107TH CONGRESS
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HOUSE OF REPRESENTATIVES
REPT. 107–541
Part 1

MEDICARE MODERNIZATION AND PRESCRIPTION DRUG ACT OF 2002 (TITLE VI: PROVISIONS RELATING TO PARTS A AND 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

[To accompany H.R. 4987]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 4987) to amend title XVIII of the Social Security Act to improve payments for home health services and for direct graduate medical education, and for other purposes, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

CONTENTS

PURPOSE AND SUMMARY

The purpose of H.R. 4987 is to preserve the home health benefit and shift hospital residency positions to areas where they are needed most. This legislation also establishes two demonstration programs to test new ways to treat Medicare beneficiaries. H.R. 4987

also includes important reforms of the Medicare Payment Advisory Commission.

BACKGROUND AND NEED FOR LEGISLATION

Until 1998, home health care was one of Medicare's fastest growing benefits. Concerns about rising spending, fraud and abuse, and inadequate oversight led Congress to enact a number of initiatives to better control Medicare's home health care costs. In particular, the Balanced Budget Act of 1997 (BBA), P.L. 105–33, mandated that the Centers for Medicare and Medicaid Services (CMS) move away from a cost-based method of payment and implement a prospective payment system (PPS) of fixed, predetermined rates for home health services. The BBA also required aggregate Medicare home health payments in the first year of the PPS to be reduced by 15 percent.

The home health industry has argued that home health agencies have experienced tremendous period of change over the past few years and that the 15 percent reduction will serve to exacerbate the many challenges facing the industry. H.R. 4987 eliminates the scheduled 15 percent reduction in aggregate Medicare home health payments, recognizing the drastic and destabilizing effect such a one-year cut could have on the home health care community. It also adjusts annual updates for home health services to help finance this cut. In addition, the Committee has followed up on the regulatory relief legislation considered last year, addressing the home health industry's top regulatory priority in H.R. 4987—the Outcomes and Assessment Information Set (OASIS). This legislation creates a task force to examine the data collection and reporting requirements of OASIS.

Beneficiary access to physician services is also a priority of the Committee, particularly the geographic distribution of physicians. The Federal government is the largest single financing source for graduate medical education, covering the direct costs of approved medical education programs (such as salaries of residents, interns, and faculty, and other education costs for residents, interns, nurses, and allied health professionals training in hospital-operated programs, including the overhead costs for classroom training) and indirect costs associated with teaching activities and a teaching hospital's research mission. There is continuing concern about the geographic distribution of physicians across the country and the effect such distribution has on beneficiary access to needed medical care. Although the total number of physicians has grown over the years, there continues to be a significant number of areas of the country—both rural and urban—in which there is an inadequate supply of physicians. The current system used to distribute medical residency positions tends to contribute to this disparity, clustering too many positions in areas where they cannot be filled. H.R. 4987 allows CMS to reallocate a certain percentage of unfilled residency positions to areas that are having trouble recruiting physicians. This balanced approach shifts some unfilled positions to rural and small urban areas. At the same time, it does not take away all of the unfilled positions from those hospitals that may be making strides to become more efficient through consolidation.

HEARINGS

The Committee on Energy and Commerce has not held hearings on the legislation.

COMMITTEE CONSIDERATION

On Friday, June 21, 2002, the Full Committee met in open mark-up session and favorably ordered reported a Committee Print on Provisions Relating to Parts A and B by voice vote, as amended, a quorum being present. Chairman Tauzin then introduced H.R. 4987 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 to the measure, including the names of those members voting for and against. A motion by Mr. Tauzin to order H.R. 4987 reported to the House, as amended, was agreed to by a voice vote.

COMMITTEE ON ENERGY AND COMMERCE -- 107TH CONGRESS
ROLL CALL VOTE # 54

BILL: H.R. 4987, Provisions Relating to Parts A and B.

AMENDMENT: An amendment offered by Mr. Waxman, No. 1, for the establishment of reduced copayment for a home health service episode of care for certain beneficiaries.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 0 yeas to 44 nays, and 2 present.

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				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 # 55

BILL: H.R. 4987, Provisions Relating to Parts A and B.

AMENDMENT: An amendment offered by Mr. Engel, No. 5, to strike section 611 relating to extension of update limitation on high cost programs.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 18 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	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				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			
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 has not held oversight or legislative hearings on this legislation.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

The objective of H.R. 4987 is to preserve the home health benefit and shift hospital residency positions to areas where they are needed most.

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. 4987, to amend title XVIII of the Social Security Act to improve payments for home health services and for direct graduate medical education, and for other purposes, would result in no new or increased budget authority, entitlement authority, or tax expenditures or revenues.

COMMITTEE COST ESTIAMTE

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 ESTIAMTE

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

An advisory committee within the meaning of section 5(b) of the Federal Advisory Committee Act is created by this legislation. However, the legislation exempts the task force created in section 603 from the Federal Advisory Committee Act.

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 VI—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

Section 601. Elimination of 15 Percent Reduction in Payment Rates Under the Prospective Payment System

Section 601 eliminates the adjustment to PPS rates based on the 15 percent reduction in the cost limits and per beneficiary limits under the interim payment system. The adjustment would have been effective for episodes of home health care concluding on or after October 1, 2002.

This section takes effect as if included in amendments made by the Benefits Improvement and Protection Act of 2000 (BIPA), P.L. 106–554.

Section 602. Update in Home Health Services

Section 602 changes the implementation of updates to the home health PPS amounts from a fiscal year cycle to a calendar year cycle. It also changes the update for 2003 to 2 percent. The update in 2004 is set at 1.1 percent and the update in 2005 is set at 2.7 percent. Beginning in 2003, the total amount of outlier payments for home health care services in a given year is limited to no more than 3 percent of total projected home health payments.

This section applies to years beginning with 2003.

Section 603. OASIS Task Force; Suspension of Certain OASIS Data Collection Requirements Pending Task Force Submittal of Report

Section 603 requires the Secretary to establish and appoint a task force to examine the data collection and reporting requirements of OASIS. The task force will be composed of staff from CMS with expertise in post-acute care, representatives of home health agencies, health care professionals and research and health quality experts outside the federal government with experience in post-acute care, and advocates for individuals requiring home health services. The task force will review and make recommendations to the Secretary within 18 months of enactment regarding changes in OASIS to improve and simplify data collection for the purposes of assessing the quality of home health services and providing consistency in classification of patients into home health resource groups for payment under the PPS. The task force is mandated to examine the 41 outcome measures currently in use, the timing and frequency of data collection, and the collection of information on comorbidities and clinical indicators. The task force is exempt from the Federal Advisory Committee Act. Further, starting on January 1, 2003 and until the task force submits its report, the Secretary is prohibited from requiring home health agencies to gather and

submit information on patients that are not covered by Medicare and Medicaid.

This section is effective upon enactment.

Section 604. MedPAC Study on Medicare Margins of Home Health Agencies

Section 604 directs the Medicare Payment Advisory Commission (MedPAC) to conduct a study examining whether systematic differences in payment margins for home health agencies are related to differences in case mix. MedPAC must submit a report on this study to Congress within 2 years of enactment.

This section is effective upon enactment.

Section 605. Review of Application of Absence of Infrequent or Short Duration in Establishing Home Confinement for Purposes of Eligibility for Home Health Services

Section 605 directs the Secretary to review the standards used by fiscal intermediaries in allowing infrequent or short duration absences from the home for individuals eligible to receive home health services. The Secretary is directed to specifically examine how the infrequent or short duration absence provision applies to individuals who have permanent and severe disabilities. The Secretary must submit a report to Congress on this review within 6 months of enactment and include findings and recommendations for changes in guidance or regulations respecting the treatment of infrequent or short duration absences.

Subtitle B—Direct Graduate Medical Education

Section 611. Extension of Update Limitation on High Cost Programs

Hospitals with per resident amounts above 140 percent of the geographically adjusted national average amount had payments frozen at current levels in FY 2001 and FY 2002. Payments will continue to be frozen for these hospitals through 2012.

This section is effective upon enactment.

Section 612. Redistribution of Unused Resident Positions

Section 612 redistributes unused resident positions. Starting on July 1, 2003, hospitals can apply to receive these unfilled positions and applications will be accepted through December 31, 2004. The Secretary will consider the need for an increase by specialty and location, first distributing an increase to programs or hospitals located in rural or small urban areas on a first-come-first-served basis, based on a demonstration that the hospital will fill the positions made available under this clause. No hospital can receive more than an increase of 25 full-time equivalent positions during this redistribution process. Hospitals will be reimbursed for direct graduate medical education costs for the new positions they receive at 100 percent of the adjusted national average per resident amount. Those hospitals that have unfilled positions (they have not reached their cap on the number of residents for which Medicare will pay direct graduate medical education costs) and have not met their cap over the past three cost reporting periods will have their cap adjusted. Starting January 1, 2003, their cap will be reduced

by 75 percent of the difference between the cap and the highest number of filled positions over the past three cost reporting periods. In other words, their cap will be adjusted to reflect the highest number of filled positions over the past three cost reporting periods, plus 25 percent of the remaining unfilled positions. Those hospitals that fill positions during the cost reporting period that includes July 1, 2002 can apply to the Secretary for an adjustment to reflect a greater number of filled positions than would otherwise be demonstrated based on their past three cost reporting periods. Reductions in resident counts would affect a hospital's indirect medical education (IME) adjustment. Any resulting increase in resident counts would not affect a hospital's IME adjustment. The Committee encourages the Secretary to consult with appropriate service and education organizations in implementing the redistribution of resident positions as described in this section. Section 612 also directs the Secretary to submit a report to Congress by July 1, 2004, which will recommend whether to extend the application deadline for increases in resident limits.

This section is effective upon enactment.

Subtitle C—Other Provisions

Section 621. Modifications to Medicare Payment Advisory Commission (MedPAC)

Before making any recommendations, MedPAC will examine the budget impact of their recommendations either directly or through consultation with experts. Section 621 also requires MedPAC to review payment policies under Parts A and B, including the factors affecting expenditures for "the efficient provision of" services in different sectors. In addition, MedPAC will conduct a study and submit a report to Congress by June 1, 2003 on the need for current data and data sources to determine the solvency and financial circumstances of hospitals and other Medicare providers. They will also submit a report to Congress by June 1, 2003 on the investments and capital financing of hospitals participating under the Medicare program and related foundations.

This section is effective upon enactment.

Section 622. Demonstration Project for Disease Management for Certain Medicare Beneficiaries with Diabetes

Section 622 directs the Secretary to conduct a demonstration project that will last no longer than 3 years to understand the impact on costs and health outcomes of applying disease management to up to 30,000 Medicare beneficiaries with diabetes. These beneficiaries will be Hispanic, meet specific medical criteria, get their physicians' approval to participate, and will not be enrolled in a Medicare+Choice (M+C) plan. Participants will receive disease management services for their diabetes and be eligible for payment of all prescription drugs whether or not they relate to diabetes (with modest cost-sharing). The Secretary will contract with up to three disease management organizations, which demonstrate that they can produce improved health outcomes and reduce aggregate Medicare expenditures. The contracts will require organizations to: (1) provide prescription drug coverage; (2) receive a negotiated payment established by the Secretary in an effort to reduce expendi-

tures; and, (3) guarantee, through reinsurance, a prohibition on net increases in expenditures. Payments will be made through the Medicare Trust Funds. The Secretary will establish a working group consisting of employees of the Department of Health and Human Services (HHS) to oversee the project, establish policy and criteria for Medicare disease management programs, identify targeted medical conditions and individuals, select areas for such programs, monitor health outcomes under such programs, measure the effectiveness of such programs in meeting budget neutrality requirements, and serve as a central focal point within HHS for dissemination of information on programs. Participants will be offered certain protections for the period of the demonstration project that are afforded to Medicare beneficiaries enrolled in M+C plans with respect to their existing Medicare supplemental insurance policies. Section 622 requires the Secretary to submit to Congress an interim report of the project within 2 years of implementation and a final report within 6 months of completion. Reports will include costs and health outcomes associated with the program and recommendations on the cost-effectiveness of extending or expanding the project. In addition, this section requires the Comptroller General to compare Medicare disease management programs to private sector programs, identifying the cost-effectiveness of such programs and savings realized by such programs. A report will be submitted to Congress within 18 months of enactment.

This section is effective upon enactment.

Section 623. Demonstration Project for Medical Adult Day Care Services

Section 623 directs the Secretary to establish a demonstration project for home health agencies to directly or under arrangements with a medical adult day care facility provide medical adult day care services as a substitute for certain home health services that would otherwise be provided at home. The payment amount for the episode of care, including the medical adult day care service, under the demonstration project will be at a rate of 95 percent of the amount that would otherwise apply for such home health services. Home health agencies or medical adult day care facilities may not separately charge a beneficiary for medical adult day care services furnished under the plan of care. The demonstration project will not result in additional expenditures from the Trust Funds—aggregate payments under the home health PPS will be reduced to reflect any increases in amounts expended as a result of the demonstration project. The project will be conducted in up to five sites in States chosen by the Secretary that license or certify providers of medical adult day care services for a period of 3 years. Up to 15,000 beneficiaries can participate in the project on a voluntary basis. The Secretary will give preference to home health agencies that are currently licensed or certified to provide medical adult day care services and have provided such services to Medicare beneficiaries for a continuous 2-year period prior to the project. The Secretary may waive requirements under title XVIII of the Social Security Act except for the requirement that the beneficiary be homebound in order to be eligible for home health care. Section 623 also directs the Secretary to conduct an evaluation of the clinical and cost-effectiveness of the demonstration project. A report to

Congress will be submitted within 30 months of project initiation and will include a comparative analysis of the patient outcomes and cost of care between settings of care and recommendations on program extension, expansion, or termination. Section 623 defines home health agency as it is defined in previous statute. In this section, medical adult day care facility means a facility that has been licensed or certified by a State to provide medical adult day care services for a continuous 2-year period, is engaged in providing skilled nursing services and other therapeutic services directly or under agreement with a home health agency, and meets standards established by the Secretary to ensure quality of care and patient safety. Medical adult day care services are defined as home health services provided in a medical adult day care facility, a program of supervised activities furnished in a group setting in a facility that is designed to promote the physical and mental health of the individuals, and any other services specified by the Secretary. Medicare beneficiary under this section means an individual enrolled in either Part A, Part B, or both.

This section is effective upon enactment.

The Committee believes it is important for CMS to include in the annual Medicare statement of benefits useful information to seniors, such as the ability of seniors to participate in clinical trials. Should the Administrator of CMS choose to include such information in this format, the Committee urges the Administrator in such statement to direct seniors to government-sponsored sites on the world wide web wherein this information is located.

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

* * * * * * *

MEDICARE PAYMENT ADVISORY COMMISSION

SEC. 1805. (a) * * *

(b) DUTIES.—

(1) * * *

(2) SPECIFIC TOPICS TO BE REVIEWED.—

(A) * * *

(B) ORIGINAL MEDICARE FEE-FOR-SERVICE SYSTEM.—Specifically, the Commission shall review payment policies under parts A and B, including—

(i) the factors affecting expenditures for *the efficient provision of* services in different sectors, including the

process for updating hospital, skilled nursing facility, physician, and other fees,

* * * * * * *

(8) EXAMINATION OF BUDGET CONSEQUENCES.—Before making any recommendations, the Commission shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities.

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PART D—MISCELLANEOUS PROVISIONS

* * * * * * *

PAYMENT TO HOSPITALS FOR INPATIENT HOSPITAL SERVICES

SEC. 1886. (a) * * *
(d)(1) * * *

* * * * * * *

(5)(A) * * *
(B) The Secretary shall provide for an additional payment amount for subsection (d) hospitals with indirect costs of medical education, in an amount computed in the same manner as the adjustment for such costs under regulations (in effect as of January 1, 1983) under subsection (a)(2), except as follows:
(i) * * *

* * * * * * *

(v) In determining the adjustment with respect to a hospital for discharges occurring on or after October 1, 1997, the total number of full-time equivalent interns and residents in the fields of allopathic and osteopathic medicine in either a hospital or nonhospital setting may not exceed the number (or, 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent interns and residents in the hospital with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996. Rules similar to the rules of subsection (h)(4)(F)(ii) shall apply for purposes of this clause. *The provisions of clause (i) of subparagraph (I) of subsection (h)(4) shall apply with respect to the first sentence of this clause in the same manner as it applies with respect to subparagraph (F) of such subsection, but the provisions of clause (ii) of such subparagraph shall not apply.*

* * * * * * *

(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.—

(i) * * *

* * * * * * *

(iv) ADJUSTMENT IN RATE OF INCREASE FOR HOSPITALS WITH FTE APPROVED AMOUNT ABOVE 140 PERCENT OF LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—

(I) FREEZE FOR FISCAL YEARS 2001 [AND 2002] *THROUGH 2012*.—For a cost reporting period beginning [during fiscal year 2001 or fiscal year 2002] *during the period beginning with fiscal year 2001 and ending with fiscal year 2012*, if the approved FTE resident amount for a hospital for the preceding cost reporting period exceeds 140 percent of the locality adjusted national average per resident amount computed under subparagraph (E) for that hospital and period, [subject to subclause (III),] the approved FTE resident amount for the period involved shall be the same as the approved FTE resident amount for the hospital for such preceding cost reporting period.

[(II) 2 PERCENT DECREASE IN UPDATE FOR FISCAL YEARS 2003, 2004, AND 2005.—For a cost reporting period beginning during fiscal year 2003, fiscal year 2004, or fiscal year 2005, if the approved FTE resident amount for a hospital for the preceding cost reporting period exceeds 140 percent of the locality adjusted national average per resident amount computed under subparagraph (E) for that hospital and preceding period, the approved FTE resident amount for the period involved shall be updated in the manner described in subparagraph (D)(i) except that, subject to subclause (III), the consumer price index applied for a 12-month period shall be reduced (but not below zero) by 2 percentage points.]

[(III)] *(II)* NO ADJUSTMENT BELOW 140 PERCENT.—In no case shall subclause (I) [or (II)] reduce an approved FTE resident amount for a hospital for a cost reporting period below 140 percent of the locality adjusted national average per resident amount computed under subparagraph (E) for such hospital and period.

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(4) DETERMINATION OF FULL-TIME-EQUIVALENT RESIDENTS.—

(A) * * *

* * * * * * *

(F) LIMITATION ON NUMBER OF RESIDENTS IN ALLOPATHIC AND OSTEOPATHIC MEDICINE.—

(i) IN GENERAL.—Such rules shall provide that for purposes of a cost reporting period beginning on or after October 1, 1997, *subject to subparagraph (I),* the

total number of full-time equivalent residents before application of weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic medicine and osteopathic medicine may not exceed the number (or, 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.

* * * * * * *

(H) SPECIAL RULES FOR APPLICATION OF SUBPARAGRAPHS (F) AND (G).—

(i) NEW FACILITIES.—The Secretary shall, consistent with the principles of subparagraphs (F) and (G), *subject to subparagraph (I),* prescribe rules for the application of such subparagraphs in the case of medical residency training programs established on or after January 1, 1995. In promulgating such rules for purposes of subparagraph (F), the Secretary shall give special consideration to facilities that meet the needs of underserved rural areas.

* * * * * * *

(I) REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.—

(i) REDUCTION IN LIMIT BASED ON UNUSED POSITIONS.—

(I) IN GENERAL.—If a hospital's resident level (as defined in clause (iii)(I)) is less than the otherwise applicable resident limit (as defined in clause (iii)(II)) for each of the reference periods (as defined in subclause (II)), effective for cost reporting periods beginning on or after January 1, 2003, the otherwise applicable resident limit shall be reduced by 75 percent of the difference between such limit and the reference resident level specified in subclause (III) (or subclause (IV) if applicable).

(II) REFERENCE PERIODS DEFINED.—In this clause, the term "reference periods" means, for a hospital, the 3 most recent consecutive cost reporting periods of the hospital for which cost reports have been settled (or, if not, submitted) on or before September 30, 2001.

(III) REFERENCE RESIDENT LEVEL.—Subject to subclause (IV), the reference resident level specified in this subclause for a hospital is the highest resident level for the hospital during any of the reference periods.

(IV) ADJUSTMENT PROCESS.—Upon the timely request of a hospital, the Secretary may adjust the reference resident level for a hospital to be the resident level for the hospital for the cost reporting period that includes July 1, 2002.

(ii) REDISTRIBUTION.—

(I) IN GENERAL.—The Secretary is authorized to increase the otherwise applicable resident limits for hospitals by an aggregate number estimated by the Secretary that does not exceed the aggregate reduction in such limits attributable to clause (i) (without taking into account any adjustment under subclause (IV) of such clause).

(II) EFFECTIVE DATE.—No increase under subclause (I) shall be permitted or taken into account for a hospital for any portion of a cost reporting period that occurs before July 1, 2003, or before the date of the hospital's application for an increase under this clause. No such increase shall be permitted for a hospital unless the hospital has applied to the Secretary for such increase by December 31, 2004.

(III) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subclause (I), the Secretary shall take into account the need for such an increase by specialty and location involved, consistent with subclause (IV).

(IV) PRIORITY FOR RURAL AND SMALL URBAN AREAS.—In determining for which hospitals and residency training programs an increase in the otherwise applicable resident limit is provided under subclause (I), the Secretary shall first distribute the increase to programs of hospitals located in rural areas or in urban areas that are not large urban areas (as defined for purposes of subsection (d)) on a first-come-first-served basis (as determined by the Secretary) based on a demonstration that the hospital will fill the positions made available under this clause and not to exceed an increase of 25 full-time equivalent positions with respect to any hospital.

(V) APPLICATION OF LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—With respect to additional residency positions in a hospital attributable to the increase provided under this clause, notwithstanding any other provision of this subsection, the approved FTE resident amount is deemed to be equal to the locality adjusted national average per resident amount computed under subparagraph (E) for that hospital.

(VI) CONSTRUCTION.—Nothing in this clause shall be construed as permitting the redistribution of reductions in residency positions attributable to voluntary reduction programs under paragraph (6) or as affecting the ability of a hospital to establish new medical residency training programs under subparagraph (H).

(iii) RESIDENT LEVEL AND LIMIT DEFINED.—In this subparagraph:

(I) RESIDENT LEVEL.—The term "resident level" means, with respect to a hospital, the total number of full-time equivalent residents, before the application of weighting factors (as determined under this paragraph), in the fields of allopathic and osteopathic medicine for the hospital.

(II) OTHERWISE APPLICABLE RESIDENT LIMIT.—The term "otherwise applicable resident limit" means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) on the resident level for the hospital determined without regard to this subparagraph.

* * * * * * *

PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES

SEC. 1895. (a) * * *

(b) SYSTEM OF PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES.—

(1) * * *

* * * * * * *

(3) PAYMENT BASIS.—

[(A) INITIAL BASIS.—

[(i) IN GENERAL.—Under such system the Secretary shall provide for computation of a standard prospective payment amount (or amounts) as follows:

[(I) Such amount (or amounts) shall initially be based on the most current audited cost report data available to the Secretary and shall be computed in a manner so that the total amounts payable under the system for the 12-month period beginning on the date the Secretary implements the system shall be equal to the total amount that would have been made if the system had not been in effect.

[(II) For the 12-month period beginning after the period described in subclause (I), such amount (or amounts) shall be equal to the amount (or amounts) determined under subclause (I), updated under subparagraph (B).

[(III) For periods beginning after the period described in subclause (II), such amount (or amounts) shall be equal to the amount (or amounts) that would have been determined under subclause (I) that would have been made for fiscal year 2001 if the system had not been in effect and if section 1861(v)(1)(L)(ix) had not been enacted but if the reduction in limits described in clause (ii) had been in effect, updated under subparagraph (B).

Each such amount shall be standardized in a manner that eliminates the effect of variations in relative case mix and area wage adjustments among different home health agencies in a budget neutral manner consistent with the case mix and wage level adjustments pro-

vided under paragraph (4)(A). Under the system, the Secretary may recognize regional differences or differences based upon whether or not the services or agency are in an urbanized area.

[(ii) REDUCTION.—The reduction described in this clause is a reduction by 15 percent in the cost limits and per beneficiary limits described in section 1861(v)(1)(L), as those limits are in effect on September 30, 2000.]

(A) INITIAL BASIS.—Under such system the Secretary shall provide for computation of a standard prospective payment amount (or amounts) as follows:

(i) Such amount (or amounts) shall initially be based on the most current audited cost report data available to the Secretary and shall be computed in a manner so that the total amounts payable under the system for fiscal year 2001 shall be equal to the total amount that would have been made if the system had not been in effect and if section 1861(v)(1)(L)(ix) had not been enacted.

(ii) For fiscal year 2002 and for the first quarter of fiscal year 2003, such amount (or amounts) shall be equal to the amount (or amounts) determined under this paragraph for the previous fiscal year, updated under subparagraph (B).

(iii) For 2003, such amount (or amounts) shall be equal to the amount (or amounts) determined under this paragraph for fiscal year 2002, updated under subparagraph (B) for 2003.

(iv) For 2004 and each subsequent year, such amount (or amounts) shall be equal to the amount (or amounts) determined under this paragraph for the previous year, updated under subparagraph (B).

Each such amount shall be standardized in a manner that eliminates the effect of variations in relative case mix and area wage adjustments among different home health agencies in a budget neutral manner consistent with the case mix and wage level adjustments provided under paragraph (4)(A). Under the system, the Secretary may recognize regional differences or differences based upon whether or not the services or agency are in an urbanized area.

(B) ANNUAL UPDATE.—

(i) IN GENERAL.—The standard prospective payment amount (or amounts) shall be adjusted for [each fiscal year (beginning with fiscal year 2002)] *fiscal year 2002 and for each subsequent year (beginning with 2003)* in a prospective manner specified by the Secretary by the home health applicable increase percentage (as defined in clause (ii)) applicable to the fiscal year *or year* involved.

(ii) HOME HEALTH APPLICABLE INCREASE PERCENTAGE.—For purposes of this subparagraph, the term "home health applicable increase percentage" means, with respect to—

(I) [each of fiscal years 2002 and 2003] *fiscal year 2002, the home health market basket percentage increase (as defined in clause (iii)) minus 1.1 percentage points;*

(II) 2003, [the home health market basket percentage increase (as defined in clause (iii)) minus 1.1 percentage points] *2.0 percentage points*; [or]

(III) 2004, 1.1 percentage points;

(IV) 2005, 2.7 percentage points; or

[(II)] *(V)* any subsequent [fiscal] year, the home health market basket percentage increase.

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

(iv) ADJUSTMENT FOR CASE MIX CHANGES.—Insofar as the Secretary determines that the adjustments under paragraph (4)(A)(i) for a previous fiscal year *or year* (or estimates that such adjustments for a future fiscal year *or year*) did (or are likely to) result in a change in aggregate payments under this subsection during the fiscal year *or year* that are a result of changes in the coding or classification of different units of services that do not reflect real changes in case mix, the Secretary may adjust the standard prospective payment amount (or amounts) under paragraph (3) for subsequent fiscal years *or years* so as to eliminate the effect of such coding or classification changes.

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(5) OUTLIERS.—The Secretary may provide for an addition or adjustment to the payment amount otherwise made in the case of outliers because of unusual variations in the type or amount of medically necessary care. The total amount of the additional payments or payment adjustments made under this paragraph with respect to a fiscal year *or year* may not exceed [5] *3* percent of the total payments projected or estimated to be made based on the prospective payment system under this subsection in that year.

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