster care—Direct spending	83	112	111	31	4	342
SSI—Subject to appropriation	4	3	4	4	4	19
SSI—Direct spending	23	68	94	120	141	446
Child support enforcement	0	2	2	2	2	8
Medicaid	28	60	71	96	107	362
Food stamps	−2	−8	−13	−16	−16	−55
Total: Part 1						
Subject to appropriation	102	135	138	138	138	651
Direct spending	132	424	655	823	838	2,873
Total spending	234	559	793	961	976	3,524
Part 2: SSI Service Improvements						
Subpart A: Initiative for the poor elderly:						
Sec. 10241. SSI benefit increase:						
SSI	70	100	105	160	115	550
Medicaid	(2)	5	5	5	5	20
Food stamps	−10	−15	−15	−20	−15	−75
Total	60	90	95	145	105	495
Sec. 10242. Establish SSI outreach—Adults:						
SSI—Subject to appropriation	20	5	5	5	5	40
SSI—Direct spending	35	55	55	50	50	245
Medicaid	40	60	60	60	60	280
Food stamps	−5	−5	−5	−5	−5	−25
Subject to appropriation	20	5	5	5	5	40
Direct spending	70	110	110	105	105	500
Total	90	115	115	110	110	540
Sec. 10243. Reform representative payee procedures and tracking (subject to appropriation)	5	1	1	2	2	11
Sec. 10244. Modify one-third reduction rule:						
SSI—Subject to appropriation	5	3	3	3	3	17
SSI—Direct spending	45	60	65	70	70	310
Total	50	63	68	73	73	327
Sec. 10245. Exclude domestic travel tickets from SSI income	2	(2)	(2)	(2)	(2)	(2)
Sec. 10246. Reduction in time when separated couples income treated jointly	2	2	2	2	2	10
Sec. 10247. Exclude interest income on burial spaces	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 10248. Deem certain recipients of Title II disability insurance to have received SSI:						
SSI	2	2	3	4	5	16
Medicaid	(2)	4	6	7	9	26
Total	2	6	9	11	14	42
Sec. 10249. Exclude victims compensation payments	2	(2)	(2)	(2)	(2)	(2)
Subpart B: Other Service Improvements:						
Sec. 10251. Determination of good faith	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 10252. Assist homeless	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 10253. Notice requirements	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 10254. Representation of claimants	(2)	(2)	(2)	(2)	(2)	(2)

TITLE X: BUDGET RECONCILIATION PROVISIONS OF THE COMMITTEE ON WAYS AND MEANS—Continued

[Outlays by fiscal year, in millions of dollars]

	1990	1991	1992	1993	1994	Total 1990–94
Sec. 10255. Application of administrative res judicata	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 10256. Misinformation for beneficiaries	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 10257. Same day personnel interview	(2)	(2)	(2)	(2)	(2)	(2)
Subtotal: Part 2:						
SSI—Subject to appropriation	30	9	9	10	10	68
SSI—Direct spending	154	219	230	286	242	1,131
Medicaid	40	69	71	72	74	326
Food Stamps	−15	−20	−20	−25	−20	−100
Subtotal: Part 2:						
Subject to appropriation	30	9	9	10	10	68
Direct spending	179	268	281	333	296	1,357
Total spending	209	277	290	343	306	1,425
Part 3: Miscellaneous Amendments						
Sec. 10261. Option for school employees	5	0	0	0	0	5
Sec. 10263. Extend moratorium on implementation of regulation on homeless AFDC families [9]	0	0	0	0	0	0
Sec. 10264. Authorize self-employment demonstration program subject to appropriation	(2)	(2)	(2)	0	0	1
Sec. 10265. Minnesota AFDC demonstration	(2)	(2)	(2)	(2)	(2)	1
Subtotal: Part 3:						
Direct spending	5	0	0	0	0	6
Total spending	5	0	0	0	0	6
Part 4: AFDC Quality Control Amendments						
Subpart A: Resolution of disallowance backlog through fiscal year 1990						
Sec. 10271. Modify treatment of quality control sanctions backlog	0	314	515	167	161	1,157
Subpart B: Permanent modification of quality control system after fiscal year 1990:						
Sec. 10281. Modify quality control system [10]	0	0	0	0	0	0
Subtotal: Part 4:						
Direct spending	0	314	515	167	161	1,157
Total spending	0	314	515	167	161	1,157
Subtitle C: Total:						
Subject to appropriation	132	144	147	148	148	719
Direct spending	316	1,006	1,451	1,323	1,295	5,393
Total effect assuming appropriations	448	1,150	1,598	1,471	1,443	6,112
SUBTITLE D—TRADE AMENDMENTS						
Part 1—Trade Agency Authorizations for Fiscal Year 1990						
Sec. 10301. United States International Trade Commission (subject to appropriation)	34	3	1	1	(2)	40
Sec. 10302. United States Customs Service (subject to appropriation)	984	134	70	11	5	1,203
Sec. 10303. United States Trade Representative (subject to appropriation)	18	3	(2)	(2)	(2)	21
Subtotal: Part 1 subject to appropriation	1,036	140	71	12	5	1,264

TITLE X: BUDGET RECONCILIATION PROVISIONS OF THE COMMITTEE ON WAYS AND MEANS—Continued

[Outlays by fiscal year, in millions of dollars]

	1990	1991	1992	1993	1994	Total 1990–94
Part 2—Customs User Fees						
Sec. 10311–10316 Customs user fees	154	−773	8	12	4	−595
Subtotal: Part 2 Offsetting Receipts	154	−773	8	12	4	−595
Subtitle D: Total:						
Subject to appropriation	1,036	140	71	12	5	1,264
Direct spending (Offsetting receipts)	154	−773	8	12	4	−595
Total effect assuming appropriations	1,190	−633	79	24	9	669
SUBTITLE E—CARIBBEAN BASIN ECONOMIC RECOVERY						
Part 2—Amendments to the Caribbean Basin Economic Recovery Act and related provisions						
Subpart A—Amendments to the Caribbean Basin Economic Recovery Act:						
Sec. 10412. Exceptions to General duty-free treatment revenue	−29	−32	−37	−10	0	−108
Subpart B—Amendments to the harmonized tariff schedule and other provisions affecting CBI beneficiary countries:						
Sec. 10423. Duty-Free Treatment of Articles Assembled From U.S. Components Revenue	−1	−2	−2	−2	−2	−9
Subtotal: Part 2 Revenue	−30	−34	−39	−12	−2	−117
Part 3—Scholarship Assistance and Tourism Promotion						
Sec. 10433. Pilot Preclearance Program (subject to appropriation)	1	1	0	0	0	2
Subtotal: Part 3 subject to appropriation	1	1	0	0	0	2
Subtitle E: Total:						
Revenues	−30	−34	−39	−12	−2	−117
Subject to appropriation	1	1	0	0	0	2
Total effect assuming appropriations	31	35	39	12	2	119
SUBTITLE F—TARIFF PROVISIONS						
Subtitle F: Total:						
Revenues	−121	−152	−178	−58	−14	−523
Subject to appropriation	(2)	(2)	(2)	(2)	(2)	1
Total effect assuming appropriations	121	152	178	58	14	523

[1] Savings associated with current law reflect no further action taken by Congress. Directed baseline savings assume no expenditure target specifications in future years as directed in the legislative language.

[2] Less than $500,000.

[3] Estimates of the provisions relating to the MCCA of 1988 are based on July reestimates, except for the Part B premium adjustment, which is based on the CBO February 1989 Baseline.

[4] Revenue estimate provided by the Joint Committee on Taxation.

[5] The estimate for the voluntary option assumes that those who do not enroll or who disenroll (except for those under the working aged/disabled provisions) will be subject to current penalties for late enrollment and the supplemental premium would be increased by 15% as a further penalty.

[6] The Ad Hoc premium increase is $3.50 in 1990, $4.00 in 1991, and $4.10 in 1992 and 1993, and would be increased by the Social Security Cost-of-Living adjustment (COLA) in 1994 and beyond.

[7] Standards are to be set by the Secretary of Health and Human Services. Because the standards are not yet known, an estimate of cost or savings cannot be done at this time.

[8] Estimated administrative costs included in Sec. 10024.

[9] The moratorium would have no cost because the regulation was never implemented and thus is not in CBO's baseline. According to the Administration, a regulation limiting assistance could save $35 to $85 million a year.

[10] Changes in the quality control system after 1990 would have no cost during the 1990–1994 period because CBO's baseline estimates include the collection of sanction only for years through 1989. There would be a cost of this provision in the years after 1994.

Note.—Savings associated with current law reflect no further action taken by Congress. Directed base savings assume no expenditure target in specifications in future years as directed in the legislative language. Estimated savings in the Medicare Catastrophic Coverage Act are based on July reestimates, except for the Part B premium adjustment, which is based on the CBO's February 1989 baseline. Estimated savings under February assumptions are displayed below. Details may not add to totals because of rounding. All estimates are relative to the CBO February 1989 Baseline. Certain provisions that are expected to have no cost have been omitted from the table.

TITLE XI: REVENUE PROVISIONS OF THE COMMITTEE ON WAYS AND MEANS 1990 RECONCILIATION BILL [1]

[Outlays, in millions of dollars by fiscal year]

	1990	1991	1992	1993	1994	Total 1990–94
SUBTITLE I—CHILD CARE PROVISIONS						
Sec. 11901: Grants to States for child care	120	266	362	394	400	1,542
Sec. 11902: Incentive grants for improving child care standards (subject to appropriations)	17	68	75	75	75	310
Sec. 11903: Expansion of Earned Income Tax Credit: [2]						
Outlays	0	378	3,717	3,986	4,266	12,347
Revenues	0	−37	−355	−380	−407	−1,179
Subtitle I: Total:						
Direct spending	120	644	4,079	4,380	4,666	13,889
Revenues	0	−37	−355	−380	−407	−1,179
Net deficit effect	120	681	4,434	4,760	5,073	15,068
Subject to appropriations	17	68	75	75	75	310
Total effect on deficit assuming appropriations	137	749	4,509	4,835	5,148	15,378

[1] This table does not include estimates for the revenue provisions in Subtitle A–H of Title XI.
[2] Estimates provided by the Joint Committee on Taxation.

DETAIL OF BUDGET EFFECTS OF TITLE X AND XI ITEMS INCLUDING BOTH REVENUES AND OUTLAYS—FISCAL YEARS 1989–94

[In millions of dollars]

Item	1990	1991	1992	1993	1994	1990–94
A. Repeal financial institutions (FSLIC and FDIC) tax benefits (H.R. 1278) (effective May 10, 1989):						
1. Revenue effect	842	634	389	310	213	2,388
2. Offsetting outlay	−274	−603	−38			−915
B. Amendments to Medicare Catastrophic Program:						
1. Revenue effect	−2,475	−2,456	−2,375	−2,679	−3,029	−13,014
2. Offsetting outlay	2,885	2,640	2,445	3,340	NA	11,310
C. Include certain deferred compensation in calculation of indexing of FICA base (effective Jan. 1, 1990):						
1. Revenue effect	400	1,100	1,100	1,100	1,100	4,800
2. Offsetting outlay		−5	−13	−17	−31	−66
D. Child care initiative: Expanded earned income tax credit (effective Jan. 1, 1991)						
1. Adjustments for family size (3+): phase-in 17 percent, 21 percent, 25 percent; phase-out 12 percent, 15 percent, 18 percent:						
a. Revenue effect		−27	−259	−278	−298	−862
b. Outlay effect		−269	−2,619	−2,814	−3,017	−8,719
2. Supplemental for children under 6 years old: phase-in 6 percent; phaseout 4.25 percent:						
a. Revenue Effect		−10	−96	−102	−109	−317
b. Outlay effect		−109	−1,098	−1,172	−1,249	−3,528

Note: Outlay estimates were provided by the Congressional Budget Office.

Source: Joint Committee on Taxation.

TABLE 3.—ESTIMATES OF REVENUE EFFECTS OF ITEMS REPORTED PURSUANT TO BUDGET RECONCILIATION INSTRUCTIONS—TITLE XI: FISCAL YEARS 1990–94

[In millions of dollars]

Item	1990	1991	1992	1993	1994	1990–94
I. ADMINISTRATION PROPOSALS*						
A. Suspend airport and airway trust fund tax reduction trigger until expiration of present taxes (effective Jan. 1, 1990) [1]	851	269				1,120
B. Loophole closers:						
1. Characterize certain high-yield original issue discount (OID) obligations as preferred stock	25	51	94	131	160	461
2. Require consolidated computation of earnings and profits for corporations filing consolidated returns	27	69	123	170	224	613
3. Like-kind exchanges:						
a. Limit like-kind exchanges to similar use property	143	222	273	325	378	1,341
b. Restrict basis shifting techniques between related parties	100	120	130	140	151	641
c. Amend holding period requirements	(2)	(2)	(2)	(2)	(2)	(2)
4. Limit section 104 exclusion from income to amount received for personal injury	4	8	8	10	12	42
5. Tax pre-contribution gain on certain in-kind partnership distributions	9	20	26	31	36	122
6. Limit nonrecognition treatment when securities are received in certain section 351 transactions	105	165	168	159	81	678
Subtotal	1,264	924	822	966	1,042	5,018
II. MODIFIED ADMINISTRATION PROPOSALS*						
A. Impose oil spill liability trust fund petroleum tax (effective Oct. 1, 1989, through Dec. 31, 1991) at $0.03 per barrel (cap at $300 million); without waiting for authorizing legislation	69	122	41			232
B. Telephone excise tax:						
1. Permanent extension		1,717	2,737	2,936	3,149	10,539
2. Modify collection period of tax (100 percent speedup, effective for taxes billed by service producers after June 30, 1990)	102	−102				
Subtotal	171	1,737	2,778	2,936	3,149	10,771
III. OTHER PROVISIONS*						
A. Employee stock ownership plans (ESOP's):						
1. Repeal partial exclusion for interest paid on ESOP loans (section 133) (generally effective June 7, 1989)	1,008	1,258	1,663	2,036	2,369	8,334
2. Repeal the deduction for dividends paid on employer securities obtained by an ESOP (section 404(k))	307	404	536	657	765	2,669
3. Impose 3-year holding period on seller to be eligible for tax-free rollover (section 1042)	(2)	(2)	(2)	(2)	(2)	(2)
4. Repeal sections 2057, 2210, 415(c)(6), and 382(l)(3)(C)	77	166	99	50	50	442
B. Repeal transition rule for certain high withholding tax interest (effective Jan. 1, 1990)	168	229	150	81	22	650
C. Repeal remaining portion of completed contract method of accounting	171	390	262	116	28	967
D. Corporate mergers and acquisitions:						
1. Certain transactions involving foreign and other tax-exempt investors:						
a. Limit interest deductions for earnings-stripping payments to related parties	28	38	44	47	49	206
b. Tax stock gains of certain foreign investors	2	5	6	35	50	98
2. Clarify Treasury regulation authority relating to bifurcation of an instrument into debt and equity portions (section 385)	(2)	(2)	(2)	(2)	(2)	(2)
3. Require reporting to IRS of acquisitions and recapitalizations (effective on date of enactment)	(2)	(2)	(2)	(2)	(2)	(2)

TABLE 3.—ESTIMATES OF REVENUE EFFECTS OF ITEMS REPORTED PURSUANT TO BUDGET RECONCILIATION INSTRUCTIONS—TITLE XI: FISCAL YEARS 1990–94—Continued

[In millions of dollars]

Item	1990	1991	1992	1993	1994	1990–94
4. Treasury study of "debt versus equity" and integration issues						
E. Permit limited use of excess pension funds to pay current retiree health benefits (effective Jan. 1, 1990)	286	465	176	(3)	(3)	927
F. Impose gasoline excise tax when gasoline is received at terminal (effective Oct. 1, 1989)	117	60	60	60	60	357
G. Require corporate estimated tax payments on tax liability for certain subchapter S income (effective Jan. 1, 1990)	25	(2)	(2)	(2)	(2)	25
H. Impose income tax withholding on the wages of certain agricultural workers (effective Jan. 1, 1990)	270	68	21	22	23	404
I. Require regulated investment companies (mutual funds) to distribute 98 percent of ordinary income to their shareholders (effective for taxable years ending after July 10, 1989)	50	5	5	5	5	70
J. Adjust basis for mutual fund load charge only if shareholder holds shares for 30 days	14	28	13	5	3	63
K. Reduce built-in gain or loss threshold of sections 382 and 384 to lesser of 15 percent or $10 million	25	42	44	46	49	206
L. Increase enforceability of section 482 with respect to U.S. subsidiaries and branches of foreign corporations through improved reporting	60	80	85	90	95	410
M. Modify excess loss account recapture rules to prevent shifting of basis to debt	54	69	61	52	42	278
N. Require basis reduction for nontaxed portion of dividends on self-liquidating ("wasting") stock	6	10	11	12	13	52
O. Modify treatment of costs of acquiring franchises, trademarks, and trade names	75	135	173	203	225	811
P. Conform tax years of controlled foreign corporations and foreign personal holding companies to the tax years of their U.S. shareholders	48	71	71	71	36	297
Q. Change the sourcing of foreign income of certain commonly controlled nonconsolidated corporations	20	37	41	45	49	192
R. Limit nonrecognition treatment when securities are received by corporate transferors in certain section 351 transactions (effective July 11, 1989)	52	83	84	80	40	339
S. Deny expensing for certain R&D not performed in the United States (effective for taxable years beginning after Dec. 31, 1989)	43	81	68	57	47	296
T. Include dividends in income of RIC's (regulated investment companies) on ex-dividend date (effective for ex-dividend dates after date of enactment)	110	20	20	20	20	190
U. Deny retroactive certification of WIN credit	38	28	12			78
V. Deny amortization of life estate in related-party joint purchases		7	7	8	8	30
W. Treat cellular telephones and other similar telecommunications equipment as "listed property"	2	10	14	18	24	68
X. Require reporting of mortgage points by lender	2	5	5	5	5	22
Subtotal	3,058	3,794	3,731	3,821	4,077	18,481
IV. CHILD CARE PROVISIONS						
A. Expanded earned income tax credit (effective Jan. 1, 1991):						
1. Adjustment for family size (3+): phasein 17 percent, 21 percent, 25 percent; phaseout 12 percent, 15 percent, 18 percent		−296	−2,878	−3,092	−3,315	−9,581
2. Supplemental for children under 6 years old: phasein 6 percent; phaseout 4.25 percent		−119	−1,194	−1,274	−1,358	−3,945
B. Expansion of title XX block grant for child care services (4)	−120	−266	−362	−394	−400	−1,542
Subtotal	−120	−681	−4,434	−4,760	−5,073	−15,068

VI. ADDITIONAL VIEWS

ADDITIONAL VIEWS OF HON. BILL ARCHER, HON. GUY VANDER JAGT, HON. PHILIP M. CRANE, HON. BILL FRENZEL, HON. RICHARD T. SCHULZE, HON. WILLIAM M. THOMAS, HON. HANK BROWN, HON. ROD CHANDLER, HON. E. CLAY SHAW, HON. DON SUNDQUIST, AND HON. NANCY JOHNSON ON COMMITTEE ON WAYS AND MEANS BUDGET RECONCILIATION PROVISIONS

The process of budget reconciliation is not purely a dollars and cents exercise designed to meet mandated deficit reduction targets. There is an equally important measure of accountability which must always be in the forefront of our minds—that of maintaining responsible public policy. By that test, the reconciliation actions of the Committee on Ways and Means succeed in some areas and fall considerably short in others.

On the positive side, the Committee's decision to stimulate national savings and job-creating investment through improvements in the tax treatment of capital gains is an important economic victory for the American people. A bipartisan majority made the right choice—creating, rather than squandering, an opportunity for Americans to find better jobs and reap more of the rewards that our society had to offer.

To his credit, the Chairman of the Committee allowed a bipartisan majority to work its will on this important economic issue. It is unfortunate, however, that those who attempted to make capital gains a partisan political issue were able to delay its consideration for so long that the budget reconciliation process has been endangered needlessly.

This is an economic issue that crosses party lines, and the common sense coalition that formed the majority in Committee properly resisted efforts to politicize it.

We currently tax investments so many times (i.e., multiple potential taxes at each level of corporate ownership, taxes on distributions to shareholders, and taxes on capital gains caused to a large extent by inflation) that the rewards of saving are insufficient to counterbalance the immediate gratification of spending.

This capital gains provision is an important step in reducing those disincentives for savings and toward reducing a tax on capital that ranks as the highest among our international competitors. It is a positive step in restoring our competitiveness in the international marketplace and in reducing our dependence on foreign investment in U.S. industry to keep our economy growing and providing more and better jobs for our people. It is an important ele-

ment in preserving the hard-earned nest eggs of middle income taxpayers.

Unfortunately, not all of the tax provisions in the Committee's reconciliation package can be viewed as having that same kind of positive impact on savings and investment. New restrictions on like-kind exchanges will have an adverse impact on investment in real estate and other areas of the economy.

Capital gains taxes placed on investments by foreigners (longstanding treaties to the contrary notwithstanding) will prematurely erode that source of investment before the changes in capital gains treatment for American taxpayers can sufficiently fill that void. Earnings of many corporations will be artificially inflated for tax purposes (through the disallowance of legitimate interest deductions) making it more difficult for them to attract investors.

Similarly, from the perspectives of both the budget deficit and sound social policy, the Ways and Means Committee's actions on human resources spending and on child care missed the mark.

At a time when we face annual budget deficits in the $100 billion range, the Committee is attempting to put new, permanent provision in the law that will cost some $22.5 billion over the next five years.

While most Republican Members of the Committee indeed are willing to provide additional federal support for child care (as evidenced by alternatives a number of our Members have put forward in Committee and in the full House of Representatives), we have serious objections to the unnecessarily expensive provisions adopted by the Committee.

The human resource and child care proposals are cleverly crafted to spend some $650 million in the first year and $1.9 billion in the second year of the two years covered by reconciliation instructions. In the third year, however, spending explodes to $6.4 billion, then rises gradually to $6.9 billion in the fifth year.

This is bacteria budeting—put a little bacteria in the right place and watch it explode into a raging disease. The budget problems associated with these new spending programs are serious enough, but they are also quite difficult to justify in terms of social policy.

Given our nation's recent difficulties in international comparisons of everything from trade to academic achievement, this is a particularly appropriate time to invest in "human capital" by spending money in such a way that returns to society exceed the original outlay.

By this criterion, the increased social spending in the Committee's bill fails utterly. We have no evidence that the $2.7 billion we currently send to the states annually in the Title XX program is really achieving its intended results, yet the Committee increased Title XX funding by nearly $3.6 billion over 5 years. It is a important to note that by 1993, the increased Title XX spending will amount to $1 billion per year.

We expect the states to spend the money on worthy projects, and we realize that inflation eats away at the funds each year. That is why most Committee Republicans were willing to increase Title XX by an amount that would equal inflation pending information that the spending produces real benefits to society.

The Committee made another significant change, beyond the funding increase in Title XX. Without hearings or significant debate, the Committee proposes to change the fundamental nature of the Title XX program. Not satisifed to allow states to decide how best to spend Title XX funds, the Committee earmarked over 40 percent of the new spending for a particular program—day care.

It doesn't matter that some states, in which the marketplace has worked well in providing child care, may feel that they do not have a need to spend additional Title XX funds for that purpose. It doesn't matter that they may have a far greater need for assistance in dealing with with adolescent drug problems or the needs of their elderly citizens..

The Committee has dictated that states spend this money on day care—and not on just any day care. All states currently have regulations that apply to child care centers, and all but four states have regulations that apply to family day care homes.

The Ways and Means Committee has decided that these state regulations are not adequate and that states should therefore be required to strengthen them. That determination was made in spite of the fact that the record of witnesses before our Committee contains little systematic evidence that children in day care are at risk for injuries, abuses, or other conditions that would be addressed by regulations.

Similarly, the record contains no evidence showing that strengthening regulations would have positive effects on children's development. We heard a number of anecdotes regarding children in bad day care programs, but anecdotes alone are not an adequate basis for formulating national policy. Nor are they a valid basis for federal interference in policy decisions already made, as they should be, by parents and state and local governments.

The Committee bill contains a provision that would cut of Title XX funding to any state that reduces its day care standards—even if the revised standards still met all the other requirements of the Committee bill. If, for example, the state with the highest standards in the nation on staff-child ratios wanted to reduce the ratios to allow more children to be cared for, the state would be in danger of losing its Title XX funds—even if its revised ratios were still the highest in the nation.

We disagree with the Committee's proposal to interfere in state and local regulation of child care; this provision on denigration of standards goes beyond all boundaries of reason.

The Census Bureau recently released a study showing that Americans spend about $14 billion annually on child care. Studies by the Labor Department and reputable non-government groups estimate federal spending on day care at about $6 billion.

When the Committee day care provisions are fully implemented by 1992, the federal government will pay for more than half of all day care used by American families. That ought to give Members reason to question the actions of the Committee on this expensive issue.

BILL ARCHER.
GUY VANDER JAGT.
PHIL CRANE.
BILL FRENZEL.
DICK SCHULZE.
BILL THOMAS.
HANK BROWN.
ROD CHANDLER.
E. CLAY SHAW, Jr.
DON SUNDQUIST.
NANCY JOHNSON.

ADDITIONAL VIEWS OF HON. BILL ARCHER, HON. PHILIP M. CRANE, HON. BILL FRENZEL, HON. RICHARD T. SCHULZE, HON. WILLIAM M. THOMAS, HON. HANK BROWN, HON. ROD CHANDLER, HON. DON SUNDQUIST, HON. E. CLAY SHAW, AND HON. NANCY JOHNSON ON AMENDMENTS TO THE MEDICARE CATASTROPHIC COVERAGE ACT OF 1988

The Ways and Means Committee did not just squander a great opportunity in budget reconciliation to restructure the unfair and controversial financing of the Medicare Catastrophic Coverage Act. It may well have created a whole new set of policy and political problems by adopting a new financing scheme which is guaranteed to exacerbate the unfairness of current law and anger even larger numbers of the nation's elderly.

The change will not quell the political firestorm which has been growing ever stronger as the months go by. On the contrary, the amendment creates new inequities which will be even more unacceptable to medicare beneficiaries once they are understood.

Under the current law, two-thirds of the dollars financing the new catastrophic benefits come from a surtax, euphemistically called a "supplemental premium," which is levied on those who are eligible for Part A Medicare benefits.

The surtax singles out 40 percent of the elderly and disabled to be penalized. In effect, the surtax requires taxpaying beneficiaries who served during their working lives to subsidize up to six of their fellow medicare recipients.

While the Committee's amendment reduces the rates for the surtax, the cost of the reduction is shifted to all medicare beneficiaries through an increase in the Part B flat premium and to those beneficiaries who would use the outpatient prescription drug coverage by increasing the deductible for that benefit.

In other words, those less well off and the sick are expected, in this refinement of the Act, to pay the price for the flawed supplemental premium.

Despite the fact that the amendment reduces the rates for the surtax, it leaves the surtax in the law and continues to penalize those who have saved for their retirement years. In failing to repeal this surtax, we have retained in our tax code a tremendous disincentive for savings, a disincentive that only compounds the effect of other savings disincentives.

And, just as importantly, the door is left wide open for future surtax increases on the same group of the elderly who have saved to finance expanded benefits for those who have not.

The amendment further creates new concerns by purporting to make the medicare catastrophic benefits "voluntary". This is truly misleading. Through the amendment, medicare catastrophic benefits are linked to all Part B benefits. "Voluntary," in this case,

means that beneficiaries must "throw the baby out with the bath water," and give up all coverage under Part B of medicare, if they choose to opt out of the catastrophic benefit.

For twenty-five years, since the inception of the medicare program, the elderly and disabled have had the option to buy outpatient and physician coverage through Medicare Part B. Now, those existing benefits, for which premiums are prepaid, would be denied to beneficiaries who do not need the catastrophic coverage or do not think the surtax is affordable.

This is wrong. Those less well off may very well be seduced into dropping needed Part B benefits by the prospect of avoiding the flat Part B premium and surtax.

Many other millions of beneficiaries who have supplemental medigap coverage through their former employers might mistakenly think they can opt out of Medicare Part B and have total coverage through their retiree health insurance.

In fact, for most of those retirees, their retiree health coverage is dependent upon their acceptance of Medicare, so that to withdraw from Part B would threaten even the private coverage they earned during their working lives. For these people the so-called "voluntary" option is no option at all. For them to withdraw from Part B would mean losing not only Medicare but also eligibility for their private coverage. That constitutes pure coercion on the part of the Committee to force people to remain in the catastrophic program.

The amendment also removes the hospital trust fund from the catastrophic financing while retaining the catastrophic benefits under Part A. The trust fund will therefore pay for hospital, home health, and skilled nursing facility benefits for which it receives no additional funding.

This means that a process has been set in place which allows as much as two billion dollars to be spent annually from the trust fund without a mechanism for replacement. Clearly, this dollar drain increases the likelihood of trust fund insolvency. It could well be the nail in the coffin of fiscal balance of the trust fund.

Fatally flawed as it is, the catastrophic benefit package was at least designed to be self-financing. This principle was critical to President Reagan and the Congress in structuring this expansion of medicare. The amendment undermines that principle and the fiscal integrity of the hospital trust fund.

Finally, the amendment may not just allow further fiscal mischief, but may in fact promote it. The amendment is budget neutral through 1993. But, since it does not fund directly the catastrophic hospital, home health, skilled nursing facility benefits, the money to offset those expenditures, raised through the surtax and flat premium, is all plowed into the Part B and drug trust funds.

This "extra money" will sit in the Part B trust fund. We are sure, in future years, that the temptation to use these monies to finance new benefits will be too great for some to resist. Thus, the amendment is likely to completely undo the financing for the hospital, home health, and skilled nursing facility benefits expanded by the Medicare Catastrophic Coverage Act, and lead to future, irresponsible spending.

The elderly and disabled should get an even break under medicare. They should expect no less than they have been promised by

the Congress. This amendment breaks that promise. Both the reduction in the surtax and its "voluntary approach" to the catastrophic benefits are disingenuous, and our constituents will see this bad deal for what it is.

BILL ARCHER.
PHIL CRANE.
BILL FRENZEL.
DICK SCHULZE.
BILL THOMAS.
HANK BROWN.
ROD CHANDLER.
DON SUNDQUIST.
NANCY JOHNSON.
E. CLAY SHAW, Jr.

ADDITIONAL VIEWS OF HON. BILL ARCHER, HON. HANK BROWN, HON. DON SUNDQUIST AND HON. NANCY JOHNSON ON MEDICARE PART B EXPENDITURE TARGETS

The adoption by the Ways and Means Committee of expenditure targets as part of medicare physician payment reform is bad policy, and we oppose this action. Expenditure targets are designed to place simplistic and arbitrary limits on future expenditures under medicare Part B for physician payment. The expenditure target policy will encourage under-reimbursement with the inevitable erosion in access to quality care and discourage the tough decisions necessary to address the causes of the health care cost explosion.

Expenditure targets will have a deleterious effect on physician payment and patient care. The arbitrary ceiling on payment required by the targets could limit honest physicians in providing needed care and will provide no guarantee that unscrupulous doctors will be prevented from offering unnecessary services. If the target is breached, both the conservative practitioner and the system's abusers will be punished by reduced reimbursement.

We have seen in other programs like medicare where expenditures are constrained by State budget targets that access to care and quality of care suffer. Medicaid targets are set by a State's ability to tax, not by the medical needs of its indigent citizens. Despite the promise of medicaid, many of the poor lack access to care because providers cannot afford to give service for extraordinary underfunded payments.

We have seen the same result from limits on budgeting for health care in the Veterans Administration. Cuts in appropriations have eliminated health care services for whole categories of veterans, while the services that remain have been likewise reduced. These cuts may meet budget goals, but those entitled to care are left wanting. We do not want the same result to occur in the medicare program which, since its inception in 1965, has assured the elderly (and later the disabled) access to the same quality of services that Americans with private health insurance enjoy.

Further, it is within our power to take additional measures to reduce the cost of the medicare program without unduly threatening the financial viability of hospitals and physicians. Medical malpractice reform will cut the cost of liability insurance and the pressure for physicians to practice costly defensive medicine. Also, streamlining the medicare program and cutting the red tape will free providers from excessive administrative requirements. Finally, targeting the development of practice guidelines to ferret out inappropriate services will also help eliminate expenditures as well as enhance the quality of care and the well-being of the elderly and disabled.

Expenditure targets are irresponsible social and budgetary policy. Adopting the relative value scale, funding outcomes and

patterns of practice research and continuing to address the causes of the explosion in heath care costs, will address the problems in our health care system without resorting to rationing.

BILL ARCHER.
HANK BROWN.
DON SUNDQUIST.
NANCY L. JOHNSON.

ADDITIONAL VIEWS OF HON. BILL ARCHER, HON. HANK BROWN AND HON. RICHARD T. SCHULZE ON THE SOCIAL SECURITY PROVISIONS OF THE COMMITTEE ON WAYS AND MEANS BUDGET RECONCILIATION RECOMMENDATIONS

While we support the creation of the Social Security Administration as an agency independent of Health and Human Services, we have concerns about the proposed management structure, a three member Board of Directors. In response to these concerns, the language of the provision has been strengthened to clarify the Board's responsibility for policy, and the Executive Director's responsibility for the day-to-day management of the agency.

Still, based on the early experiences of the first Social Security Board, the structure may prove troublesome. In a 1984 Congressional Research Service report, the shortcomings of that first board were noted:

Board members perceived it to be their right and their duty to intervene directly in program operations.

The board system led to indecision, delay and conflict among certain top staff and their followers within the bureau.

Although the Board was comprised of individuals who were all intensely committed to the success of the Social Security program, decision making was impaired by the Board members' struggle to reach agreement. The board found it difficult and time-consuming to make decisions, even about relatively small matters.

The National Academy of Public Administrators, which appeared before the Congressional Panel on Social Security Organization in 1983, expressed strong support for SSA leadership by a single administrator. "Single administrators," NAPA said, "are far more effective and accountable than multiperson boards or commissions, bipartisan or otherwise."

A single administrator was recommended in the Panel's 1983 report to the Committee, and more recently in GAO's testimony before the Social Security Subcommittee.

The proposed bipartisan board has a further weakness. It is entirely possible that two of the three board members will be from a party different from that of the President. While some level of political independence is highly desirable for the social security program, this potential conflict could make it difficult for the President to carry out his or her duties as Chief Executive.

For these reasons, the undersigned would prefer to see the agency led by an Executive Director with the assistance of a nine member part-time advisory board, as was recommended in the 1983 report cited above.

BILL ARCHER.
DICK SCHULZE.
HANK BROWN.

ADDITIONAL VIEWS OF REPRESENTATIVES FRENZEL, GRADISON, GOODLING, DENNY SMITH, THOMAS, ROGERS, ARMEY, BUECHNER, HOUGHTON, McCRERY, GALLO

Across-the-board cuts in domestic and defense spending are scheduled to occur in only four weeks, on October 16. Projections by the Office of Management and Budget make it clear that the only practical way to avoid this mechanical formula-approach to deficit reduction is for Congress to pass and the President to sign a budget reconciliation bill of the dimensions called for in the FY 1990 Budget Resolution.

Lamentably, the likelihood is daily growing slimmer that this deficit reduction package will reach the President's desk by that deadline. Predictably, the prospects are even more remote that the final package will make any measurable contribution toward permanent deficit reduction.

There is ample precedent for shortcomings in reconciliation bills. This bill is full of deceptive practices used in previous bills and contains some new ones as well.

The reconciliation process is supposed to be a way to trim entitlement programs whose costs cannot be controlled through the appropriations process. Therefore it is particularly discouraging that reconciliation is serving instead as a vehicle to carry entitlement changes whose costs will mushroom in years to come. These new and expanded programs have insignificant costs in FY 1990 which eventually will balloon in the out years and make it impossible to meet future Gramm-Rudman targets.

The Budget Resolution contemplated Medicaid liberalizations amounting to $200 million in FY 1990. According to the Congressional Budget Office, the Medicaid expansion contained in the reconciliation bill begins with $183 million for the last four months of FY 1990, but expands to a total cost increase of $4.15 billion over the five fiscal years 1990–1994. The Office of Management and Budget, which serves as the official scorekeeper for Gramm-Rudman purposes, estimates the five-year total as double that amount, nearly $8.9 billion.

Similarly, the entitlement for child care submitted by the Committee on Ways and Means increases the deficit by $120 million in FY 1990, rising to nearly $5.1 billion by FY 1994. As a result of this one reconciliation item, the federal deficit will increase by over $15 billion over the next five fiscal years, FY 1990–1994.

The reconciliation bill is plagued with cunningly-crafted provisions designed to produce the appearance of budget savings while avoiding actual reductions in government spending. A number of these gimmicks involving shifting spending or payments from one fiscal year to another in order to minimize the FY 1990 deficit.

What normally would have been FY 1990 agricultural deficiency payments are moved into FY 1989. Payments by the off-budget

Postal Service to the Labor Department for workers' compensation coverage are speeded up by a few days so that they fall into FY 1990 rather than FY 1991. Medicare payments to hospitals and health providers are delayed for two days starting in FY 1990 to produce claimed savings of half a billion dollars and payments are suspended for five days at the end of FY 1990 for an additional "savings" of $2 billion. Altogether, timing shifts probably make up a quarter of the touted deficit reduction in the reconciliation bill. Despite a 1987 amendment to the Budget Act and Gramm-Rudman-Hollings to prevent timing shifts from counting as deficit reduction, Committees have used a loophole to continue this practice. We strongly urge that this loophole be closed as soon as possible.

Numerous extraneous provisions having no impact on fiscal policy are sprinkled throughout the bill. Examples include an amendment to the broadcasting "fairness doctrine" and the so-called "dial-porn" provisions, and moving the Social Security Administration out of the Department of Health and Human Services.

The bill also contains reauthorizations at current or higher funding levels which customarily proceed as separate bills, including authorizations for maternal and child health, the Customs Service, and trade agencies. Several extraneous provisions, such as child care legislation and pension law changes, involve highly significant changes in public policy which should receive the most careful scrutiny rather than a free ride on the reconciliation bill.

For Republicans, the provisions creating a capital gains differential and repealing Section 89 employee benefit nondiscrimination rules stand out as bright exceptions in this otherwise dismal budget package. The Jenkins-Archer-Flippo capital gains plan, adopted with a bipartisan vote by the Committee on Ways and Means, provides a two-year 30 percent capital gains exclusion followed by indexation of asset basis for post-1991 inflation. We believe a capital gains differential will help to encourage investment, expand the economy and create jobs for all economic groups.

The FY 1990 Bipartisan Budget Agreement generated scant enthusiasm, and the Budget Resolution based on it was little better received. Small surprise, therefore, that this reconciliation bill delivered up by ten committees, more or less in compliance with Budget Resolution instructions, has minimal deficit reduction value. The FY 1990 budget sequence started out as first step toward an ambitious FY 1991 plan. Instead, the built-in spending increases contained in this package now promise to make the deficit reduction job harder in the future.

Is the reconciliation bill worth enacting? For some, it will be worthwhile if it averts a FY 1990 sequestration. But to have essential merit in its own right, the reconciliation bill ought to reduce the deficit permanently. Next year, the deficit target will be $64 billion. It will be $28 billion in FY 1992. We need a reconciliation bill that will enable us to achieve those targets without substantial tax increases.

BILL FRENZEL.
BILL GRADISON.
BILL GOODLING.
DENNY SMITH.
BILL THOMAS.
HAL ROGERS.
DICK ARMEY.
JACK BUECHNER.
AMO HOUGHTON.
JIM MCCRERY.
DEAN GALLO.

ADDITIONAL VIEWS OF CONGRESSMAN HAL ROGERS

Once more this year's budget reconciliation package has become immersed in a myriad of legislative initiatives that have nothing to do with deficit reduction. In fact, this package attracts a $4.2 billion medicaid expansion over fiscal years 1990–1994, and a $15.1 billion child care initiative over five years. Although the child care costs during the first year appear minimal, it quickly multiplies in the out years. The Budget Committee's preliminary estimates projects outlays that could rise from $652.0 million in FY 1991 to $6.4 billion in FY 1993.

While these numbers may not directly impact FY 1990, the Ways and Means proposal does include $120.0 million in new entitlement authority in FY 1990 for expansion of the Title XX Social Services Block Grant program. Should the capital gains proposal be defeated on the House floor, this social services block grant expansion must either be removed or offset by spending reductions elsewhere.

In addition to these two program expansions, the proposal also incorporates an omnibus nongermane pension plan reform package. These provisions have no place in a deficit reduction bill. Specifically, the bill includes the "Visclosky Amendment" which requires every pension plan under the Employees Retirement Income Security Program (ERISA) to elect a joint employee-employer board of trustees to manage the nation's two trillion dollar pension industry. For years, single-employer pension plans administered by a professional have provided long-term security to employees they serve. If specific concerns have been raised, then reforms should be considered independently.

In addition, the bill mandates a new user-fee on administrative filings for employees benefit plans. This is essentially a tax on voluntary employee benefits and it is terribly misguided. At a time when Congress should be examining ways to encourage employee health benefits, the committee is making compliance more costly and burdensome. Finally, the committee included provisions prohibiting or restricting pension reversions, which may actually increase the budget deficit. These exotic provisions serve no purpose in a deficit reduction package.

Adding further insult to injury is the current fiasco over the Catastrophic Health Care Act. As enacted, the program yields about four to five billion in revenues for FY 1990. Repeal will prompt additional offsets, or an exemption from Gramm-Rudman. The truly offensive aspect of this situation is that Gramm-Rudman does not afford Congress the opportunity to review and amend past policy decisions without major budget disruptions.

It is particularly distressing to know that we might have avoided the sequester axe if the House leadership had permitted the Ways and Means Committee to complete their actions prior to the August recess. With a new fiscal year upon us, and without quick

action to execute the required sayings—sequestration will be in order. This is wholly irresponsible.

The only way out of this box is to enact a "clean" and direct reconciliation bill. If Congress is unable to execute the very minimal steps required in the budget resolution, how can we initiate serious discussion for deficit reduction in FY 1991? Today's fiscal facts demand that these major program expansions and nongermane items be addressed separately, not buried in an omnibus budget reconciliation measure.

HAROLD ROGERS.

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