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107TH CONGRESS, 2d Session | HOUSE OF REPRESENTATIVES | REPT. 107–549, Part 1

MEDICARE MODERNIZATION AND PRESCRIPTION DRUG ACT OF 2002 (TITLE V: PROVISIONS RELATING TO PART B)

JUNE 26, 2002.—Ordered to be printed

Mr. TAUZIN, from the Committee on Energy and Commerce, submitted the following

R E P O R T

together with

ADDITIONAL VIEWS

[To accompany H.R. 4986]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 4986) to amend part B of title XVIII of the Social Security Act to improve payments for physicians' services and other outpatient services furnished under the medicare program, and for other purposes, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

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PURPOSE AND SUMMARY

The purpose of H.R. 4986 is to ensure that Medicare beneficiaries continue to have access to needed medical care. This legislation includes an important new benefit and cost-sharing protection for Medicare beneficiaries, along with payment adjustments and improvements for several different Medicare providers, including physicians, therapists, ambulance operators, and renal dialysis facilities. It also formalizes the competitive bidding program that has been successful in helping to protect taxpayers from overpaying for certain types of medical equipment and supplies.

BACKGROUND AND NEED FOR LEGISLATION

Beneficiary access to high quality medical care continues to be of paramount concern to the Committee. Medicare covers several preventive benefits under Part B of the program, including bone mass measurements, colorectal cancer screening, diabetes services and supplies, glaucoma screening, mammogram screening, pap test and pelvic examinations, prostate cancer screening, and vaccinations. However, Medicare does not currently cover a physical examination. H.R. 4986 adds coverage of a one-time physical to the list of Medicare-covered preventive benefits. Available to all Medicare beneficiaries when they enter the program, a one-time physical can help detect a number of problems early and avoid costly hospitalizations later. Moreover, in combination with the new outpatient drug benefit, seniors will be able to prevent a number of diseases that can be treated with prescription medicines.

Medicare beneficiaries share some of the costs for health care services they receive under the Medicare program. However, the financial burden a Medicare beneficiary bears varies depending on the service provided. Beneficiaries must pay a premium for Part B coverage while also being responsible for deductibles, coinsurance, and copayments.

Beneficiaries pay coinsurance for hospital outpatient services under Part B, which varies by service and may exceed 50 percent. Before implementation of the prospective payment system for hospital outpatient services, beneficiary coinsurance was generally based on 20 percent of the hospital's charges, while the Medicare program based its payments on the hospital's costs. Over time, hospitals' charges grew more quickly than costs; as a result, the share paid by beneficiaries grew to about 50 percent. The Balanced Budget Act of 1997 (BBA), P.L. 105–33, provided for a gradual decrease in the portion paid by beneficiaries. Under the new payment system, coinsurance is set at 20 percent of historical national median charges for all services in the group. For all ambulatory payment classification (APC) groups with coinsurance rates above 20 percent, the dollar amounts are frozen until the coinsurance represents 20 percent of total payments. The Medicare Payment Advisory Commission (MedPAC) estimated this process could take several decades for certain services. The Balanced Budget Refinement Act of 1999 (BBRA), P.L. 106–113, limited the coinsurance by placing a dollar cap on the coinsurance for a given service equal to the inpatient hospital deductible. The Benefits Improvement and Protection Act of 2000 (BIPA), P.L. 106–554, established an additional coinsurance reduction policy. H.R. 4986 accelerates the reduction in

beneficiary coinsurance payments for hospital outpatient services, so that by 2012 the coinsurance rate will be 20 percent for such services.

In addition to beneficiary access and cost-sharing issues, the Committee has also examined provider payment adjustments and improvements. In February 2002, the Subcommittee on Health held a hearing to examine the effect of the 5.4 percent payment reduction physicians are experiencing this year. At the hearing, witnesses testified about flaws in the sustainable growth rate (SGR) formula, which is used to update physician payments. H.R. 4986 addresses these flaws in the formula and the significant cuts looming in the future, providing relief to physicians in the short term and permanently reducing instability in payment changes from year-to-year.

The Committee has also examined the need for payment adjustments for ambulance providers and suppliers. Medicare covers medically necessary ambulance services, but only when no other transportation is appropriate for the beneficiary's medical condition and when the provider meets basic vehicle and staffing requirements. Prior to April 1, 2002, Medicare paid for ambulance services based on the amount providers historically charged for their services. This payment system led to wide variation in payment rates for the same service, depending on where the service was provided. In BBA, Congress required that the Centers for Medicare and Medicaid Services (CMS) replace the existing ambulance cost- and charge-based payment system with a national fee schedule developed through a negotiated rulemaking process. This process allowed interested parties affected by the ambulance fee schedule to play an integral part in developing the proposed rule. The new fee schedule will be phased in over 5 years, blending the current payment with the new fee schedule rates. H.R. 4986 recognizes that some ambulance suppliers and providers in different regions across the country have had historically higher charges/costs than average, which makes moving to a national fee schedule a major adjustment for them. This legislation provides relief, easing the current transition with a regional blend.

Following up on a request for reports included in the regulatory relief bill passed late last year, the Committee has also directed attention to therapy services. Between 1990 and 1996, Medicare spending for outpatient rehabilitation therapy services grew at nearly double the rate of Medicare spending overall. At the same time, inadequate program controls failed to ensure that this spending growth was warranted. As a result, Congress enacted BBA and required Medicare to pay providers on the basis of a fee schedule. In fact, therapy providers are now paid under the physician fee schedule. The BBA also limited coverage beginning in 1999. Specifically, the law provided for an annual $1,500 per-beneficiary cap on payments for outpatient physical therapy and speech language pathology services combined and a separate $1,500 cap on outpatient occupational therapy. Application of these caps was delayed in subsequent legislation. Currently, the caps are scheduled to go into effect beginning in 2003. Rehabilitation therapy providers have raised concerns that the limits will arbitrarily curtail necessary treatments for Medicare beneficiaries, particularly victims of stroke, hip injuries, or multiple medical incidents within a single

year. These concerns have led to several legislative proposals since the enactment of BBA to include exceptions to the caps or eliminate them altogether. To ensure continued access to therapy services, H.R. 4986 extends the current moratorium on the outpatient therapy caps for an additional 2 years and calls for an Institute of Medicine study identifying conditions or diseases that should justify conducting an assessment of the need to waive the therapy caps.

HEARINGS

The Subcommittee on Health held a hearing on Medicare Payment Policy: Ensuring Stability and Access Through Physician Payments on February 14, 2002. The Subcommittee received testimony from The Honorable Thomas Scully, Administrator, Centers for Medicare and Medicaid Services; William J. Scanlon, Director, Health Care Issues, U.S. General Accounting Office; Theodore Lewers, M.D., Trustee, American Medical Association; Allison Shuren, C.P.N.P., C.N.S., J.D., American College of Nurse Practitioners; Thomas R. Russell, M.D., F.A.C.S., Executive Director, American College of Surgeons; Martha McSteen, President, National Committee to Preserve Social Security and Medicare; Susan Turney, M.D., F.A.C.P., Board of Directors, Medical Group Management Association, Director of Reimbursement, Marshfield Clinic.

COMMITTEE CONSIDERATION

On Friday, June 21, 2002, the Full Committee met in open markup session and favorably ordered reported a Committee Print on Provisions Relating to Part B by voice vote, as amended, a quorum being present. Chairman Tauzin then introduced H.R. 4986 to reflect the Committee's action.

COMMITTEE VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee to list the record votes on the motion to report legislation and amendments thereto. The following are the record votes taken on the amendments offered by the measure, including the names of those members voting for and against. A motion by Mr. Tauzin to order H.R. 4986 reported to the House, as amended, was agreed to by a voice vote.

COMMITTEE ON ENERGY AND COMMERCE -- 107TH CONGRESS
ROLL CALL VOTE # 49

BILL: H.R. 4986, Provisions Relating to Part B.

AMENDMENT: An amendment offered by Mr. Dingell, No. 2, for an extension of application of SGR revisions.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 22 yeas to 27 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Tauzin		X		Mr. Dingell	X		
Mr. Bilirakis		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Markey			
Mr. Upton		X		Mr. Hall			
Mr. Stearns		X		Mr. Boucher	X		
Mr. Gillmor				Mr. Towns	X		
Mr. Greenwood		X		Mr. Pallone	X		
Mr. Cox		X		Mr. Brown	X		
Mr. Deal		X		Mr. Gordon			
Mr. Burr		X		Mr. Deutsch	X		
Mr. Whitfield		X		Mr. Rush	X		
Mr. Ganske	X			Ms. Eshoo			
Mr. Norwood	X			Mr. Stupak	X		
Mrs. Cubin		X		Mr. Engel	X		
Mr. Shimkus		X		Mr. Sawyer	X		
Mrs. Wilson		X		Mr. Wynn	X		
Mr. Shadegg		X		Mr. Green	X		
Mr. Pickering		X		Ms. McCarthy			
Mr. Fossella		X		Mr. Strickland	X		
Mr. Blunt		X		Ms. DeGette	X		
Mr. Davis		X		Mr. Barrett	X		
Mr. Bryant		X		Mr. Luther	X		
Mr. Ehrlich		X		Ms. Capps	X		
Mr. Buyer		X		Mr. Doyle	X		
Mr. Radanovich		X		Mr. John			
Mr. Bass		X		Ms. Harman			
Mr. Pitts		X					
Ms. Bono		X					
Mr. Walden		X					
Mr. Terry		X					
Mr. Fletcher	X						

COMMITTEE ON ENERGY AND COMMERCE -- 107TH CONGRESS
ROLL CALL VOTE # 50

BILL: H.R. 4986, Provisions Relating to Part B.

AMENDMENT: An amendment offered by Mr. Stupak, No. 6, on ambulance payment rates.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 20 yeas to 28 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Tauzin		X		Mr. Dingell	X		
Mr. Bilirakis		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Markey	X		
Mr. Upton	X			Mr. Hall			
Mr. Stearns				Mr. Boucher			
Mr. Gillmor				Mr. Towns	X		
Mr. Greenwood		X		Mr. Pallone	X		
Mr. Cox		X		Mr. Brown	X		
Mr. Deal		X		Mr. Gordon			
Mr. Burr		X		Mr. Deutsch	X		
Mr. Whitfield		X		Mr. Rush	X		
Mr. Ganske		X		Ms. Eshoo			
Mr. Norwood		X		Mr. Stupak	X		
Mrs. Cubin		X		Mr. Engel	X		
Mr. Shimkus		X		Mr. Sawyer	X		
Mrs. Wilson		X		Mr. Wynn	X		
Mr. Shadegg		X		Mr. Green	X		
Mr. Pickering		X		Ms. McCarthy			
Mr. Fossella		X		Mr. Strickland	X		
Mr. Blunt		X		Ms. DeGette	X		
Mr. Davis		X		Mr. Barrett	X		
Mr. Bryant		X		Mr. Luther	X		
Mr. Ehrlich		X		Ms. Capps	X		
Mr. Buyer		X		Mr. Doyle	X		
Mr. Radanovich		X		Mr. John			
Mr. Bass		X		Ms. Harman			
Mr. Pitts		X					
Ms. Bono		X					
Mr. Walden		X					
Mr. Terry		X					
Mr. Fletcher		X					

COMMITTEE ON ENERGY AND COMMERCE -- 107TH CONGRESS
ROLL CALL VOTE # 51

BILL: H.R. 4986, Provisions Relating to Part B.

AMENDMENT: An amendment offered by Mr. Engel, No. 8, for a Prospective Payment System for hospital outpatient department services.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 18 yeas to 29 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Tauzin		X		Mr. Dingell	X		
Mr. Bilirakis		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Markey			
Mr. Upton		X		Mr. Hall			
Mr. Stearns				Mr. Boucher			
Mr. Gillmor				Mr. Towns	X		
Mr. Greenwood		X		Mr. Pallone	X		
Mr. Cox		X		Mr. Brown	X		
Mr. Deal		X		Mr. Gordon			
Mr. Burr		X		Mr. Deutsch	X		
Mr. Whitfield		X		Mr. Rush	X		
Mr. Ganske		X		Ms. Eshoo			
Mr. Norwood		X		Mr. Stupak	X		
Mrs. Cubin		X		Mr. Engel	X		
Mr. Shimkus		X		Mr. Sawyer	X		
Mrs. Wilson		X		Mr. Wynn	X		
Mr. Shadegg		X		Mr. Green	X		
Mr. Pickering		X		Ms. McCarthy			
Mr. Fossella		X		Mr. Strickland	X		
Mr. Blunt		X		Ms. DeGette	X		
Mr. Davis		X		Mr. Barrett	X		
Mr. Bryant		X		Mr. Luther	X		
Mr. Ehrlich		X		Ms. Capps	X		
Mr. Buyer		X		Mr. Doyle	X		
Mr. Radanovich		X		Mr. John			
Mr. Bass		X		Ms. Harman			
Mr. Pitts		X					
Ms. Bono		X					
Mr. Walden		X					
Mr. Terry		X					
Mr. Fletcher		X					

COMMITTEE ON ENERGY AND COMMERCE -- 107TH CONGRESS
ROLL CALL VOTE # 52

BILL: H.R. 4986, Provisions Relating to Part B.

AMENDMENT: An amendment offered by Mr. Strickland, No. 9, for parity in treatment for outpatient mental health services.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 21 yeas to 26 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Tauzin		X		Mr. Dingell	X		
Mr. Bilirakis		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Markey	X		
Mr. Upton		X		Mr. Hall			
Mr. Stearns		X		Mr. Boucher			
Mr. Gillmor				Mr. Towns	X		
Mr. Greenwood		X		Mr. Pallone	X		
Mr. Cox		X		Mr. Brown	X		
Mr. Deal		X		Mr. Gordon			
Mr. Burr		X		Mr. Deutsch	X		
Mr. Whitfield		X		Mr. Rush	X		
Mr. Ganske				Ms. Eshoo			
Mr. Norwood		X		Mr. Stupak	X		
Mrs. Cubin		X		Mr. Engel	X		
Mr. Shimkus		X		Mr. Sawyer	X		
Mrs. Wilson	X			Mr. Wynn	X		
Mr. Shadegg		X		Mr. Green	X		
Mr. Pickering		X		Ms. McCarthy			
Mr. Fossella		X		Mr. Strickland	X		
Mr. Blunt		X		Ms. DeGette	X		
Mr. Davis		X		Mr. Barrett	X		
Mr. Bryant		X		Mr. Luther	X		
Mr. Ehrlich	X			Ms. Capps	X		
Mr. Buyer		X		Mr. Doyle	X		
Mr. Radanovich				Mr. John			
Mr. Bass		X		Ms. Harman			
Mr. Pitts		X					
Ms. Bono		X					
Mr. Walden		X					
Mr. Terry		X					
Mr. Fletcher		X					

COMMITTEE ON ENERGY AND COMMERCE -- 107TH CONGRESS
ROLL CALL VOTE # 53

BILL: H.R. 4986, Provisions Relating to Part B.

AMENDMENT: An amendment offered by Mr. Barrett, No. 11, improving the fairness of payments to providers under the Medicare fee-for-service program.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 19 yeas to 28 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Tauzin		X		Mr. Dingell	X		
Mr. Bilirakis		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Markey	X		
Mr. Upton		X		Mr. Hall			
Mr. Stearns				Mr. Boucher			
Mr. Gillmor				Mr. Towns	X		
Mr. Greenwood		X		Mr. Pallone	X		
Mr. Cox		X		Mr. Brown	X		
Mr. Deal		X		Mr. Gordon			
Mr. Burr		X		Mr. Deutsch	X		
Mr. Whitfield		X		Mr. Rush	X		
Mr. Ganske		X		Ms. Eshoo			
Mr. Norwood		X		Mr. Stupak	X		
Mrs. Cubin		X		Mr. Engel	X		
Mr. Shimkus		X		Mr. Sawyer	X		
Mrs. Wilson		X		Mr. Wynn	X		
Mr. Shadegg		X		Mr. Green	X		
Mr. Pickering		X		Ms. McCarthy			
Mr. Fossella		X		Mr. Strickland	X		
Mr. Blunt		X		Ms. DeGette	X		
Mr. Davis		X		Mr. Barrett	X		
Mr. Bryant		X		Mr. Luther	X		
Mr. Ehrlich		X		Ms. Capps	X		
Mr. Buyer		X		Mr. Doyle	X		
Mr. Radanovich				Mr. John			
Mr. Bass		X		Ms. Harman			
Mr. Pitts		X					
Ms. Bono		X					
Mr. Walden		X					
Mr. Terry		X					
Mr. Fletcher		X					

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee held an oversight hearing and made findings that are reflected in this report.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

The objective of H.R. 4986 is to ensure that Medicare beneficiaries continue to have access to needed medical care and to improve payment policies for several Medicare providers.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee finds that H.R. 4986, to amend part B of title XVIII of the Social Security Act to improve payments for physicians' services and other outpatient services furnished under the Medicare Program, and for other purposes, would result in no new or increased budget authority, entitlement authority, or tax expenditures or revenues.

COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974, which is included in the report to accompany H.R. 4984.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the cost estimate provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974 is included in the report to accompany H.R. 4984.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act. The estimate is included in the report to accompany H.R. 4984.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this legislation.

CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to clause 3(d)(1) of rule XIII of the Rules of the House of Representatives, the Committee finds that the Constitutional authority for this legislation is provided in Article I, section 8, clause 3, which grants Congress the power to regulate commerce with foreign nations, among the several States, and with the Indian tribes.

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

TITLE V—PROVISIONS RELATING TO PART B

Subtitle A—Provisions Relating to Physicians' Services

Section 501. Revision of Updates for Physicians' Services

Section 501 modifies the calculation of the updates for 2003 through 2005. The 2003 update to the conversion factor is set at 2 percent. The calculation of the 2004 and 2005 update will be modified in the following manner—the base year for the calculation (April 1, 1996) is reset to 2002 (January 1, 2002), the allowed expenditures for 2002 are deemed to be equal to actual expenditures for services furnished during 2002, and the current GDP component is increased to GDP+1. Section 501 permanently changes the current GDP component of the sustainable growth rate formula to a 10-year rolling average of GDP. The 10-year rolling average of GDP is to be calculated first, to which one percentage point will be added according to the special payment rules established in this section. Section 501 also eliminates budget neutrality adjustments for 2003 through 2005. It also directs the Comptroller General to examine the adequacy of current reimbursements for inhalation therapy under the Medicare program. The Comptroller General must submit a report on this study to Congress by May 1, 2003.

In BBRA, Congress stated that the data to be used in calculating the sustainable growth rates for a given year and the preceding two years must be the best data available to the Secretary as of September 1 of the year preceding the year for which the calculation is made. Nothing in this section supersedes this requirement. This requirement continues to apply for the payment periods that are governed by the special rules established in this section.

This section is effective upon enactment.

Section 502. Studies on Access to Physicians' Services

Section 502 directs the Comptroller General to study Medicare beneficiary access to physician services. The study will (1) assess beneficiaries' use of physician services, (2) examine changes in beneficiaries' use of services over time, and (3) examine the extent to which physicians are not accepting new Medicare beneficiaries as patients. Within 1 year of enactment, the Comptroller General will submit to Congress a report regarding this study focusing on whether Medicare claims data indicate potential access problems in certain geographic areas and whether access to physician services may have improved, remained constant, or deteriorated over time. Section 502 also directs the Secretary to request that the Institute of Medicine of the National Academy of Sciences conduct a study on the adequacy of the supply of physicians (including specialists) in the United States and the factors that affect such supply. Within 2 years of enactment, the Secretary must submit to Congress a re-

port on the results of this study, including any recommendations for legislation.

This section is effective upon enactment.

Section 503. MedPAC Report on Payment for Physicians' Services

Section 503 directs the Medicare Payment Advisory Commission (MedPAC) to submit a report to Congress within 1 year of enactment on the effect of refinements to the practice expense component of payments for physicians' services in the case of services for which there are no physician work relative value units. The study should examine this issue as it relates to each physician specialty, specifically: (1) the effect of such refinements on payment for physicians' services; (2) the interaction of the practice expense component with other components of and adjustments to payment for physicians' services; (3) the appropriateness of the amount of compensation by reason of such refinements; (4) the effect of such refinements on access to care; and, (5) the effect of such refinements on physician participation under the Medicare program.

Nothing in this section should be construed as precluding the implementation (by statute or otherwise) of reform of the reimbursements for prescription drugs currently covered under Part B.

This section is effective upon enactment.

Section 504. Physician Fee Schedule Wage Index Revision

Section 504 raises the lower limit or floor of the geographic adjustment for wages in 2004 and allows 34 localities across the country to receive a higher reimbursement rate without harming any other localities. It also directs the Comptroller General to carefully evaluate the methodology used for these types of adjustments, including the economic basis for such calculations. The Comptroller General will also look at the effect of geographic adjustments on where physicians practice and will evaluate recruitment costs and retention rates to better understand what it takes to keep physicians in underserved areas. The report will include recommendations on how to permanently fix this problem for all affected physicians.

This section applies to payment under the physician fee schedule for physicians' services furnished during 2004.

Subtitle B—Other Services

Section 511. Competitive Acquisition of Certain Items and Services

Section 511 directs the Secretary to establish competitive acquisition areas throughout the United States for certain Part B items and services beginning in 2004. This policy, phased in evenly over a 3-year period, specifies that certain durable medical equipment and off-the-shelf orthotics will be subject to competitive bidding practices. The Secretary will have the discretion to choose the appropriate codes for competitive bidding. Exemptions may be made for areas that are not competitive due to low-population density (rural areas) or for items and services for which competitive bidding will not likely result in significant savings. This policy limits beneficiaries' copayments to 20 percent of the contract price and ensures that multiple suppliers in each geographic area will be maintained. Additionally, quality and customer service standards

will be created for the items and services subject to competition. Section 511 also directs the Secretary to conduct a demonstration project of competitive bidding for clinical diagnostic laboratories and submit to Congress an initial report on the project by December 31, 2004. The Comptroller General is directed to undertake a study examining differences in laboratory payment rates between public and private payors and submit a report on such study within 18 months of enactment.

This section is effective upon enactment.

Section 512. Payment for Ambulance Services

By January 1, 2003, the Secretary is required to develop nine regional fee schedules corresponding to the nine Census Divisions. These fee schedules are to be based on the same methodology and data used to construct the national fee schedule. The regional conversion factor in each regional fee schedule will be adjusted in the same way the national conversion factor is adjusted—the relative value units will be used with each regional conversion factor to create a regional base payment rate for each level of service. In addition, the same payment adjustments will apply in the regional fee schedules, including the rural mileage adjustments. Payments under the appropriate regional fee schedule will be blended with the payment amount under the national fee schedule within the existing fee schedule transition. This blend replaces the national fee schedule amount in the current transition. In 2003, the blended rate will be based on 20 percent of the payment under the national fee schedule and 80 percent of the payment under the appropriate regional fee schedule. In 2004, the blended rate will be based on 40 percent of the national fee schedule amount and 60 percent of the regional fee schedule amount. In 2005, the blended rate will be based on 60 percent of the national fee schedule amount and 40 percent of the regional fee schedule amount. In 2006, the blended rate will be based on 80 percent of the national fee schedule and 20 percent of the regional fee schedule amount. Beginning in 2007, payment for ambulance services will be based entirely on the national fee schedule. In those cases where a provider would be paid a higher amount under the national fee schedule without the regional blend, the payment will be entirely based on the national fee schedule amount consistent with the current transition schedule. Section 512 also increases mileage payments for ground ambulance trips above 50 miles. Such payments will be increased by at least one-quarter of the payment per mile otherwise established under the fee schedule for trips on or after January 1, 2003 through December 31, 2007.

The Committee recognizes the concerns of low-volume, rural ambulance providers and suppliers about the effect the new ambulance fee schedule is having on low-volume, rural areas. The Committee notes that the Final Rule, issued on February 27, 2002, clearly states that the Negotiated Rulemaking Committee on the Medicare Ambulance Fee Schedule was unable to reach agreement on this issue. BIPA required the Comptroller General to submit a study to Congress on the cost of efficiently providing ambulance services for trips originating in rural areas. The Comptroller General was also directed to examine ways to identify rural areas with low population density for the purpose of designating areas in

which the cost of providing ambulance services would be expected to be higher. BIPA also required the Comptroller General to submit recommendations on steps that should be taken to assure access to ambulance services in rural areas. The Committee is awaiting the receipt of this information from the Comptroller General and will examine this information closely to determine if an additional adjustment should be made to ensure access to ambulance services in low-volume, rural areas.

This section applies to ambulance services furnished on or after January 1, 2003.

Section 513. 2-Year Extension of Moratorium on Therapy Caps; Provisions Relating to Reports

Section 513 continues the current moratorium on the payment limits established per beneficiary for all outpatient therapy services provided by non-hospital providers through the end of calendar year 2004. It also urges the Secretary to submit required therapy reports to Congress by December 31, 2002. Section 513 also directs the Secretary to request that the Institute of Medicine of the National Academy of Sciences identify conditions or diseases that should justify conducting an assessment of the need to waive the therapy caps. When identifying conditions that would justify such an assessment, the Institute of Medicine should include consideration of comorbidities and how they may affect the need for therapy. In addition, the study should address conditions in which there are multiple incidents of need occurring for the same beneficiary during one calendar year. The Secretary must submit to Congress a preliminary report on the conditions and diseases identified by October 1, 2003 and a final report by December 31, 2003.

Section 513 also directs the Comptroller General to study access to physical therapist services in States that authorize such services without a physician referral and in States that require such a referral, examining the use of and referral patterns for patients age 50 and older, including patients who are Medicare beneficiaries. This review should also examine the delivery of physical therapists' services within facilities of the Department of Defense. In addition, the Comptroller General is directed to analyze the potential impact on Medicare beneficiaries and on Medicare expenditures of eliminating the need for a physician referral. The report will be submitted to Congress within 1 year of enactment.

This section is effective upon enactment.

Section 514. Accelerated Implementation of 20 Percent Coinsurance for Hospital Outpatient Department (OPD) Services; Other OPD Provisions

Section 514 accelerates the reduction in beneficiary coinsurance payments for hospital outpatient services, so that by 2012 the coinsurance rate will be 20 percent. This section also removes devices used for temperature-monitored cryoablation from the list of drugs and devices that are eligible for receiving an additional transitional pass-through payment.

This section is effective upon enactment, except the provision dealing with temperature monitored cryoablation applies to payments for services furnished on or after January 1, 2003.

When the hospital outpatient department prospective payment system was established, there was significant concern that it would delay the availability of new drugs and biologicals in the outpatient hospital setting. As a result, this Committee and others worked to develop a transitional pass-through system to ensure beneficiary access to new technologies as early as possible after product introduction. The Committee observes that the implementation of the transitional pass-through system for new drugs and technologies has been problematic. Members of the Committee have communicated concerns about the imposition of a pro rata reduction for pass-through products in FY 2002, and we have concerns about the treatment of former pass-through products in FY 2003.

In fashioning this legislation, the Committee addressed the issue of whether the reimbursement for pharmaceuticals in the outpatient prospective payment system fully met the standards established in 1833(t) and considered whether the statute should be amended to clarify the intent of Congress and to ensure adequate access to new drugs and biologicals for Medicare beneficiaries.

Upon examination, the Committee determined that further statutory clarification should not be necessary because the statute reflects the clear intent of Congress that the payment weights in any classification system adopted by the Secretary reflect not only acquisition costs of pharmacy products, but also fully and explicitly account for both the direct and indirect costs of handling, storing and dispensing pharmacy therapy. The Committee is concerned that the wide degree of cost variation among drugs and biologicals could make it impossible to design a packaging system that complies with statutory requirements, possibly hindering patient access to important therapies. The Committee urges the Secretary to implement systems in 2003 that will ensure appropriate beneficiary access to needed therapies and new technologies.

Section 515. Coverage of an Initial Preventive Physical Examination

On or after January 1, 2004, Medicare will cover an initial preventive physical examination for individuals whose coverage period begins on or after such date (and within 6 months of the date the individual's coverage period first begins). An initial preventive physical examination is defined as physician services consisting of a physical examination that promotes health and disease detection, as well as items and services that the Secretary may specify in regulation.

This section applies to services furnished on or after January 1, 2004.

Section 516. Renal Dialysis Services

Section 516 directs the Comptroller General to study and report back to Congress within 1 year of enactment on the differences in costs between home and in-facility dialysis (including overhead costs) and evaluate whether the charges for home dialysis supplies and equipment are reasonable and necessary. This section also exempts pediatric dialysis facilities (at least 50 percent of the facilities' patients are individuals under 18 years of age) from the rule limiting reimbursement to the composite rate. Section 516 also increases the composite rate for in-facility dialysis furnished in 2004 by 1.2 percent.

This section is effective upon enactment.

Section 517. Improved Payment for Certain Mammography Services

Section 517 excludes both screening and diagnostic mammography from the hospital outpatient prospective payment system and directs the Secretary to determine a new reimbursement rate for diagnostic mammography based on the most current cost data available.

This section applies to mammography performed on or after January 1, 2004.

Cardiac rehabilitation includes medical evaluation, prescribed exercise, cardiac risk factor modification, education, counseling, and behavioral interventions. There is no specific Medicare benefit category for cardiac rehabilitation programs; rather, they are covered as services furnished incident to a physician's professional service and have been covered by Medicare as an "incident to" service since the 1980s. To be covered by Medicare, "incident to" services must be "reasonable and necessary" and provided under a physician's direct supervision.

Section 35–25 of the Medicare Coverage Issues Manual defines direct supervision for cardiac rehabilitation as requiring a physician to be

> in the exercise program area and immediately available and accessible for an emergency at all times the exercise program is conducted. It does not require that a physician be physically present in the exercise room itself.

The Committee believes that direct physician supervision, which has been required for Medicare coverage of cardiac rehabilitation since the 1980s, is the correct level of supervision for cardiac rehabilitation services that are currently covered by Medicare, i.e., those services furnished to patients who (1) have a documented diagnosis of acute myocardial infarction within the preceding 12 months; (2) have had coronary bypass surgery; or, (3) have stable angina pectoris.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) 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 brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * * * *

PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

* * * * * * *

PAYMENT OF BENEFITS

SEC. 1833. (a) * * *

* * * * * * *

(g)(1) * * *

* * * * * * *

(4) This subsection shall not apply to expenses incurred with respect to services furnished during 2000, 2001, [and 2002] *2002, 2003, and 2004.*

* * * * * * *

(t) PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.—

(1) * * *

* * * * * * *

(6) TRANSITIONAL PASS-THROUGH FOR ADDITIONAL COSTS OF INNOVATIVE MEDICAL DEVICES, DRUGS, AND BIOLOGICALS.—

(A) IN GENERAL.—The Secretary shall provide for an additional payment under this paragraph for any of the following that are provided as part of a covered OPD service (or group of services):

(i) * * *

(ii) CURRENT CANCER THERAPY DRUGS AND BIOLOGICALS AND BRACHYTHERAPY.—A drug or biological that is used in cancer therapy, including (but not limited to) a chemotherapeutic agent, an antiemetic, a hematopoietic growth factor, a colony stimulating factor, a biological response modifier, a bisphosphonate, and a device of brachytherapy [or temperature monitored cryoablation], if payment for such drug, biological, or device as an outpatient hospital service under this part was being made on such first date.

* * * * * * *

(8) COPAYMENT AMOUNT.—

(A) * * *

* * * * * * *

(C) LIMITATION ON COPAYMENT AMOUNT.—

(i) * * *

(ii) TO SPECIFIED PERCENTAGE.—The Secretary shall reduce the national unadjusted copayment amount for a covered OPD service (or group of such services) furnished in a year in a manner so that the effective copayment rate (determined on a national unadjusted basis) for that service in the year does not exceed the following percentage:

(I) * * *

* * * * * * *

[(III) For procedures performed in 2004, 50 percent.

[(IV) For procedures performed in 2005, 45 percent.

[(V) For procedures performed in 2006 and thereafter, 40 percent.]

(III) For procedures performed in 2004, 45 percent.

(IV) For procedures performed in 2005, 40 percent.

(V) For procedures performed in 2006, 2007, 2008 and 2009, 35 percent.

(VI) For procedures performed in 2010, 30 percent.

(VII) For procedures performed in 2011, 25 percent.

(VIII) For procedures performed in 2012 and thereafter, 20 percent.

* * * * * * *

SPECIAL PAYMENT RULES FOR PARTICULAR ITEMS AND SERVICES

SEC. 1834. (a) * * *

* * * * * * *

(l) ESTABLISHMENT OF FEE SCHEDULE FOR AMBULANCE SERVICES.—

(1) * * *

(2) CONSIDERATIONS.—In establishing such fee schedule, the Secretary shall—

(A) * * *

* * * * * * *

(E) phase in the application of the payment rates under the fee schedule in an efficient and fair manner *consistent with paragraph (10)*, except that such phase-in shall provide for full payment of any national mileage rate for ambulance services provided by suppliers that are paid by carriers in any of the 50 States where payment by a carrier for such services for all such suppliers in such State did not, prior to the implementation of the fee schedule, include a separate amount for all mileage within the county from which the beneficiary is transported.

* * * * * * *

[(8)**]** *(9)* TRANSITIONAL ASSISTANCE FOR RURAL PROVIDERS.—In the case of ground ambulance services furnished on or after July 1, 2001, and before January 1, 2004, for which the transportation originates in a rural area (as defined in section 1886(d)(2)(D)) or in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)), the fee schedule established under this subsection shall provide that, with respect to the payment rate for mileage for a trip above 17 miles, and up to 50 miles, the rate otherwise established shall be increased by not less than ½ of the additional payment per mile established for the first 17 miles of such a trip originating in a rural area.

(10) PHASE-IN PROVIDING FLOOR USING BLEND OF FEE SCHEDULE AND REGIONAL FEE SCHEDULES.—In carrying out the phase-in under paragraph (2)(E) for each level of service furnished in a year before January 1, 2007, the portion of the payment

amount that is based on the fee schedule shall not be less than the following blended rate of the fee schedule under paragraph (1) and of a regional fee schedule for the region involved:

(A) For 2003, the blended rate shall be based 20 percent on the fee schedule under paragraph (1) and 80 percent on the regional fee schedule.

(B) For 2004, the blended rate shall be based 40 percent on the fee schedule under paragraph (1) and 60 percent on the regional fee schedule.

(C) For 2005, the blended rate shall be based 60 percent on the fee schedule under paragraph (1) and 40 percent on the regional fee schedule.

(D) For 2006, the blended rate shall be based 80 percent on the fee schedule under paragraph (1) and 20 percent on the regional fee schedule.

For purposes of this paragraph, the Secretary shall establish a regional fee schedule for each of the 9 Census divisions using the methodology (used in establishing the fee schedule under paragraph (1)) to calculate a regional conversion factor and a regional mileage payment rate and using the same payment adjustments and the same relative value units as used in the fee schedule under such paragraph.

(11) ADJUSTMENT IN PAYMENT FOR CERTAIN LONG TRIPS.—In the case of ground ambulance services furnished on or after January 1, 2003, and before January 1, 2008, regardless of where the transportation originates, the fee schedule established under this subsection shall provide that, with respect to the payment rate for mileage for a trip above 50 miles the per mile rate otherwise established shall be increased by 1/4 of the payment per mile otherwise applicable to such miles.

* * * * * * *

[SEC. 1847. DEMONSTRATION PROJECTS FOR COMPETITIVE ACQUISITION OF ITEMS AND SERVICES.

[(a) ESTABLISHMENT OF DEMONSTRATION PROJECT BIDDING AREAS.—

[(1) IN GENERAL.—The Secretary shall implement not more than 5 demonstration projects under which competitive acquisition areas are established for contract award purposes for the furnishing under this part of the items and services described in subsection (d).

[(2) PROJECT REQUIREMENTS.—Each demonstration project under paragraph (1)—

[(A) shall include such group of items and services as the Secretary may prescribe,

[(B) shall be conducted in not more than 3 competitive acquisition areas, and

[(C) shall be operated over a 3-year period.

[(3) CRITERIA FOR ESTABLISHMENT OF COMPETITIVE ACQUISITION AREAS.—Each competitive acquisition area established under a demonstration project implemented under paragraph (1)—

[(A) shall be, or shall be within, a metropolitan statistical area (as defined by the Secretary of Commerce), and

[(B) shall be chosen based on the availability and accessibility of entities able to furnish items and services, and the probable savings to be realized by the use of competitive bidding in the furnishing of items and services in such area.

[(b) AWARDING OF CONTRACTS IN AREAS.—

[(1) IN GENERAL.—The Secretary shall conduct a competition among individuals and entities supplying items and services described in subsection (c) for each competitive acquisition area established under a demonstration project implemented under subsection (a).

[(2) CONDITIONS FOR AWARDING CONTRACT.—The Secretary may not award a contract to any entity under the competition conducted pursuant to paragraph (1) to furnish an item or service unless the Secretary finds that the entity meets quality standards specified by the Secretary and that the total amounts to be paid under the contract are expected to be less than the total amounts that would otherwise be paid.

[(3) CONTENTS OF CONTRACT.—A contract entered into with an entity under the competition conducted pursuant to paragraph (1) is subject to terms and conditions that the Secretary may specify.

[(4) LIMIT ON NUMBER OF CONTRACTORS.—The Secretary may limit the number of contractors in a competitive acquisition area to the number needed to meet projected demand for items and services covered under the contracts.

[(c) EXPANSION OF PROJECTS.—

[(1) EVALUATIONS.—The Secretary shall evaluate the impact of the implementation of the demonstration projects on medicare program payments, access, diversity of product selection, and quality. The Secretary shall make annual reports to the Committees on Ways and Means and Commerce of the House of Representatives and the Committee on Finance of the Senate on the results of the evaluation described in the preceding sentence and a final report not later than 6 months after the termination date specified in subsection (e).

[(2) EXPANSION.—If the Secretary determines from the evaluations under paragraph (1) that there is clear evidence that any demonstration project—

[(A) results in a decrease in Federal expenditures under this title, and

[(B) does not reduce program access, diversity of product selection, and quality under this title,

the Secretary may expand the project to additional competitive acquisition areas.

[(d) SERVICES DESCRIBED.—The items and services to which this section applies are all items and services covered under this part (except for physicians' services as defined in section 1861(s)(1)) that the Secretary may specify. At least one demonstration project shall include oxygen and oxygen equipment.

[(e) TERMINATION.—Notwithstanding any other provision of this section, all projects under this section shall terminate not later than December 31, 2002.]

COMPETITIVE ACQUISITION OF CERTAIN ITEMS AND SERVICES

SEC. 1847. (a) ESTABLISHMENT OF COMPETITIVE ACQUISITION PROGRAMS.—

(1) IMPLEMENTATION OF PROGRAMS.—

(A) IN GENERAL.—The Secretary shall establish and implement programs under which competitive acquisition areas are established throughout the United States for contract award purposes for the furnishing under this part of competitively priced items and services (described in paragraph (2)) for which payment is made under this part. Such areas may differ for different items and services.

(B) PHASED-IN IMPLEMENTATION.—The programs shall be phased-in among competitive acquisition areas over a period of not longer than 3 years in a manner so that the competition under the programs occurs in—

(i) at least 1/3 of such areas in 2004; and

(ii) at least 2/3 of such areas in 2005.

(C) WAIVER OF CERTAIN PROVISIONS.—In carrying out the programs, the Secretary may waive such provisions of the Federal Acquisition Regulation as are necessary for the efficient implementation of this section, other than provisions relating to confidentiality of information and such other provisions as the Secretary determines appropriate.

(2) ITEMS AND SERVICES DESCRIBED.—The items and services referred to in paragraph (1) are the following:

(A) DURABLE MEDICAL EQUIPMENT AND INHALATION DRUGS USED IN CONNECTION WITH DURABLE MEDICAL EQUIPMENT.—Covered items (as defined in section 1834(a)(13)) for which payment is otherwise made under section 1834(a), other than items used in infusion, and inhalation drugs used in conjunction with durable medical equipment.

(B) OFF-THE-SHELF ORTHOTICS.—Orthotics (described in section 1861(s)(9)) for which payment is otherwise made under section 1834(h) which require minimal self-adjustment for appropriate use and does not require expertise in trimming, bending, molding, assembling, or customizing to fit to the patient.

(3) EXEMPTION AUTHORITY.—In carrying out the programs under this section, the Secretary may exempt—

(A) areas that are not competitive due to low population density; and

(B) items and services for which the application of competitive acquisition is not likely to result in significant savings.

(b) PROGRAM REQUIREMENTS.—

(1) IN GENERAL.—The Secretary shall conduct a competition among entities supplying items and services described in subsection (a)(2) for each competitive acquisition area in which the program is implemented under subsection (a) with respect to such items and services.

(2) CONDITIONS FOR AWARDING CONTRACT.—

(A) IN GENERAL.—The Secretary may not award a contract to any entity under the competition conducted in an

competitive acquisition area pursuant to paragraph (1) to furnish such items or services unless the Secretary finds all of the following:

(i) The entity meets quality and financial standards specified by the Secretary or developed by accreditation entities or organizations recognized by the Secretary.

(ii) The total amounts to be paid under the contract (including costs associated with the administration of the contract) are expected to be less than the total amounts that would otherwise be paid.

(iii) Beneficiary access to a choice of multiple suppliers in the area is maintained.

(iv) Beneficiary liability is limited to the applicable percentage of contract award price.

(B) QUALITY STANDARDS.—The quality standards specified under subparagraph (A)(i) shall not be less than the quality standards that would otherwise apply if this section did not apply and shall include consumer services standards. The Secretary shall consult with an expert outside advisory panel composed of an appropriate selection of representatives of physicians, practitioners, and suppliers to review (and advise the Secretary concerning) such quality standards.

(3) CONTENTS OF CONTRACT.—

(A) IN GENERAL.—A contract entered into with an entity under the competition conducted pursuant to paragraph (1) is subject to terms and conditions that the Secretary may specify.

(B) TERM OF CONTRACTS.—The Secretary shall rebid contracts under this section not less often than once every 3 years.

(4) LIMIT ON NUMBER OF CONTRACTORS.—

(A) IN GENERAL.—The Secretary may limit the number of contractors in a competitive acquisition area to the number needed to meet projected demand for items and services covered under the contracts. In awarding contracts, the Secretary shall take into account the ability bidding entities to furnish items or services in sufficient quantities to meet the anticipated needs of beneficiaries for such items or services in the geographic area covered under the contract on a timely basis.

(B) MULTIPLE WINNERS.—The Secretary shall award contracts to more than one entity submitting a bid in each area for an item or service.

(5) PARTICIPATING CONTRACTORS.—Payment shall not be made for items and services described in subsection (a)(2) furnished by a contractor and for which competition is conducted under this section unless—

(A) the contractor has submitted a bid for such items and services under this section; and

(B) the Secretary has awarded a contract to the contractor for such items and services under this section.

(6) AUTHORITY TO CONTRACT FOR EDUCATION, OUTREACH AND COMPLAINT SERVICES.—The Secretary may enter into a contract with an appropriate entity to address complaints from bene-

ficiaries who receive items and services from an entity with a contract under this section and to conduct appropriate education of and outreach to such beneficiaries with respect to the program.

(c) ANNUAL REPORTS.—The Secretary shall submit to Congress an annual management report on the programs under this section. Each such report shall include information on savings, reductions in cost-sharing, access to items and services, and beneficiary satisfaction.

(d) DEMONSTRATION PROJECT FOR CLINICAL LABORATORY SERVICES.—

(1) IN GENERAL.—The Secretary shall conduct a demonstration project on the application of competitive acquisition under this section to clinical diagnostic laboratory tests—

(A) for which payment is otherwise made under section 1833(h) or 1834(d)(1) (relating to colorectal cancer screening tests); and

(B) which are furnished without a face-to-face encounter between the individual and the hospital or physician ordering the tests.

(2) TERMS AND CONDITIONS.—Such project shall be under the same conditions as are applicable to items and services described in subsection (a)(2).

(3) REPORT.—The Secretary shall submit to Congress—

(A) an initial report on the project not later than December 31, 2004; and

(B) such progress and final reports on the project after such date as the Secretary determines appropriate.

* * * * * * *

PAYMENT FOR PHYSICIANS' SERVICES

SEC. 1848. (a) * * *

* * * * * * *

(d) CONVERSION FACTORS.—

(1) * * *

* * * * * * *

(4) UPDATE FOR YEARS BEGINNING WITH 2001.—

(A) * * *

(B) UPDATE ADJUSTMENT FACTOR.—For purposes of subparagraph (A)(ii), subject to subparagraph (D) *and paragraph (6)*, the "update adjustment factor" for a year is equal (as estimated by the Secretary) to the sum of the following:

(i) * * *

* * * * * * *

(F) TRANSITIONAL ADJUSTMENT DESIGNED TO PROVIDE FOR BUDGET NEUTRALITY.—Under this subparagraph the Secretary shall provide for an adjustment to the update under [subparagraph (A)—

[(i) for each of 2001, 2002, 2003, and 2004, of −0.2 percent; and

[(ii) for 2005 of +0.8 percent.] *subparagraph (A), for each of 2001 and 2002, of −0.2 percent.*

(5) UPDATE FOR 2003.—The update to the single conversion factor established in paragraph (1)(C) for 2003 is 2 percent.

(6) SPECIAL RULES FOR UPDATE FOR 2004 AND 2005.—The following rules apply in determining the update adjustment factors under paragraph (4)(B) for 2004 and 2005:

(A) USE OF 2002 DATA IN DETERMINING ALLOWABLE COSTS.—

(i) The reference in clause (ii)(I) of such paragraph to April 1, 1996, is deemed to be a reference to January 1, 2002.

(ii) The allowed expenditures for 2002 is deemed to be equal to the actual expenditures for physicians' services furnished during 2002, as estimated by the Secretary.

(B) 1 PERCENTAGE POINT INCREASE IN GDP UNDER SGR.—The annual average percentage growth in real gross domestic product per capita under subsection (f)(2)(C) for each of 2003, 2004, and 2005 is deemed to be increased by 1 percentage point.

* * * * * * *

(f) SUSTAINABLE GROWTH RATE.—

(1) * * *

(2) SPECIFICATION OF GROWTH RATE.—The sustainable growth rate for all physicians' services for a fiscal year (beginning with fiscal year 1998 and ending with fiscal year 2000) and a year beginning with 2000 shall be equal to the product of—

(A) * * *

* * * * * * *

(C) 1 plus the Secretary's estimate of the [projected] *annual average* percentage growth in real gross domestic product per capita (divided by 100) [from the previous applicable period to the applicable period involved] *during the 10-year period ending with the applicable period involved*, and

* * * * * * *

(j) DEFINITIONS.—In this section:

(1) * * *

* * * * * * *

(3) PHYSICIANS' SERVICES.—The term "physicians' services" includes items and services described in paragraphs (1), (2)(A), (2)(D), (2)(G), (2)(P) (with respect to services described in subparagraphs (A) and (C) of section 1861(oo)(2)), (2)(R) (with respect to services described in suparagraphs (B), (C), and (D) of section 1861(pp)(1)), (2)(S), *(2)(W),* (3), (4), (13), (14) (with respect to services described in section 1861(nn)(2)), and (15) of section 1861(s) (other than clinical diagnostic laboratory tests and, except for purposes of subsection (a)(3), (g), and (h) such other items and services as the Secretary may specify).

* * * * * * *

PART D—MISCELLANEOUS PROVISIONS

DEFINITIONS OF SERVICES, INSTITUTIONS, ETC.

SEC. 1861. For purposes of this title—

Spell of Illness

(a) * * *

* * * * * * *

Medical and Other Health Services

(s) The term "medical and other health services" means any of the following items or services:

(1) * * *

(2)(A) * * *

* * * * * * *

(U) screening for glaucoma (as defined in subsection (uu)) for individuals determined to be at high risk for glaucoma, individuals with a family history of glaucoma and individuals with diabetes; **[**and**]**

(V) medical nutrition therapy services (as defined in subsection (vv)(1)) in the case of a beneficiary with diabetes or a renal disease who—

(i) * * *

* * * * * * *

(iii) meets such other criteria determined by the Secretary after consideration of protocols established by dietitian or nutrition professional organizations; *and*

(W) an initial preventive physical examination (as defined in subsection (ww));

* * * * * * *

Initial Preventive Physical Examination

(ww) The term "initial preventive physical examination" means physicians' services consisting of a physical examination with the goal of health promotion and disease detection and includes items and services specified by the Secretary in regulations.

EXCLUSIONS FROM COVERAGE AND MEDICARE AS SECONDARY PAYER

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) * * *

* * * * * * *

(H) in the case of colorectal cancer screening tests, which are performed more frequently than is covered under section 1834(d), **[**and**]**

(I) the frequency and duration of home health services which are in excess of normative guidelines that the Secretary shall establish by regulation**[**;**]***, and*

(J) in the case of an initial preventive physical examination, which is performed not later than 6 months after the date the individual's first coverage period begins under part B;

* * * * * * *

(7) where such expenses are for routine physical checkups, eyeglasses (other than eyewear described in section 1861(s)(8)) or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, procedures performed (during the course of any eye examination) to determine the refractive state of the eyes, hearing aids or examinations therefor, or immunizations (except as otherwise allowed under section 1861(s)(10) and subparagraph (B), (F), (G), ❚or (H)❚ *(H), or (J)* of paragraph (1));

* * * * * * *

MEDICARE COVERAGE FOR END STAGE RENAL DISEASE PATIENTS

SEC. 1881. (a) * * *
(b)(1) * * *

* * * * * * *

(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. 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. ❚The Secretary❚ *Subject to section 422(a)(2) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, 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 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) * * *

* * * * * * *

MEDICARE, MEDICAID, AND SCHIP BENEFITS IMPROVEMENT AND PROTECTION ACT OF 2000 (BIPA)

* * * * * * *

TITLE IV—PROVISIONS RELATING TO PART B

* * * * * * *

Subtitle C—Other Services

* * * * * * *

SEC. 422. UPDATE IN RENAL DIALYSIS COMPOSITE RATE.

(a) UPDATE.—

(1) * * *

(2) PROHIBITION ON EXCEPTIONS.—

(A) IN GENERAL.—Subject to subparagraphs (B) **[**and (C)**]**, *(C), and (D)*, the Secretary of Health and Human Services may not provide for an exception under section 1881(b)(7) of the Social Security Act (42 U.S.C. 1395rr(b)(7)) on or after December 31, 2000.

(B) DEADLINE FOR NEW APPLICATIONS.—**[**In the case**]** *Subject to subparagraph (D), in the case* of a facility that during 2000 did not file for an exception rate under such section, the facility may submit an application for an exception rate by not later than July 1, 2001.

* * * * * * *

(D) INAPPLICABILITY TO PEDIATRIC FACILITIES.—Subparagraphs (A) and (B) shall not apply, as of October 1, 2002, to pediatric facilities that do not have an exception rate described in subparagraph (C) in effect on such date. For purposes of this subparagraph, the term "pediatric facility" means a renal facility at least 50 percent of whose patients are individuals under 18 years of age.

* * * * * * *

ADDITIONAL VIEWS

We are generally supportive of the provisions included in H.R. 4986. We believe, however, that more should be done to address the cuts in physician reimbursement under Medicare.

Flaws in Medicare's physician payment formula have led to payment cuts this year, and expected reductions in the next few years as well. These payment reductions have deeply affected physicians. Some are questioning whether to remain in the program; others are reducing the number of Medicare patients they see or not accepting new patients. This is troubling because physicians are the bedrock of the Medicare program. Currently, nearly all physicians across the country participate in the Medicare program. They are the providers that beneficiaries see most often, providers that seniors often have known for years, providers that they trust.

It is imperative that Congress address the problems with the sustainable growth rate formula to eliminate the projected reductions in physician payments. We have only to look to the Medicaid program, which has a long standing history of inadequate payment rates, to see how dramatically this can affect beneficiaries access to care. Continued cuts to physician payments threaten the continued viability of fee-for-service Medicare.

This bill does a curious thing in this regard. It addresses the problem of physician payments—but only for the next three years—through 2005. The next year, doctors will face a significant reduction in payments—as much as 18%—due to the formula, which will mean cuts stretched out over a number of years. Coincidentally, this is right at the time that the Republican "privatization" plan is set to begin.

If physicians are troubled now and are re-evaluating their participation in Medicare after a 5.4% cut—imagine the situation when they are facing an 18% cut. We will see doctors dropping out of the Medicare program and seniors left with no choice but to enroll in private plans.

Therefore, we believe that a permanent solution is required to ensure that physician payments are stable for years to come. Some will say that the provision in the bill is just a temporary fix so that we have time to examine the problem and find a better solution. Democrats, however, believe that our first goal should be to shore up the fee-for-service program and ensure that providers that seniors depend on are not facing uncertainty in payments.

Democrats believe that the fee-for-service program is worth investing in so it can continue to provide the same dependable quality health care that seniors have counted on for more than 35 years.

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LOIS CAPPS.
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TOM SAWYER.
DIANA DEGETTE.
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